Department of Regulatory Agencies

Office of Policy, Research and Regulatory Reform

2008 Sunset Review: Colorado Board of Nursing

October 15, 2008

Consumer Protection

Department of Regulatory Agencies

Executive Director's Office
D. Rico Munn
Executive Director

Bill Ritter, Jr.
Governor

October 15, 2008

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunset reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed the evaluation of the Colorado Board of Nursing. I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2009 legislative committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), which states in part:

> The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...
>
> The department of regulatory agencies shall submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination….

The report discusses the question of whether there is a need for the regulation provided under Article 38 of Title 12, C.R.S. The report also discusses the effectiveness of the Board of Nursing and Division of Registrations staff in carrying out the intent of the statutes and makes recommendations for statutory and administrative changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

D. Rico Munn
Executive Director

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Department of Regulatory Agencies

2008 Sunset Review:
Colorado Board of Nursing

Summary

What Is Regulated?
Registered nurses (RNs, also called professional nurses) and licensed practical nurses (LPNs).

Why Is It Regulated?
To assure that registered and practical nurses meet a standard level of competency.

Who Is Regulated?
In fiscal year 06-07 there were a total of 67,009 active nurses. Of these, 56,918 were RNs and 10,091 were LPNs.

How Is It Regulated?
The Colorado Board of Nursing (Board) is housed in the Division of Registrations of the Department of Regulatory Agencies. The Board licenses RNs and LPNs, and approves education programs preparing nurses for licensure. Applicants for RN or LPN licensure must demonstrate having completed an approved nursing education program and pass a national licensing examination. To qualify for Board approval, a nursing education program must demonstrate that it has sufficient financial, administrative, and clinical resources to operate such program, and the program's curriculum, faculty, and leadership must meet specific requirements.

What Does It Cost?
The fiscal year 06-07 expenditure to oversee this program was $2.9 million, and there were 15.5 full-time equivalent employees associated with this program.

What Disciplinary Activity Is There?
For the period fiscal year 02-03 through fiscal year 06-07, the Board issued 773 disciplinary actions including revocation of licenses, suspension of licenses, probation, letters of admonition, denial of licenses and injunctions.

Where Do I Get the Full Report?
The full sunset review can be found on the internet at: www.dora.state.co.us/opr/oprpublications.htm.

Key Recommendations

Continue the Board of Nursing and the regulation of registered nurses and licensed practical nurses for 11 years, until 2020.
The number of people employed in the nursing professions and the broad array of skill sets and practice settings among licensees makes for a complex regulatory environment. Consumers could not be reasonably expected to have the expertise to determine whether individuals are minimally competent to provide nursing care. The Board, through its licensing, enforcement activities, as well as its role in approving nursing education programs and facilitating Colorado's compliance with changes in national nursing regulation, provides a vitally important public service. For these reasons, the Board should be continued.

Modify the collaborative agreement requirement for advanced practice nurses with prescriptive authority, and remove the limitations on the types of medication that such nurses may prescribe.
Sections 12-38-111.6(3)(a) and (b), C.R.S., place restrictions on the types of medications that advanced practice nurses (APNs) with prescriptive authority may prescribe. Because these restrictions may compromise patient care by prohibiting qualified APNs from prescribing medications within their scope of practice, the restrictions should be lifted. Further, the collaborative agreement requirement as it currently stands is flawed. As the first step in improving the framework for collaborative agreements, the General Assembly should make several statutory changes regarding these agreements.

Repeal the Nursing Shortage Alleviation Act of 2002.
The Nursing Shortage Alleviation Act of 2002 (Act) suggests that the Board collaborate with the Department of Public Health and Environment to identify and encourage remedies for Colorado's nursing shortage. The Act contains no mandates, and does not grant the Board any additional powers. No funding or resources were provided to implement the provisions of the Act. The Board has numerous legislative mandates to fulfill, and cannot neglect its public protection activities in order to pursue the worthy—but ultimately optional—objectives outlined in the Act. Lacking additional funding and resources, the Board cannot be reasonably expected to implement the Act. Therefore, the Act should be repealed.

Major Contacts Made During This Review

American Association of Retired Persons
American Diabetes Association
Center for Nursing Excellence
Center for People with Disabilities
Colorado Board of Medical Examiners
Colorado Board of Nursing
Colorado Community College System
Colorado Cross-Disability Coalition
Colorado Department of Law
Colorado Federation of Nursing Organizations
Colorado Health Care Association
Colorado Hospital Association
Colorado Medical Society
Colorado Nurses Association
Colorado Society of Anesthesiologists
COPIC Insurance Company
Home Care Association of Colorado
National Association of School Nurses
Visiting Nurses Association

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether or not they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are Prepared by:
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Background

Introduction

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are based on the following statutory criteria:

- Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;
- If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;
- Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;
- Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;
- The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;
- Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;
- Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;
- Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

[1] Criteria may be found at § 24-34-104, C.R.S.

Types of Regulation

Regulation, when appropriate, can serve as a bulwark of consumer protection. Regulatory programs can be designed to impact individual professionals, businesses or both.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

Regulation, then, has many positive and potentially negative consequences.

There are also several levels of regulation.

Licensure

Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Title Protection

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

Regulation of Businesses

As regulatory programs relate to businesses, they can enhance public protection, promote stability and preserve profitability. But they can also reduce competition and place administrative burdens on the regulated businesses.

Regulatory programs that address businesses can involve certain capital, bookkeeping and other recordkeeping requirements that are meant to ensure financial solvency and responsibility, as well as accountability. Initially, these requirements may serve as barriers to entry, thereby limiting competition. On an ongoing basis, the cost of complying with these requirements may lead to greater administrative costs for the regulated entity, which costs are ultimately passed on to consumers.

Many programs that regulate businesses involve examinations and audits of finances and other records, which are intended to ensure that the relevant businesses continue to comply with these initial requirements. Although intended to enhance public protection, these measures, too, involve costs of compliance.

Similarly, many regulated businesses may be subject to physical inspections to ensure compliance with health and safety standards.

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. To facilitate input from interested parties, anyone can submit input on any upcoming sunrise or sunset review via DORA's website at: www.dora.state.co.us/pls/real/OPR_Review_Comments.Main.

The regulatory functions of the Colorado Board of Nursing (Board) relating to Article 38 of Title 12, Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2009, unless continued by the General Assembly. During the year prior to this date, it is the duty of DORA to conduct an analysis and evaluation of the Board pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed regulation of registered and practical nurses should be continued for the protection of the public and to evaluate the performance of the Board and staff of the Division of Registrations (Division). During this review, the Division must demonstrate that the Board and regulation serve to protect the public health, safety or welfare, and that the regulation is the least restrictive regulation consistent with protecting the public. DORA's findings and recommendations are submitted via this report to the legislative committee of reference of the Colorado General Assembly.

Methodology

As part of this review, DORA staff attended Board meetings; interviewed Division staff; interviewed Board members; reviewed Board records and minutes, including complaint and disciplinary actions; interviewed officials with state and national professional associations; interviewed health care providers; visited nursing education programs; reviewed Colorado statutes and rules; and reviewed the laws of other states.

Profile of the Profession

Nursing has evolved considerably since Florence Nightingale planted the seeds for the modern nursing profession in the mid-19th century. At one time, nurses served primarily as assistants to physicians, working under close supervision and providing direct bedside care. In the 21st century, nurses are as likely to be administering medications and developing complex treatment plans as they are to be providing bedside care.

While nursing theory is grounded in scientific knowledge, nurses consider a patient's physical health in tandem with the patient's social, emotional, and psychological well-being. Nurses assess patients, develop plans of care, educate patients and the public about medical issues, promote health and wellness, and provide support and advice to patients and their families.

Nurses work in a wide variety of settings, from facilities providing long-term and rehabilitative care, to hospitals, clinics, schools, and military bases. Nurses may also provide care in patients' homes.

Generally speaking, the term "nurse" encompasses two distinct professions that differ in their educational preparation and scope of practice: licensed professional or registered nurses (RNs) and licensed practical nurses (LPNs, also called licensed vocational nurses).

The practice of registered nursing consists of both independent nursing functions as well as tasks delegated by a physician or other medical professional pursuant to a medical treatment plan.

Critical functions forming the core of professional nursing practice include comprehensive nursing assessment, wherein the RN evaluates the patient's health status, in concert with any social and psychological factors; developing health care plans; recommending nursing interventions; and developing a strategy for delivery of nursing services.

RNs may choose to specialize their practice in several ways. They may focus on a particular setting**,** such as perioperative, which involves caring for patients before, during, and after surgery; on the management of specific health conditions, such as diabetes; on a particular organ or body system type, such as dermatology or cardiology; or on a particular population, such as the elderly (geriatric).[2]

[2] Occupational Outlook Handbook, 2008-2009 Edition, U. S. Department of Labor, Bureau of Labor Statistics. *Registered Nurses*. Retrieved June 9, 2008, from http://stats.bls.gov/oco/print/ocos083.htm

RNs may choose to pursue advanced practice designation. Advanced practice nurses (APNs) fall into the following four categories: nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists. APNs possess specialized skills and education in their respective areas of specialty. Although the requirements for advanced practice designation vary from state to state, generally speaking, APNs hold a master's or doctoral degree in nursing and have passed a national certification examination. Depending on their specific education and training, APNs may prescribe medications, deliver babies, or administer anesthesia.

LPNs are more limited in their scope and autonomy. Although they may administer medications and supervise nursing assistants, they typically work under the direction of a professional nurse, physician, or other medical professional and play an assistive role in assessing clients and developing care plans. LPNs are more likely than RNs to regularly assist patients with activities of daily living, such as bathing and dressing. LPNs play a particularly critical role in long-term care and home health settings, where they often hold leadership positions.

To qualify for RN or LPN licensure in the United States and its territories, candidates must first graduate from an approved nursing program. All nursing programs include both a didactic and a clinical component.

Aspiring RNs may choose to seek a diploma, associate's degree, or bachelor's degree in nursing. Once the primary educational route for nurses but now relatively uncommon, diploma programs are conducted by hospitals and take about three years to complete. Associate degree programs are offered by community colleges and take between two and three years to complete. Baccalaureate programs are typically housed at colleges or universities and take an average of four years to complete. Although a bachelor's level preparation may give candidates better job prospects, all three types of education programs are intended to prepare students for entry-level registered nursing positions.

Aspiring LPNs must complete an approved practical nursing program. These programs, which typically take one year to complete, may be housed in community colleges, vocational and technical schools, or colleges and universities.

Once they have graduated from a nursing education program, nursing candidates must pass a national licensing examination. RN candidates take the National Council Licensure Examination for Registered Nurses (NCLEX-RN) and LPN candidates must pass the National Council Licensure Examination for Practical Nurses (NCLEX-PN).

Once licensed, nurses may apply for licensure in additional states on the basis of their initial license (licensure by endorsement). Licensure by endorsement may become less common in the future, however, due to the implementation of the Nurse Licensure Compact (Compact). The Compact allows nurses who are licensed and reside in one of the member states to practice in the other member states without obtaining additional licensure. As of July 1, 2008, 23 states—including Colorado— are members of the Compact.

Nationwide, RNs form the largest occupational group in health care, holding about 2.5 million jobs in 2006. Over the coming decade, employment opportunities for RNs are projected to grow at a much faster rate than other health care and non-health care occupations. Median annual earnings of RNs were $57,280 in May 2006. The lowest-paid 10 percent earned less than $40,250, and the highest-paid 10 percent earned more than $83,440.[3]

LPNs can also look forward to rapid growth in employment opportunities, especially in the long-term care and home health settings. Median annual earnings for LPNs were $36,550 in May 2006. The lowest-paid 10 percent earned less than $26,380, and the highest 10 percent earned more than $50,480.[4]

History of Regulation

In 1905, the Colorado General Assembly created the State Board of Nurse Examiners (BNE) to maintain a registry of professional nurses. The duties of the BNE included administering examinations, issuing licenses, and revoking the licenses of those who violated the law.[5]

In 1957, the BNE was expanded from five to nine members and was granted the power to accredit nursing education programs in the state. Further, the legislature adopted the American Nurses Association's model definition of nursing, which established that some nursing tasks could be performed without physician supervision. The model definition did, however, specifically prohibit nurses from diagnosing and prescribing medications.[6] The definition was expanded to include diagnosis in 1973.

State regulation of LPNs began in 1957, with passage of Senate Bill 57-125. The bill created the Practical Nursing Practice Act (Act) and vested licensing authority with a Board of Practical Nursing (BPN). Ten years later, the Act was changed to grant LPNs authority to administer, under the direction of a professional nurse, selected treatments and medications prescribed by a physician or dentist.[7]

In response to a 1978 sunset recommendation, the General Assembly passed Senate Bill 80-105, merging the BNE and the BPN into a single Board of Nursing (Board) effective July 1, 1980. With the passage of this bill, regulation of professional and practical nurses was placed under the authority of the unified Board, and a uniform Nurse Practice Act (NPA) was put into place.

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[3] Occupational Outlook Handbook, 2008-2009 Edition, U. S. Department of Labor, Bureau of Labor Statistics. *Registered Nurses*. Retrieved June 9, 2008, from http://stats.bls.gov/oco/print/ocos083.htm

[4] Occupational Outlook Handbook, 2008-2009 Edition, U. S. Department of Labor, Bureau of Labor Statistics. *Licensed Practical and Licensed Vocational Nurses*. Retrieved June 9, 2008, from http://stats.bls.gov/oco/print/ocos102.htm

[5] *Sunset Review of the Colorado Board of Nursing,* Colorado Department of Regulatory Agencies (1994), p.1.

[6] "History of Nursing Regulation," Adapted from a white paper by Gloria Damgard, RN, MSN, *et al*., Colleagues in Caring Project, South Dakota Consortium, South Dakota Board of Nursing (2000), p. 2.

[7] *Sunset Review of the Colorado Board of Nursing,* Colorado Department of Regulatory Agencies (1994), p.2.

With the enactment of the 1980 version of the NPA, the definition of the practice of professional nursing was revised to include independent nursing functions and delegated medical functions.[8] Further, the new NPA granted LPNs the authority to supervise other health care personnel.[9]

In 1994, the General Assembly passed House Bill 94-1081, which created a registry for advanced practice nurses. The bill authorized title protection for all advanced practice nurses, including the four sub-categories of certified nurse midwife, clinical nurse specialist, certified registered nurse anesthetist, and nurse practitioner.

The 1994 sunset review of the Board culminated in the passage of House Bill 95-1007. The bill made numerous changes to the NPA, most notably, formalizing the process whereby advanced practice nurses (APNs) could prescribe medication. Under the bill, APNs meeting specified educational and experiential requirements could apply to the Board for prescriptive authority. While this authority is limited, it allows APNs to prescribe certain medications without physician supervision.

In 1999, the General Assembly passed Senate Bill 99-046, which directed the Board president to divide the Board into two inquiry panels. These panels were to meet as frequently as needed to review complaints against licensees, dismiss or order investigation of such complaints, take disciplinary actions, and determine whether to grant or deny licensure to applicants with criminal convictions. Historically, the Board had met quarterly to consider matters relating to licensing, discipline, education, and policy. This relatively infrequent meeting schedule, coupled with a high number of licensees and a correspondingly high number of complaints, resulted in considerable administrative delay. The creation of the panel system was intended to streamline the Board's regulatory activities.

In 2001, the General Assembly enacted House Bill 01-1023, which created a new "retired-volunteer" license status. This license status allowed RNs and LPNs over the age of 65 wishing to practice nursing on a volunteer basis to renew their licenses for a reduced fee.

In 2002, as Colorado grappled with an increasingly dire shortage of nurses, the General Assembly created the Nursing Shortage Alleviation Act. The bill empowered the Board to forge collaborative relationships with other state agencies, as well as the private sector, in order to develop solutions for Colorado's shortage of qualified nurses. Although the bill granted the Board the power to seek and accept donations for a nursing shortage fund, the bill lacked any specific mandates.

[8] Colorado Department of Regulatory Agencies, *Sunset Review of the Colorado Board of Nursing* (1994), p.1.
[9] Colorado Department of Regulatory Agencies, *Sunset Review of the Colorado Board of Nursing* (1994), p.2.

The General Assembly passed Senate Bill 03-050 in 2003. This legislation directed the Board to design a questionnaire to be completed by every Colorado-licensed RN and LPN at the time of renewal. The purpose of the questionnaire was to identify practitioners whose practice may endanger the public. This legislation sought to correct a loophole whereby a licensee who was convicted of a crime after being granted initial licensure might never come to the attention of the Board. The new law made licensees responsible for self-disclosing any conduct that might be grounds for discipline.

Senate Bill 06-020 laid the groundwork for the implementation of the Nurse Licensure Compact (Compact), a mutual recognition model of nurse licensure that allows a nurse licensed in one Compact state to practice in all Compact states on the basis of that license. The Board was vested with the authority to administer the provisions of the Compact in Colorado.

In March of 2007, Governor Ritter signed an executive order creating the Nurse Workforce and Patient Care Taskforce. The 14-member taskforce was charged with developing standards and processes for the measurement of nurses' contributions to the quality of patient care in licensed health care facilities. The taskforce published its final report in December 2007.

In February 2008, Governor Ritter signed an executive order commissioning the Collaborative Scopes of Care Study, and creating an advisory committee to provide guidance and advice throughout the process. The purpose of the study is to provide a systematic review and analysis of available research regarding the scopes of practice of mid-level health care providers, including APNs. The study will be published by December 31, 2008.

Legal Framework

The laws relating to nursing regulation in Colorado are contained within Article 38 of Title 12, Colorado Revised Statutes (C.R.S.). These laws are known collectively as the Nurse Practice Act (NPA).

The Colorado Board of Nursing (Board) is housed in the Division of Registrations (Division) of the Department of Regulatory Agencies (DORA). The Governor appoints the Board's eleven members, with Senate confirmation. Representation on the Board is as follows:[10]

- Two licensed practical nurses (LPNs) currently practicing as such, one of whom must be employed by a rural hospital;
- Seven registered nurses (RNs), including:
    - One engaged in professional nursing education;
    - One engaged in practical nursing education;
    - One engaged in nursing service administration;
    - One employed in home health care;
    - One registered as an advanced practice nurse pursuant to section 12-38-111.5, C.R.S.; and
    - Two staff nurses, one of whom is employed in a hospital and the other in a nursing care facility; and
- Two public members, who are not licensed, employed, or in any way connected with any health care facility, agency or insurer.

All Board members must be Colorado residents. All members holding nursing positions must be licensed in Colorado and be actively employed in their respective nursing professions: the RN members must have been so employed for at least three years.[11]

Board members serve three-year terms,[12] and may serve no more than two consecutive terms.[13] The Board must annually elect one of its members as president.[14]

The Board must meet at least quarterly.[15] Board members are entitled to a $50 per diem for days spent at Board meetings and hearings as well as reimbursement for actual and necessary expenses incurred in the discharge of their official duties.[16]

[10] § 12-38-104(1)(a), C.R.S.
[11] § 12-38-104(1)(b), C.R.S.
[12] § 12-38-104(1)(c)(I), C.R.S.
[13] § 12-38-104(1)(c)(III), C.R.S.
[14] § 12-38-104(1.5), C.R.S.
[15] § 12-38-106, C.R.S.
[16] §§ 12-38-104(3) and 24-34-102(13), C.R.S.

The powers and duties of the Board include:[17]

- To approve education programs preparing individuals for licensure;
- To issue and renew licenses of qualified applicants;
- To revoke, suspend, withhold, limit the scope of, or refuse to renew the license of any nurse who has violated the NPA;
- To place on probation or issue a letter of admonition to any nurse who has violated the NPA;
- To adopt rules and regulations;
- To investigate and conduct hearings;
- To charge and collect appropriate fees; and
- To provide for the recognition of nurse licenses from other states, including administering the provisions of the Nurse Licensure Compact (Compact).

The director of the Division appoints an executive officer and other necessary personnel to assist the Board in enforcing the provisions of the NPA.[18]

Licensing

Licensing qualified applicants forms the bulk of the Board's work. The Board delegates the authority to carry out most routine licensing functions, including issuing and renewing licenses, to the executive officer. [19]

For both RNs and LPNs, there are two primary routes to licensure: license by examination and license by endorsement.

To qualify for licensure by examination, an applicant must:[20]

- Submit a completed application;
- Provide evidence of having completed a professional or practical nursing education program that meets Board-established standards;
- Provide evidence that he or she is not addicted to any controlled substance or habitually intemperate in the use of intoxicating liquor;
- Provide evidence that he or she is lawfully present in the United States;[21]
- Pass a written examination; and
- Pay the required fee.

[17] § 12-38-108(1), C.R.S.
[18] § 12-38-107, C.R.S.
[19] § 12-38-108(1)(c), C.R.S.
[20] §§ 12-38-111(1) and 12-38-112(1), C.R.S.
[21] § 24-34-107(1)(a), C.R.S.

Applicants seeking licensure by examination must pass either the National Council Licensure Examination for Registered Nurses (NCLEX-RN) or the National Council Licensure Examination for Practical Nurses (NCLEX-PN). Both examinations are intended to test applicants on the knowledge, skills and judgments acquired in their respective nursing education programs.[22]

To qualify for licensure by endorsement, applicants must fulfill the above requirements, with one exception: instead of providing evidence of having passed the examination, applicants must provide verification of licensure in another state or territory of the United States, and present documentation that they possess credentials and qualifications that are substantially equivalent to Colorado's requirements for licensure by examination.[23]

Applicants who are licensed as RNs or LPNs in countries other than the United States may qualify for licensure by endorsement if the Board is able to establish that the applicants possess qualifications that are substantially equivalent to those for licensure by examination.[24]

Licensed RNs and LPNs are permitted to apply for retired-volunteer status if they meet the following requirements:[25]

- Are 65 years of age or older; and
- Hold a Colorado RN or LPN license that is due to expire unless renewed OR have retired from the practice of nursing and held, prior to retirement, a license in good standing from another state or U.S. territory.

If applicants meet these requirements, they must submit the following:[26]

- An application;
- Evidence of their most recent nursing licensure, either in Colorado or in another state; and
- A statement signed under penalty of perjury that the applicant agrees to accept no compensation for any nursing tasks performed while in possession of the retired-volunteer license.

The fees charged for a retired-volunteer license are capped at 50 percent of the fees charged for an active license.[27]

[22] § 12-38-110, C.R.S.
[23] §§ 12-38-111(2) and 12-38-112(2), C.R.S.
[24] §§ 12-38-111(2) and 12-38-112(2), C.R.S.
[25] § 12-38-112.5(1), C.R.S.
[26] § 12-38-112.5(4), C.R.S.
[27] § 12-38-112.5(7), C.R.S.

All licensed RNs and LPNs must renew their licenses every two years, at which time they must complete a renewal questionnaire. The purpose of the questionnaire is to identify any licensees who may have violated the NPA, or may be unfit to practice nursing with reasonable skill and safety.[28] Failure to complete the questionnaire constitutes grounds for discipline pursuant to section 12-38-117(1)(v), C.R.S.

Authorities

Authorities are special designations placed on a nursing license to indicate that the nurse has completed specialized education and training qualifying him or her to perform a certain task or practice in a particular capacity. Currently, the Board issues six types of authorities: intravenous (IV) authority for LPNs, and five different types of authorities for advanced practice RNs, including prescriptive authority.

An LPN may expand his or her scope of practice by obtaining IV authority. To qualify for IV authority, an LPN must:[29]

- Hold a Colorado LPN license without any active disciplinary sanctions;
- Complete an approved IV therapy course, which may be included as part of a basic practical nursing program;
- Submit an application;
- Pay the applicable fee; and
- Verify completion of an approved IV therapy course through a Board-approved competency checklist.

Once granted IV authority, LPNs may perform certain specified tasks related to IV therapy under the supervision of an RN, physician, dentist, or podiatrist. These tasks include:[30]

- Observing and monitoring patients receiving IV fluid therapy;
- Observing and regulating the flow rate and stopping the flow of IV infusions;
- Administering specified IV fluids through venous access devices; and
- Monitoring the systemic effects of IV therapy.

[28] §§ 12-38-111(3), 12-38-112(3), and 12-38-112.5(8), C.R.S.
[29] Board Rule IX, §§ 5.1 and 5.2.
[30] Board Rule IX, § 3.1.

RNs who have specialized education and training may apply for placement on the advanced practice registry.[31] To qualify for placement on the registry, an RN must:

- Hold a Colorado RN license without any current disciplinary sanctions;[32]
- Submit an application;[33]
- Pay the required fee;[34]
- Provide evidence of a graduate degree in the appropriate nursing specialty;[35] and
- Meet any additional requirements as outlined in Board Rule XIV, Section II.

Placement on the registry authorizes an RN to use the title "advanced practice nurse" (APN), and depending on his or her specific qualifications, the title "certified nurse midwife" (CNM), "clinical nurse specialist" (CNS), "certified registered nurse anesthetist" (CRNA), or "nurse practitioner" (NP).

An APN may expand his or her scope of practice by obtaining prescriptive authority. To qualify for prescriptive authority, an APN must provide to the Board evidence of:[36]

- A graduate degree in a nursing specialty;
- Completion of specified coursework, including a minimum of 45 clock hours in each of these subject areas:
    - Advanced health/physical and psychological assessment;
    - Advanced pathophysiology/psychopathology; and
    - Advanced pharmacology;
- At least 1,800 hours of post-graduate experience during the past five years in a relevant clinical setting based upon:
    - A structured plan of precepted experience with a physician. The plan must address the above subject areas and may also involve a licensed APN with prescriptive authority or another health professional;
    - At least weekly interaction between the nurse and the preceptor;
    - Experience with specific drugs relevant to the applicant's scope of practice.

[31] § 12-38-111.5(2), C.R.S.
[32] Board Rule XIV, § III-3.1.
[33] Board Rule XIV, § III-3.1.
[34] Board Rule XIV, § III-3.1.
[35] § 12-38-111.5(4)(c), C.R.S. This requirement became effective for new APN applicants starting July 1, 2008. APNs who do not possess graduate degrees but were listed on the registry as of June 30, 2008, may continue to be included on the registry.
[36] § 12-38-111.6(4), C.R.S., and Board Rule XV, § II.

Once prescriptive authority has been granted, an APN may prescribe controlled substances and prescription drugs to treat patients requiring:[37]

- Routine health maintenance or routine preventive care;
- Care for an acute, self-limiting[38] condition;
- Care for a chronic condition that has stabilized; or
- Terminal comfort care.

As a condition of prescriptive authority, the APN must enter into a written collaborative agreement with a Colorado-licensed physician, whose practice specialty area is similar to that of the APN. The written collaborative agreement must specify the duties and responsibilities of both the physician and the APN, include provisions for referral and consultation, and provide a mechanism for assuring appropriate prescriptive practice.[39]

APNs holding the CRNA authority are not required to obtain prescriptive authority[40] because the graduate degree and certification the Board requires CRNAs to complete are almost exclusively focused on anesthesia care.

With prescriptive authority, as with all areas of professional nursing practice, the APNs are limited to treating those patients within their respective scopes of practice.

Temporary Licenses and Permits

The Board may issue temporary licenses or permits under the following circumstances:[41]

- Endorsement applicants who have shown evidence of current licensure in another state or country may be eligible for a four-month temporary license, pending compliance with the requirements for licensure.
- Examination applicants awaiting the results of the NCLEX-RN or NCLEX-PN may be eligible for a four-month temporary permit, pending compliance with the requirements for licensure.
- Nurses who are licensed in another state or country and are in Colorado for special training or observation of nursing educational programs may be eligible for a permit to practice for up to two years. Such nursing practice is limited to that performed as part of the special training or nursing educational program.

If the temporary license/permit-holder fails to meet the requirements for permanent licensure, the Board may summarily withdraw the license/permit.[42]

[37] §§ 12-38-111.6(3)(a) and (b), C.R.S.
[38] § 12-38-111.6(3)(c), C.R.S., defines "self-limiting" as a condition that has a defined diagnosis and a predictable outcome and is not threatening to life or limb.
[39] § 12-38-111.6(4)(d), C.R.S., and Board Rule XV, § III.A.1.
[40] § 12-38-111.6(8)(c)(2), C.R.S.
[41] § 12-38-115, C.R.S.
[42] § 12-38-115(5), C.R.S.

Nurse Licensure Compact

One of the Board's duties is to administer the provisions of the Compact.[43] Developed by the National Council of State Boards of Nursing, the Compact is an agreement between states to recognize each others' licensees. The laws governing the administration of the Compact are included in section 24-60-3202, C.R.S. The Compact applies equally to RNs and LPNs.

In the Compact, the "home" state refers to the nurse's primary state of residence, and the other Compact states are referred to as "remote" states.[44] Since Colorado entered into the Compact in October 2007, nurses identifying Colorado as their home state are authorized to hold a multistate privilege.[45] This privilege permits these nurses to practice in other Compact states without having to obtain an additional license. For example, a Colorado-licensed nurse may practice in Texas without having to obtain a Texas nursing license. Similarly, nurses who are licensed in other Compact states may practice in Colorado without having to obtain a Colorado nursing license.[46]

When a complaint is filed against a nurse holding a multistate privilege, the Compact authorizes both the home state and the remote state to investigate the allegations. If warranted, the home state may take disciplinary action against the nurse's license and the remote state may revoke the nurse's privilege to practice in that state.

Nurses are required to notify the Board when they change their primary state of residence. Whether the new state of residence is a Compact state or not, the nurses must secure either a Compact license or a single-state license from their new state of residence.

Licensees with disciplinary orders either limiting or requiring monitoring of their practice are ineligible for the multistate privilege. These licensees are issued "single state" licenses that restrict their practice to the home state until the terms of the order have been met.[47]

The Compact does not automatically qualify Colorado APNs to practice as APNs in other Compact states.[48] LPN IV Authority must also be obtained in each state of practice.

[43] § 12-38-108(4), C.R.S.
[44] § 24-60-3202, Article II(e) and (k), C.R.S.
[45] § 24-60-3202, Article III(a), C.R.S.
[46] Board Rule XX, § 1.7.
[47] Board Rule XX, § 3.1.
[48] § 24-60-3202, Article III(d), C.R.S.

Complaints and Enforcement

A critical responsibility of the Board is to assure public protection by revoking, suspending, placing on probation, or otherwise disciplining licensees who are found to have violated the NPA.[49] The Board may also deny initial licensure to an applicant if there is probable cause to believe that the applicant has violated the NPA.[50]

Grounds for discipline include:[51]

- Procuring or attempting to procure a license by fraud, deceit, misrepresentation, misleading omission, or material misstatement of fact;
- Having been convicted of a felony or any crime that would constitute a violation of the NPA;
- Willfully or negligently acting in a manner inconsistent with the health or safety of persons under his or her care;
- Having had a license to practice nursing or any other health care occupation suspended or revoked in any jurisdiction;
- Negligently or willfully practicing nursing in a manner failing to meet generally accepted standards for such nursing practice;
- Negligently or willfully violating any order, rule, or regulation of the Board;
- Falsifying or failing to make essential entries on patient records;
- Having an addiction to or dependence on alcohol or habit-forming drugs;
- Having a diagnosis of a physical or mental disability rendering a nurse unable to practice nursing with reasonable skill and safety to the patients and which may endanger the health or safety of persons under the nurse's care;
- Engaging in any conduct constituting a crime as defined in Title 18, C.R.S., and which conduct relates to employment as a nurse;
- Willfully and repeatedly ordering or performing, without clinical justification, demonstrably unnecessary laboratory tests or treatments;
- Failing to obtain consultations or perform referrals when failing to do so is not consistent with the standard of care for the profession;
- Committing a fraudulent insurance act, as defined in section 10-1-128, C.R.S.;
- Administering, dispensing, or prescribing any habit-forming drug, controlled substance, or anabolic steroid other than in the course of legitimate professional practice;
- Willfully failing to respond in a materially factual and timely manner to a complaint issued pursuant to the NPA;
- Negligently or willfully failing to accurately complete and submit to the Board the required renewal questionnaire; and
- Practicing as a nurse during a period when the person's license has been suspended or revoked.

[49] § 12-38-108(1)(b.5), C.R.S.
[50] § 12-38-118(2), C.R.S.
[51] § 12-38-117, C.R.S.

Any person believing a licensed nurse has violated these grounds for discipline may file a written complaint with the Board. Complaints may also be initiated by the Board on its own motion. [52]

To handle disciplinary matters, the 11-member Board is divided into two panels of five members each, with the Board president serving on both panels.[53] Each panel acts as both an inquiry and a hearings panel.[54] The role of the inquiry panel is to evaluate complaints and, if appropriate, recommend further investigation. If an inquiry panel finds a complaint merits investigation, the licensee complained against is given written notice of the complaint, and is given 30 days to respond to the complaint in writing. Upon receipt of the nurse's answer or at the conclusion of 30 days, whichever occurs first,[55] the inquiry panel may refer the complaint for further investigation.[56]

If, upon receiving the results of the investigation, the inquiry panel determines that formal action is required, the panel refers the complaint to the Attorney General's Office (AGO) for the filing of formal charges.[57]

Upon receiving the results of the investigation, the panel may determine that formal action is not required. In this case, the panel may decide to:[58]

- Dismiss the complaint;
- Issue a confidential letter of concern; or
- Issue a letter of admonition.

Within 20 days of receiving a letter of admonition, a licensee has the right to request in writing that formal disciplinary proceedings be initiated. If the panel receives the licensee's request in a timely manner, the letter of admonition is vacated and the matter is referred for hearing.[59]

Either a hearings panel or an administrative law judge (ALJ) may conduct a formal disciplinary hearing. All matters referred to one panel for investigation are heard by the other panel if referred for formal hearing. If the ALJ presides over a hearing, he or she issues an initial decision pursuant to the Administrative Procedure Act.[60] The hearings panel that would have heard the case had it not been referred to an ALJ may file exceptions to the initial decision, as may the respondent.[61]

The licensee complained against may be present in person, represented by counsel, or both, to offer evidence in his or her defense. At formal hearings, witnesses must be sworn and a complete record must be made of all proceedings and testimony.[62]

[52] § 12-38-116.5(3)(a)(II), C.R.S.
[53] § 12-38-116.5(1), C.R.S.
[54] § 12-38-116.5(1)(b), C.R.S.
[55] § 12-38-116.5(3)(a)(II), C.R.S.
[56] § 12-38-116.5(3)(a)(III), C.R.S.
[57] § 12-38-116.5(3)(c)(V)(a), C.R.S.
[58] § 12-38-116.5(3)(c), C.R.S.
[59] § 12-38-116.5(3)(c)(IV), C.R.S.
[60] § 12-38-116.5(1)(c), C.R.S.
[61] § 12-38-116.5(1)(d), C.R.S.
[62] § 12-38-116.5(4)(a), C.R.S.

If the charges in the complaint are not proven at hearing, the hearings panel or ALJ must enter an order dismissing the complaint. [63]

If the charges in the complaint are proven at hearing, the hearings panel or ALJ may recommend discipline be imposed. The disciplinary options include: [64]

- Issuing a letter of admonition;
- Suspending the license for a specified time period, or indefinitely;
- Revoking the license; or
- Placing the licensee on probation.

If the hearings panel or ALJ finds the nurse may not be able to practice nursing with reasonable skill and safety, either due to a mental or physical condition, the licensee may be ordered to undergo a mental or physical examination.[65]

If the Board receives credible evidence—via a written complaint or otherwise—that a nurse is acting in a manner that poses an imminent threat to the public health and safety, the Board may summarily suspend the nurse's license while the complaint is being investigated.[66] The Board may also issue cease and desist orders against those who are found to be practicing nursing without a license.[67]

Any final disciplinary action of the Board is subject to judicial review in the Colorado Court of Appeals, in accordance with section 24-4-106, C.R.S. [68]

Nursing Peer Health Assistance or Alternative to Discipline Program

In reviewing a complaint, the Board may find that a licensee complained against may require treatment for chemical or alcohol dependency or psychiatric, psychological, or emotional problems. If the public health and safety can be assured, the Board may refer the licensee to the nursing peer health assistance or alternative to discipline program in lieu of pursuing formal discipline.[69] This program is designed to assess and monitor individuals with chemical or alcohol dependency, or psychiatric, psychological, or emotional problems. The Board contracts with one or more peer health assistance organizations or nurse alternative to discipline programs to provide these services.[70]

If a licensee agrees to enroll in the program voluntarily, the complaint may be resolved confidentially. If the licensee does not enroll voluntarily, the Board may compel the licensee to enroll as a condition of licensure via a public stipulated agreement.

[63] § 12-38-116.5(4)(c)(II), C.R.S.
[64] § 12-38-116.5(4)(c)(III), C.R.S.
[65] § 12-38-116.5(8)(a), C.R.S.
[66] § 12-38-116.5(15)(a), C.R.S.
[67] § 12-38-116.5(5)(a), C.R.S.
[68] § 12-38-116.5(12), C.R.S.
[69] § 12-38-117(1)(i), C.R.S.
[70] § 12-38-131(3)(a), C.R.S.

The Board may summarily suspend the license of any nurse referred to the program who either fails to attend or fails to complete the program. If the licensee objects to the suspension, he or she may submit a written request to the Board for a formal hearing. In the hearing, the licensee bears the burden of proving that his or her license should not be suspended.[71]

Approval of Nursing Education Programs

The Board is responsible for approving all education programs preparing RNs and LPNs for licensure. Any institution wishing to offer a nursing education program must apply to the Board.[72]

All nursing education programs must be located in, or otherwise accredited as, a post-secondary educational institution with state approval to grant the appropriate degree or certificate.[73] The organization, administration, and implementation of the program must be consistent and compliant with the NPA, the Board's rules, and all other state or federal regulations.[74] Over the course of the application process, the institution must provide evidence of such to the Board. The institution must also document that it possesses sufficient qualified faculty, including a qualified director, and sufficient financial and clinical resources to support the program.[75]

The institution must also demonstrate that the program curricula meet certain criteria. Both professional and practical nursing programs must include:

- Content fundamental to the knowledge and skills required for clinical nursing;[76]
- Content relating to the principles of biological, physical, social, and behavioral sciences;[77]
- Skills in IV therapy;[78] and
- Theory and clinical experience in the four recognized specialty areas of:
  - Pediatrics;
  - Obstetrics;
  - Psychiatric; and
  - Medical-surgical nursing.[79]

Practical nursing programs must offer a minimum 400 clinical hours[80] and 300 theory hours.[81] Professional nursing education programs must offer a minimum of 750 clinical hours[82] and 450 theory hours.[83]

[71] § 12-38-131(4), C.R.S.
[72] § 12-38-116(1), C.R.S.
[73] Board Rule II, § 3.1.
[74] Board Rule II, § 3.3.
[75] Board Rule II, § 3.3.
[76] §§ 12-38-116(2)(a) and (3)(a), C.R.S.
[77] §§ 12-38-116(2)(b) and (3)(b), C.R.S.
[78] Board Rule II, § 3.13 A.
[79] Board Rule II, § 3.13 A.

There are four phases to the program approval process. The Board must review and approve each application before it can move to the next phase. If the Board does not approve an application at any phase, the Board will send a list of deficiencies to the institution. Once the deficiencies are corrected, the Board will review the application again.

1. Phase I. The institution must file documentation of intent to establish a program. This documentation must include a description of the proposed program, a timetable for its development, and evidence of adequate financial resources to support the program.[84]
2. Phase II. The institution must hire a qualified director to administer the program, as well as form an advisory committee to develop the program, and submit documentation of such to the Board. Once the Board has granted Phase II approval, the program may begin admitting students.[85]
3. Phase III. The Board will conduct a site visit of the program within 90 days of admitting students, and notify the program in writing of any deficiencies. The program must begin submitting semiannual progress reports to the Board. The program must request final, phase IV approval within one year following the graduation date of the initial class. In order to receive full approval, the NCLEX pass rate for the program's graduates must be 75 percent or higher.[86]
4. Phase IV. The program has completed the application process. The Board must conduct a site visit of all programs with full approval once every five years.[87]

Nursing education programs granted full approval after January 1, 2006, must provide evidence of national accreditation within four years of receiving such approval. All nursing education programs that were granted full approval prior to January 1, 2006, must either be nationally accredited, or must have achieved candidacy status for and demonstrate satisfactory progression toward obtaining such accreditation, by January 1, 2010.[88]

[80] Board Rule II, § 3.13 C.4.a.
[81] Board Rule II, § 3.13 C.5.a.
[82] Board Rule II, § 3.13 C.4.b.
[83] Board Rule II, § 3.13 C.5.b.
[84] Board Rule II, § 4.2.
[85] Board Rule II, § 4.3.
[86] Board Rule II, § 4.4.
[87] Board Rule II, § 4.5.
[88] Board Rule II, § 3.2.

The Board may withdraw full approval, either closing the nursing education program or placing it on conditional approval, if the program:[89]

- Does not meet or comply with all the provisions contained in the NPA and the rules, or other state or federal laws or regulations;
- Has been denied, had withdrawn, or had a change of program accreditation by a national, regional, or state accreditation body;
- Has provided to the Board misleading, inaccurate, or falsified information to obtain or maintain full approval; or
- Has an NCLEX pass rate average which falls below 75 percent for eight consecutive quarters.

[89] Board Rule II, § 6.1.

Program Description and Administration

The Colorado Board of Nursing (Board) is vested with the authority to regulate professional nurses (RNs) and licensed practical nurses (LPNs), and to accredit all professional and practical nursing education programs. Although the Board also has regulatory authority over licensed psychiatric technicians and certified nurse aides, each of those professions has its own practice act and is subject to a separate sunset review.

The 11-member Board is divided into two panels, Panel A and Panel B. The panels meet monthly, typically on the last Wednesday of the month, to consider licensing and disciplinary matters. Full Board meetings, where all 11 members attend, occur quarterly, in January, April, July, and October. The agendas of the full Board meetings are typically related to policy issues, including rulemaking, as well as issues in nursing education and national nursing trends.

The Division of Registrations (Division) provides administrative and managerial support for the Board in fulfilling its legislative mandate.

Table 1 illustrates, for the five fiscal years indicated, the Board's overall expenditures and staffing levels.

Table 1
Agency Fiscal Information

Category	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07
Total Program Expenditures	$2,248,479	$2,316,728	$2,387,284	$2,421,905	$2,906,168
Full-Time Equivalent (FTE) Employees	13.5	10.75	10.75	15.5	15.5

The expenditures of the Board have increased slowly but steadily, reflecting the increase in administrative costs.

In July of 2003, the Division underwent a major reorganization, creating centralized units to handle licensing, customer service, and central intake functions for all Division boards and programs. The above table reflects only those full-time equivalent (FTE) employees dedicated to the Board for enforcement, inspection, policymaking, and non-routine[90] licensing functions.

[90] "Non-routine" refers to applications requiring special Board review, such as those where the applicant was educated in a foreign country, or those where the applicant answers "yes" to one of the background screening questions.

Table 2 shows the fees the Board charges for licenses, permits, and authorities.

Table 2
Board of Nursing Fees

	RN	LPN
Original License by Examination	$83	$83
Original License by Endorsement	$38	$38
Advanced Practice Registry (per type)	$75	---
Prescriptive Authority	$150	---
Intravenous Authority	---	$45
Renewal*	$139	$106
Late Fee (for renewals after the expiration date)	$15	$15
Reinstatement	$154	$121
Retired / Volunteer Nurse (renewable)	$20	$20
Special or Student Permit	$20	$20
Duplicate Computer License	$5	$5

The renewal and reinstatement fee for both RNs and LPNs includes an $18 surcharge to fund the alternative to discipline program. Pursuant to section 24-34-105, Colorado Revised Statutes, fees are subject to change every July 1.

Licensing

Colorado has a mandatory practice act, meaning that all individuals wishing to practice as RNs or LPNs must be licensed in either Colorado or another state that is party to the Nurse Licensure Compact (Compact).

There are two primary routes to licensure in Colorado: by examination and by endorsement. Applicants must complete the appropriate application and submit it with all supporting documentation to the Division's Office of Licensing (Office). A licensing specialist reviews the application and notifies the applicant of any deficiencies. Once the application is complete, a licensing specialist evaluates the application to ensure the applicant meets the requirements for licensure. If requirements are met, the license is issued. If not, the licensing specialist notifies the applicant in writing, and the application is kept on file for one year.

Table 3 illustrates, for the five fiscal years indicated, the number of new licenses issued by method.

Table 3
New Nursing Licenses Issued by Method

	Registered Nurses (RNs)			Licensed Practical Nurses (LPNs)		
	Exam	Endorsement	Total	Exam	Endorsement	Total
FY 02-03	1,172	2,888	4,060	678	347	1,025
FY 03-04	1,184	2,634	3,818	719	317	1,036
FY 04-05	1,548	2,565	4,113	927	342	1,269
FY 05-06	1,577	3,041	4,618	957	351	1,308
FY 06-07	1,707	3,269	4,976	903	330	1,233

The number of new licenses issued by endorsement is expected to decline over the coming years due to the Compact, which Colorado joined in October 2007.

Table 4 illustrates the total number of licensed nurses for the five fiscal years indicated.

Table 4
Total Number of Licensees

Fiscal Year	Total Number of Licensed Nurses	Number of RNs	Number of LPNs
02-03	59,861	N/A*	N/A*
03-04	61,931	51,386	10,545
04-05	62,275	52,542	9,733
05-06	65,567	54,408	11,159
06-07	67,009	56,918	10,091

*The Division converted to a new licensing database in fiscal year 02-03. Due to this conversion, the number of RNs and LPNs is not available for that year.

Despite the demand for nurses, the growth in the total number of licensees has been fairly incremental. This could be partially due to the limited openings in nursing education programs nationwide. A shortage of clinical resources and qualified nursing faculty prevents nursing education programs from accepting more nursing students.

All applications for nursing licensure require applicants to answer detailed background questions. These questions are intended to identify applicants with a history of criminal convictions, disciplinary actions, alcohol or drug abuse, or other factors that may affect the applicant's ability to practice nursing safely. If the applicant answers affirmatively to any of the background questions, the application is subjected to an additional review.

The Board developed a decision tree to facilitate review of these "yes" applications. Office staff has the authority to administratively approve some of these applications within defined parameters. Examples of "yes" applications that staff may administratively approve include those disclosing:[91]

- Traffic convictions that do not involve driving under the influence (DUI), driving while ability impaired (DWAI), or felonies;
- A single conviction where the court has sealed the records; or
- Malpractice settlements that are over five years old.

If the violations are outside the parameters of authority delegated by the Board, Board staff assigns the application to one of the inquiry panels of the Board. Examples of "yes" applications that must be referred to a panel include those disclosing: [92]

- One or more felony convictions;
- Conviction(s) involving alcohol within the last 12 months; or
- Convictions that indicate a pattern or repeat offender status.

The appropriate panel reviews the application and decides whether to grant or deny licensure at one of its monthly meetings. If the Board denies the applicant licensure, the applicant is entitled to a hearing under the Administrative Procedure Act. The Board may also elect to license the applicant with conditions. In this case, the applicant enters the disciplinary process.

Authorities

Authorities are special designations placed on a nursing license to indicate that the nurse has completed specialized education and training qualifying him or her to perform a certain task, or practice in a particular capacity.

Table 5 shows the number of LPNs with intravenous (IV) authority, and the number of RNs with advanced practice nurse (APN) authorities as of July 2008. There are five different types of APN authorities: certified nurse midwife (CNM), clinical nurse specialist (CNS), nurse practitioner (NP), certified registered nurse anesthetist (CRNA), and prescriptive authority.

Table 5
Nurses with Authorities

Type of Authority	Number of Nurses
Intravenous (IV)*	3,060
Certified Nurse Midwife (CNM)**	281
Clinical Nurse Specialist (CNS)**	858
Nurse Practitioner (NP)**	1,187
Certified Registered Nurse Anesthetist (CRNA)**	466
Prescriptive Authority***	1,936

* LPN only.
** RN only.
***RN with advanced practice designation (CNM, CNS, NP, or CRNA only)

[91] Board Guideline 01, Board of Nursing Staff Approval of Licensure.
[92] Board Guideline 01, Board of Nursing Staff Approval of Licensure.

APNs typically hold more than one advanced practice authority, so the number of individual APNs is lower than the total number of authorities issued. A total of 4,033 APNs hold the 4,728 authorities listed in Table 5.

Examinations

Applicants for nursing licensure are required to pass a national examination. To qualify for Colorado licensure, RN applicants must pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN) and LPN applicants must pass the National Council Licensure Examination for Practical Nurses (NCLEX-PN). The National Council of State Boards of Nursing (NCSBN)—which represents the state licensing boards in all 50 states, the District of Columbia, and four U.S. territories—developed these examinations under the guidance of its membership. The examinations were designed to measure the competencies needed to safely and effectively perform as an entry-level nurse.

Both the NCLEX-RN and the NCLEX-PN examinations must be taken on a computer at an official testing center. They are not offered in paper-and-pencil or oral formats. The examinations are variable length adaptive tests: depending upon the pattern of correct and incorrect responses, different candidates will answer varying numbers of items and use varying amounts of time.

The NCLEX-RN can be anywhere from 75 to 265 items long. Of these items, 15 are pretest items that are not scored. The time limit for the examination is six hours. The NCLEX-PN can be anywhere from 85 to 205 items long. Of these items, 25 are pretest items that are not scored. The time limit for the examination is five hours.

Once the minimum number of items has been answered, testing stops when the candidate's ability is determined to be either above or below the passing standard with 95 percent certainty. The examination will stop when the maximum number of items has been taken or when the time limit has been reached. [93]

[93] *NCLEX Examination Candidate Bulletin*, National Council of States Boards of Nursing/Pearson-Vue (2008), p.12.

Table 6 indicates the content areas for NCLEX-RN and NCLEX-PN examinations and the percentage of questions in each content area.

Table 6
Content Areas for the NCLEX[94]

Subject Area	Percentage of Examination	
	RN	LPN
Safe and Effective Care Environment:		
Management of Care	13-19%	--
Coordinated Care	--	12-18%
Safety and Infection Control	8-14%	8-14%
Heath Promotion and Maintenance	6-12%	7-13%
Psychosocial Integrity	6-12%	8-14%
Physiological Integrity:		
Basic Care and Comfort	6-12%	11-17%
Pharmacological and Parenteral* Therapies	13-19%	--
Pharmacological Therapies	--	9-15%
Reduction of Risk Potential	13-19%	10-16%
Physiological Adaptation	11-17%	11-17%

*Parenteral: Administered in a manner other than via the digestive tract, e.g., via intramuscular or intravenous injection.

The NCSBN contracts with a testing agency, Pearson-Vue, to administer the examination. The examination costs $200.[95] This fee is in addition to the fees the Board charges applicants for licensure.

Table 7 indicates the number of examinations administered to applicants seeking Colorado licensure and the corresponding pass rates. These data include both first time and repeat test-takers.

Table 7
Examinations for Colorado Applicants

Fiscal Year	NCLEX-RN		NCLEX-PN	
	Number of Examinations Given	Pass Rate	Number of Examinations Given	Pass Rate
02-03	632	78.3%	343	95.9%
03-04	1,208	77.2%	830	90.1%
04-05	1,578	79.8%	973	91.5%
05-06	1,668	80.8%	994	91.3%
06-07	1,904	78.8%	987	89.5%

Neither Board staff nor the testing vendor were able to verify the reason for the dramatic increase in the number of examinations administered from fiscal year 02-03 to fiscal year 03-04, although increased enrollment in nursing schools in the preceding years may have been a factor.

[94] *NCLEX Examination Candidate Bulletin*, National Council of States Boards of Nursing/Pearson-Vue (2008), p.14.
[95] *NCLEX Examination Candidate Bulletin*, National Council of States Boards of Nursing/Pearson-Vue (2008), p.2.

Inspections

The Board must conduct periodic inspections, or site visits, as part of the nursing education program approval process. The inspector is a member of the Board staff who has specialized knowledge and experience in higher education.

Inspections may be conducted for several reasons:

- When a program is seeking Phase III program approval, the Board must conduct a site visit within 90 days of admitting students.
- After a program has secured full approval, the Board may conduct a site visit at any time, but must do so at least every five years to assure the program is still in compliance.
- If deficiencies were identified during a previous site visit, the Board may have to conduct an additional visit to determine whether the program has corrected the deficiencies.

During a site visit, the Board inspector might meet with the program's leadership, tour the program's facilities, interview students, review organizational materials and files, and do anything else that helps determine the program's compliance with the standards established in the laws and rules.

After the site visit, the inspector develops a detailed report and presents it to the Board at one of its quarterly full Board meetings.

Table 8 shows the number of inspections conducted by Board staff as part of the nursing education program approval process.

Table 8
Inspections

Fiscal Year	Number of Inspections
02-03	5
03-04	19
04-05	18
05-06	5
06-07	6

According to Board staff, there are several possible reasons for the increased number of inspections conducted from fiscal year 03-04 to 04-05: an increased number of applicants for initial approval; an unusual number of programs coming due for continuing approval; and a realignment within the community college system that necessitated independent inspections of several programs that were formerly inspected as a group.

As of July 2008, there were 24 associate degree RN programs, 10 baccalaureate degree RN programs, and 25 LPN programs that possess full Board approval.

Complaints/Disciplinary Actions

Anyone—a hospital, staffing agency, physician, patient, or the Board itself—may file a complaint against an RN or LPN. Board inquiry Panels A and B review complaints at their monthly meetings.

Table 9 shows the number of complaints received for the past five fiscal years.

Table 9
Complaints

Fiscal Year	Number of Complaints Received	
	RN	LPN
02-03	333	111
03-04*	791	195
04-05*	803	477
05-06*	590	243
06-07	396	119

*The methodology used in these fiscal years to determine when a matter warranted being considered a complaint was unique to the Board and has since been modified.

The sharp increase in the number of complaints in fiscal years 03-04, 04-05, and 05-06 is due to the implementation of the required renewal questionnaire. During those years, the Board had to open an unusual number of complaints to investigate the issues disclosed on the questionnaires. The number of complaints dropped again in fiscal year 06-07, because by that time all Colorado RNs and LPNs had been through one renewal cycle where they had completed the questionnaire. Since most behavior warranting investigation had already been disclosed during the previous renewal cycle, the Board did not need to open additional complaints.

Table 10 illustrates the nature of complaints filed with the Board for the five fiscal years indicated.

Table 10
Nature of Complaints

Registered Nurses					
Nature of Complaints	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**
Standard of Practice	205	162	127	219	230
Criminal Offenses	11	143	331	210	117
Physical/Mental Disability	15	199	55	47	32
Substance Abuse/Drug Diversion	70	107	227	173	164
Discipline in Another State	20	33	89	32	19
Violation of Board Order or Rule	24	108	93	117	80
Recordkeeping	12	8	17	51	76
Fraud/Misrepresentation on Application	0	1	5	3	2
Failure to Respond to Complaint	0	1	4	15	26

Practical Nurses					
Nature of Complaints	**FY 02-03**	**FY 03-04**	**FY 04-05**	**FY 05-06**	**FY 06-07**
Standard of Practice	76	63	64	85	63
Criminal Offenses	4	69	265	148	31
Physical/Mental Disability	1	8	28	21	4
Substance Abuse/Drug Diversion	20	29	82	90	45
Discipline in Another State	6	7	49	13	6
Violation of Board Order or Rule	5	19	42	6	41
Recordkeeping	3	2	9	12	18
Fraud/Misrepresentation on Application	0	1	4	10	4
Failure to Respond to Complaint	0	0	8	34	10

Note: The number of the nature of complaints will not equal the total number of complaints reported elsewhere in this report because a complaint may have more than one allegation.

The most common complaint allegations against both RNs and LPNs are standard of practice, criminal offenses, and substance abuse or drug diversion.

After investigation, the Board may find probable cause that a nurse violated the NPA and consequently pursue disciplinary action. There are several ways that a disciplinary settlement may be reached: the more traditional route via the Attorney General's Office (AGO), via mediation, or via the Office of Expedited Settlement (ESP).

Mediation is a process whereby a Board member, accompanied by the Board's counsel, meets face-to-face with the licensee and his or her attorney, if applicable. Over the course of the meeting, both parties try to come to an agreement on a suitable disciplinary action. A case must meet certain criteria to qualify for mediation, e.g., the licensee must be willing to consider accepting disciplinary action to resolve the complaint.

ESP is a centralized office within the Division. The purpose of ESP is to expedite the resolution of disciplinary actions without referral to the AGO. Resolving cases within the Division both reduces associated legal costs and allows the AGO to focus on more complex cases that require its legal counsel and expertise.

Table 11 below illustrates the total number of final actions taken by the Board for the five fiscal years indicated.

Table 11
Final Agency Actions

Type of Action	FY 02-03		FY 03-04		FY 04-05		FY 05-06		FY 06-07	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Revocation/Surrender of License	52	19	43	14	44	10	23	5	35	10
Suspension	17	2	20	4	14	3	32	12	12	7
Probation / Practice Limitation	22	8	11	4	27	15	30	12	39	27
Letter of Admonition	5	5	18	5	15	17	41	22	40	29
Injunction/Other Action*	2	2	0	1	0	2	0	0	0	0
Total Disciplinary Actions	98	36	92	28	100	47	126	51	126	73
License Denied	2	0	8	0	13	4	6	0	6	1
Dismissals**	140	46	498	83	377	214	398	190	259	72

*Other actions include but are not limited to revocations held in abeyance or stayed, suspensions held in abeyance, and cease and desist orders.
**Dismissals include confidential letters of concern which may be issued by the Board when initiation of formal disciplinary action is not warranted.

The dramatic spike in the number of disciplinary actions as well as dismissals from fiscal years 03-04, 04-05, and 05-06 corresponds to the increased number of complaints after the implementation of the required renewal questionnaire.

Nursing Peer Health Assistance or Nurse Alternative to Discipline Program

The Board contracts with an outside entity to administer this program, which is designed to assess, monitor, and refer for treatment individuals with chemical or alcohol dependency, or psychiatric, psychological, or emotional problems. The Board contracted with the Colorado Nurse Health Program from 2000 to June 30, 2008. In 2007, the contract was put out for competitive bidding and Peer Assistance Services, Inc., (PAS) was awarded the contract. PAS has been administering the program since July 1, 2008.

Licensees may enroll in the program voluntarily or the Board may compel the licensee to enroll as a condition of licensure via a public stipulated agreement.

The program is funded by a fee charged to all RN and LPN applicants, as well as to all licensed nurses at the time of renewal. Participants in the program must pay for certain services, including but not limited to urine screens and therapy appointments. However, most initial assessments and monitoring services are free to participants.

Table 12 below illustrates the number of enrollees in the program for July 1, 2006 through June 30, 2007.

Table 12
Alternative to Discipline Program Participants

Participants who successfully completed the program	30
Total number of new participants in the program	73
Participants who enrolled in the program because a complaint was lodged against their licenses	34
Participants who answered "yes" to a question on their initial licensure application or renewal questionnaire	13
Participants under stipulation with the Board	8
Voluntary participants	18
Total number of active participants on June 30, 2007*	**226**

*This total includes nurses who enrolled in the program in previous years.

The number of participants in the nursing peer health assistance or nurse alternative to discipline program has increased steadily since 2000, when the total number was about 60. That number has more than doubled since then, but it still represents a tiny fraction—about 0.23 percent—of the over 65,000 RNs and LPNs licensed in Colorado.

Analysis and Recommendations

Recommendation 1 – Continue the Board of Nursing for 11 years, until 2020.

The powers of the Colorado Board of Nursing (Board) are codified in Article 38 of Title 12, Colorado Revised Statutes (C.R.S.), known as the Nurse Practice Act (NPA). Although the regulatory functions specific to certified nurse aides (CNAs) and licensed psychiatric technicians (LPTs) are explicitly defined in Articles 38.1 and 42, respectively, and are subject to separate sunset reviews, the Board's regulatory authority is established within Article 38.

The NPA empowers the Board to regulate registered nurses (RNs), licensed practical nurses (LPNs), LPTs, and CNAs, and to approve the education programs preparing students for licensure. The central question is whether these regulatory activities are necessary to protect the public health, safety, and welfare.

In terms of sheer numbers, the Board has regulatory authority over the majority of Colorado's health care workforce. As of July 2008, a total of 91,422 RNs, LPNs, LPTs, and CNAs fell under the authority of the Board. By contrast, the Board of Medical Examiners regulates just over 20,000 physicians and physician assistants, and the Board of Dental Examiners regulates about 8,500 dentists and dental hygienists. The numbers of people employed in the nursing professions means Coloradans are more likely to receive care from nurses than any other health care professional.

The care that the Board's licensees provide spans the life cycle, and ranges from basic bedside care to sophisticated case management in a wide variety of settings. Advanced practice nurses (APNs) may prescribe drugs or deliver babies, RNs working as school nurses administer hearing tests to elementary school students, LPNs with intravenous authority administer flu shots at mobile health clinics, LPTs lead group activities in state psychiatric facilities, and CNAs provide basic care and companionship in patients' homes.

The number of people employed in the nursing professions and the broad array of skill sets and practice settings among licensees makes for a complex regulatory environment. Consumers could not be reasonably expected to have the expertise to determine whether individuals are minimally competent to provide nursing care. The very nature of health care would make this especially difficult: "shopping around" for a qualified health care provider is not a viable option after having been in a serious car accident, or for someone suffering from cognitive impairments. By establishing minimal standards for competence, and licensing individuals deemed to have met these standards, the Board acts in the public's interest.

The Board also performs a critical role when it comes to removing unsafe licensees from practice. The Board receives an average of 700 complaints in a typical year. If the Board finds, upon investigation, that a licensee has violated the NPA, it has numerous remedies at its disposal. In some cases, the Board may choose to issue a letter of admonition, or may determine that a licensee's practice would improve after a period of probation. More serious violations can lead to a license being suspended or revoked. In the most egregious cases, where the behavior of a licensee poses an immediate threat to the public health and welfare, the Board may summarily suspend the licensee, which effectively removes the licensee from practice while the case is being investigated.

The Board must be careful to tailor disciplinary actions to the level of harm licensees pose to the public. Removing safe practitioners from practice effectively limits consumers' access to health care, and doing so, especially during a time when Colorado is experiencing an ongoing nursing shortage, would not serve the public interest. The breadth of background and experience of the Board's members helps assure a balance between enforcement and remediation.

Aside from licensing qualified individuals and removing unsafe individuals from practice, the Board is charged with approving education programs that prepare students for licensure. The education and training among the licensees the Board regulates vary widely, ranging from CNAs with 75 hours of training to doctorate-prepared APNs. There is still relatively little standardization among nursing education programs, compared with, for example, medical education. Nursing education can occur in community colleges, universities, vocational-technical schools, high schools, and hospitals. National accreditation is available for nursing education programs, but in most states such accreditation is voluntary. Further, the National League for Nursing Accrediting Commission, which accredits numerous Colorado nursing programs, requires that such programs secure Board approval as a condition of accreditation.[96] Although there are efforts underway to develop more uniform standards in nursing education, it is unlikely the climate will change significantly anytime soon. Until then, the Board is the logical entity to assure education programs meet certain standards.

Health care is changing faster than ever before. It is at the top of the priority list for state and national leaders. And, because the nursing professions form the heart of the health care workforce, changes affecting nurses are inevitable. The Board plays a vital role in aligning Colorado nursing regulation with national advancements. One example of a recent change is the implementation of the Nurse Licensure Compact (Compact). The Board was responsible for making the Compact a reality in Colorado. As the states continue to standardize licensure requirements for APNs and the accreditation of nursing education, the Board will continue to take a leadership role.

The Board, through its licensing and enforcement activities, as well as its role in approving nursing education programs and facilitating Colorado's compliance with changes in national nursing regulation, provides a vitally important public service. For these reasons, the Board of Nursing should be continued for 11 years, until 2020.

[96] *Accreditation Manual,* National League for Nursing Accrediting Commission, Inc. (2008), p. 11.

Recommendation 2 – Change the means of assuring geographic diversity on the Board.

Section 12-38-104(1)(a)(I), C.R.S., mandates that the Board composition include two LPNs currently practicing as such, one of whom must be employed by a rural hospital.

This position of an LPN employed by a rural hospital has been historically difficult to fill. Because Board membership requires regular travel to the Denver metropolitan area, it has historically proven difficult to recruit and retain qualified Board members for this position. When Board member positions are vacant, this makes it more likely that the Board will be unable to form a quorum, which can delay the Board's work.

When compared with other health care boards, attaching geographical criteria to a specific seat on the Board is unusually proscriptive. Neither the Board of Medical Examiners nor the Board of Dental Examiners defines specific geographic or practice settings for prospective Board members. That said, it is unquestionably important to have a diverse Board that reflects Colorado's urban/rural balance.

Rather than placing geographic requirements on specific Board positions, a more effective way to assure geographic diversity would be to assess the overall balance of urban and rural representation on the Board when appointing any new Board member. The Dental Practice Law contains the following statement:

> Due consideration shall be given to having a geographical, political, urban, and rural balance among the board members.[97]

Adding a similar statement to the NPA and removing the requirement that one of the LPNs on the Board be employed in a rural hospital would make it easier to find qualified Board members while assuring geographic diversity among the Board's membership.

Recommendation 3 – Clarify that Board members who represent the public may not hold a health care license.

Section 12-38-104(1)(a)(III), C.R.S., mandates that the Board composition include two public members, who are not licensed, employed, or in any way connected with any health care facility, agency or insurer.

The word "licensed" in this context is confusing. Although the provision was likely intended to disqualify individuals holding health care licenses from serving as public members, the statement is misleading because it does not define the specific type of license. It would be perfectly reasonable for an individual holding a license as a teacher, attorney, or real estate agent to represent the public on a health care board.

[97] § 12-35-104(1)(a), C.R.S.

To eliminate this confusion, section 12-38-104(1)(a)(III), C.R.S., should be revised to specify that the two public members cannot hold, or have held in the past, a health care license, and that they may not be employed or in any way connected with any health care facility, agency or insurer.

Recommendation 4 – Repeal the requirement that Board members be confirmed by the Senate.

Currently, section 12-38-104(1)(a), C.R.S., requires all new Board members to receive Senate confirmation. This requirement should be removed. No other health care board requires Senate confirmation for Board members, and scheduling such confirmation can be difficult, particularly to prospective Board members who live outside of the Denver metropolitan area. Because the Senate confirmation process in this case is largely a formality, and can pose logistical difficulties for the prospective Board member and legislative staff, this requirement should be removed.

Recommendation 5 – Lengthen Board member terms from three years to four years.

Section 12-38-104(c)(I), C.R.S., establishes that Board members shall serve three-year terms. The organic statutes of other health care boards, such as the Board of Medical Examiners, the Board of Dental Examiners, the Board of Chiropractic Examiners, and the Board of Examiners of Nursing Home Administrators, have established four-year terms for board members.[98] A four-year term makes sense given the considerable body of knowledge—and correspondingly long learning curve—required to serve on health care boards, and the difficulty of recruiting and retaining qualified Board members.

For these reasons, the terms of newly appointed Board members—as well as current Board members being reappointed to a second term—should be increased to four years.

Recommendation 6 – Grant the Board fining authority and direct the Board to promulgate rules defining a fining structure.

When determining appropriate disciplinary action, the Board must first and foremost consider public protection. Beyond that, the Board may consider rehabilitative measures.

[98] §§ 12-36-103, 12-35-104,12-33-103(1), and 12-39-104 (1)(b), C.R.S., respectively.

The Board has numerous options when deciding what kind of discipline to impose on licensees. Those options include:

- **Revocation or suspension** of a license is reserved for the most serious offenses. A nursing license represents a person's livelihood, after all, and removing a person from practice either temporarily or permanently, has serious long-term consequences.
- **Probation** is generally granted to licensees who do not pose an immediate danger to the public and whose practice might benefit from a period of practice monitoring or mentoring. Ideally, at the end of a probationary period, the licensee is a better nurse. Probation demands considerable time and resources from Board staff, the licensee, and the licensee's employer.
- **Letters of admonition** (LOAs) are appropriate for offenses that do not warrant revocation, suspension, or probation, but are serious enough to warrant becoming part of the licensee's public, permanent record.

One enforcement tool the Board does not have, however, is the ability to assess fines against licensees. Administrative fining can serve a unique purpose in regulatory enforcement. It can provide clear consequences for "cut and dried" violations of the NPA.

For example, at each of their monthly meetings, the inquiry panels of the Board review numerous cases wherein nurses failed to renew their licenses by the expiration date. This is a prime example of a violation that could be punishable by an administrative fine, particularly in the case of repeat offenders.

Other health care boards within the Division of Registrations (Division) currently have the ability to assess fines against licensees:

- Under the Physical Therapy Practice Act, the Division Director has the ability to fine licensees who violate any provision of the Physical Therapy Law.[99]
- In lieu of suspending a licensee, the Chiropractic Practice Act permits the Board of Chiropractic Examiners to assess fines up to $10,000 against licensees who violate the law.[100]
- The Medical Practice Act grants the Board of Medical Examiners the authority to impose, at its discretion, fines of up to $10,000 in lieu of suspension.[101]

There is always a risk with administrative fining that such fines, particularly if they are relatively low, can become merely a cost of doing business. However, administrative fines can also be a powerful deterrent. For the Board, administrative fining could be an effective means of responding to administrative violations such as failing to renew in a timely manner, failing to respond to the Board, and violating a Board order. Adding administrative fining to the Board's enforcement toolbox would help the Board to establish clear consequences for specific violations of the NPA.

[99] § 12-41-116(1)(a), C.R.S.
[100] § 12-33-117(1.5), C.R.S.
[101] § 12-36-118(5)(g)(III), C.R.S.

Therefore, the Board should be granted fining authority and establish rules defining the use of such authority via the public rulemaking process. All fines collected should be deposited in the General Fund.

Recommendation 7 – Delete licensing provision requiring applicants to submit "proof" that they are not addicted to drugs or alcohol.

To qualify for licensure as an RN or an LPN, applicants must complete the appropriate application, pass an examination, pay a fee, and submit to the Board:

> ... proof …to show that the applicant presently is not and, for the twelve-month period immediately preceding the date of the application, was not addicted to any controlled substance… or is not a regular user of the same without a prescription … and that the applicant is not habitually intemperate in the use of intoxicating liquor [.]

If taken literally, every applicant—the vast majority of whom presumably do not have an addiction issue—would have to produce medical records, letters of reference, or an assessment from an addictionologist to meet this requirement. In all likelihood this provision was intended to identify those applicants with substance abuse problems. But rather than requiring applicants to disclose any current or recent addictions to drugs or alcohol, the wording of the provision requires applicants to affirmatively prove they are not addicted at the time of application. It is difficult, if not impossible, to prove a negative.

The Board clearly needs to have a means of identifying applicants with substance abuse problems, but the Board already has such a mechanism in place via the first requirement for licensure: the Board-approved application. Pursuant to sections 12-38-111(1)(a) and 12-38-112(1)(a), C.R.S., applicants for RN and LPN licensure must submit an application containing such information as the Board may prescribe. All applications for nursing licensure include numerous screening questions, including the following questions:

- Are you now or have you in the past five years been addicted to any controlled substance, a regular user of any controlled substance without a prescription, or habitually intemperate in the use of intoxicating liquor?
- Have you been terminated or permitted to resign in lieu of termination from a nursing or other health care position because of your use of alcohol or use of any controlled substance, habit-forming drug, prescription medication, or drugs having similar effects?
- Have you been arrested for an alcohol or drug-related offense (…)?

These questions are designed to elicit information about the applicant's past history with drugs and alcohol. Failure to answer any one of these questions would cause a Division licensing specialist to reject the application as incomplete, and return it to the applicant for completion. A "yes" answer prompts more investigation by the licensing specialist, and if warranted, the application is referred to the Board. In either case, the application is prevented from being processed. If an applicant answers "no" to all the background questions, is issued a license, and is ultimately found to have been lying, the Board is empowered to take disciplinary action against the licensee pursuant to section 12-38-117(1)(a), C.R.S.

Remember also that nurses are required to complete a renewal questionnaire every two years at renewal time. The questionnaires require nurses to answer similar questions regarding drug and alcohol abuse similar to those on the licensure applications, so if a nurse developed an addiction problem in the time since the last renewal, the nurse would be prompted to disclose such problem via the renewal questionnaire.

The Board has incorporated extensive background and self-disclosure questions into all of its licensure and renewal applications, thereby effectively screening applicants for drug and alcohol problems. Therefore, the provisions requiring applicants to submit "proof" they are not addicted should be eliminated.

Recommendation 8 – Revise the grounds for discipline to simplify the evidentiary requirements for violations regarding drugs or alcohol, clarify wording regarding the renewal questionnaire, and create a new provision establishing failure to report criminal convictions as grounds for discipline.

Section 12-38-117, C.R.S., establishes the grounds upon which the Board may take disciplinary action against licensees. Numerous small changes would clarify this section.

Section 12-38-117(1)(i), C.R.S., currently requires the Board to have evidence that a licensee is addicted to or dependent on alcohol or habit-forming drugs in order to take action on these grounds.[102] Alcohol and drug dependence and addiction can be difficult to establish, and alcohol and drug use can seriously impede the practice of nurses who are not addicted. This provision should be rephrased to mirror the Medical Practice Act, which defines "(h)abitual intemperance or excessive use of any habit-forming drug or any controlled substance" as grounds for discipline.[103]

Section 12-38-117(1)(v), C.R.S., allows the Board to take action against a licensee who "(h)as negligently or willfully failed to accurately complete and submit to the Board the designated questionnaire upon renewal of a license." The words "negligently or willfully" should be deleted, since the provision applies equally to any licensee who fails to submit the questionnaire for any reason.

[102] § 12-38-117(1)(i), C.R.S.
[103] § 12-36-117(i), C.R.S.

Lastly, a new provision should be provided that allows the Board to take action against any licensee who fails to report criminal convictions within 45 days of conviction. Currently, the Board may take action if a licensee fails to disclose a criminal conviction on an initial application or a renewal questionnaire. There is a loophole, however, whereby a licensee could be convicted of a crime one month after sending in a renewal questionnaire, and not be compelled to disclose it until the next renewal period 23 months later. This poses a clear threat to public safety, and the Board should be able to pursue disciplinary action against those who withhold this information from the Board.

Recommendation 9 – Consolidate language on unlicensed practice.

Currently, two sections of the NPA address the circumstances under which the Board may deny a license:

- Section 12-38-113, C.R.S., allows the Board to deny an applicant licensure if the applicant has had a health care license revoked in another jurisdiction, or if such license is under suspension at the time of application. Under this section, the Board may require an applicant whose license has been revoked in another jurisdiction to wait one year, and retake the NCLEX examination before being permitted to reapply for licensure.
- Section 12-38-118, C.R.S., allows the Board to deny licensure to an applicant who does not meet the qualifications outlined in sections 12-38-111 and 12-38-112, C.R.S., or if there is probable cause to believe the applicant has committed any of the acts specified in section 12-38-117, C.R.S. The section goes on to describe the process the Board must follow in denying licensure, as well as the hearings process for applicants who request it.

For clarity's sake, these two sections should be combined into a single section that addresses the grounds for denial of licensure, the administrative procedure the Board must follow in executing such denial, and terms and conditions under which applicants may reapply.

Further, additional wording should be added that allows the Board either to deny licensure, or grant limited licensure, to applicants lacking continued competency. The Medical Practice Act contains the following language:[104]

> The board may refrain from issuing a license or may grant a license subject to terms of probation if the board determines that an applicant for a license… (h)as not actively practiced medicine or practiced as a physician assistant for the two-year period immediately preceding the filing of such application or otherwise maintained continued competency during such period, as determined by the board.

[104] § 12-36-116(1)(d), C.R.S.

Adding similar language to the NPA would further the public interest by assuring that only applicants who can demonstrate competency are granted unrestricted licensure.

Recommendation 10 – Require nurses who have been denied licensure, have had their licenses revoked, or who have surrendered their licenses in lieu of disciplinary action, to wait two years to reapply.

Pursuant to section 12-38-113, C.R.S., the Board may deny licensure to applicants who have had a health care license revoked in another jurisdiction. The Board also has the power to require applicants denied under this section to wait one year and retake either the National Council Licensure Examination for Registered Nurses (NCLEX-RN) or the National Council Licensure Examination for Practical Nurses (NCLEX-PN) before being permitted to reapply for licensure. This measure accomplishes two things: it protects the public by preventing unqualified applicants from entering the practice for a specified period, and allows the Board to assure applicants meet minimal standards upon re-entry to the profession.

Interestingly, there is no such provision in place for nurses whose Colorado licenses are revoked, or for nurses who relinquish their Colorado nursing licenses in lieu of revocation. Other health care professionals, including dentists, midwives, podiatrists, and pharmacists,[105] are required to wait two years. Allowing the Board to require these individuals to wait a specified period before reapplying would enhance public protection by assuring minimal competency when they re-enter the workforce. Given the severity of the violations that result in revocation or surrender of a license, and the amount of Division time and resources it takes to process revocations and surrenders, two years is an appropriate waiting period.

The waiting period for applicants who have been denied a license should be increased to two years, and a two-year waiting period should be established for nurses who have had their licenses revoked, or who have surrendered their licenses.

Recommendation 11 – Repeal obsolete provisions.

The NPA contains numerous obsolete provisions that should be repealed.

- **Graduate nurse permits.** In the past, it could take months for RN and LPN applicants to receive the results of their licensing examination and transmit the results to the Board so that the license could be issued. To enable these applicants to work as nurses while awaiting their examination results, the Board issued them graduate nurse permits. These permits are described in section 12-38-115(2), C.R.S.

[105] §§ 12-35-129, 12-37-103, 12-32-108.5, and 12-22-116, C.R.S., respectively.

The Board ceased offering these permits with the advent of computer-based testing, which eliminated the lag time between taking the licensure examination and receiving the results. These days, examination results are transmitted to the Board electronically on a daily basis, and applicants are typically issued their permanent nursing licenses within days of passing the examination. Therefore, all references to graduate nurses, graduate practical nurses, and graduate nurse permits should be deleted.

- **Vouchers.** Section 12-38-129, C.R.S., directs that "(a)ll vouchers drawn against any such appropriation shall be signed and certified… by the executive officer of the board." Vouchers are no longer drawn against the Board's annual appropriation. Therefore, all references to vouchers should be repealed.

Recommendation 12 – Repeal the requirement that proceedings relating to complaints where formal charges were filed be subject to the Colorado Open Records Act.

Section 12-38-116.5(9), C.R.S., exempts disciplinary proceedings—including investigations, hearings, and meetings—from the Colorado Open Records Act (CORA). This exemption assures due process for the nurse undergoing disciplinary proceedings. There is, however, an exception to this exemption:

> Except when a decision to proceed with a disciplinary action has been agreed upon by a majority of an inquiry panel and a notice of formal complaint is drafted and served on the licensee by first-class mail[.]

In other words, meetings regarding disciplinary proceedings are closed, except for when a panel has filed a formal complaint against a nurse via the Attorney General's Office (AGO).

This creates an unintended double standard. When nurses agree to a settlement *before* a formal complaint is filed, the final disciplinary document becomes public, but all subsequent discussion of the case is held in closed session. When nurses agree to a settlement *after* a formal complaint is filed, then all subsequent proceedings relating to the case must be conducted in accordance with CORA. In theory, this penalizes nurses who exercise their right to due process.

In practice, the exception creates a considerable administrative burden for Board staff as well as the panels. Since discussion of cases in which formal complaints were filed is subject to the open records law, even long after the case has been settled, these cases must be conducted in open session. Board staff must sift through the 40 to 50 cases on a typical panel agenda, determine which ones fall into this category, and place those cases on the open session agenda.

Requiring that all discussion of cases where formal complaints were filed be conducted in open session is unique to the NPA and the Nurse Aide Practice Act. Similar health care boards, namely the Board of Medical Examiners, the Board of Dental Examiners, the Podiatry Board, and the Board of Chiropractic Examiners,[106] carry no such exception: although formal complaints and final disciplinary documents are public, disciplinary proceedings may be conducted in closed session.

Removing the requirement that these cases be discussed in open session will in no way reduce the public's access to disciplinary information. Formal complaints prepared by the AGO and all final disciplinary documents would remain part of the public record.

Therefore, the requirement that cases where formal complaints were filed be subject to CORA should be eliminated. Doing so would bring the Board in line with other health care boards, and would streamline the administration of panel meetings without compromising public safety.

Recommendation 13 – Clarify that the Board has the power to conduct criminal history record checks against any person under the Board's regulatory authority.

As a routine part of the complaint investigation process, the Office of Investigations within the Division conducts name-based criminal history record checks of individuals under the Board's jurisdiction.

The authority under which these checks are conducted is presently unclear. Pursuant to section 12-38-108(1)(l)(B), C.R.S., the Board has the specific authority to conduct criminal history record checks on any CNA against whom a complaint has been filed. However, there is no similarly specific language for nurses and LPTs. Although the Board arguably has the authority to conduct such checks on any nurse pursuant to section 12-38-108(1)(h), C.R.S., the lack of specific wording could potentially call the Board's authority into question.

The Board largely relies on self-disclosure at the time of application and renewal to identify individuals with criminal histories. However, once a complaint has been filed, the Board must have the ability to conduct criminal history record checks against any individual within its regulatory authority. This is critical to protecting the public. Therefore, section 12-38-108(1)(l)(B), C.R.S., should be expanded to include all individuals subject to the regulatory authority of the Board.

[106] §§ 12-36-118(10) and 12-35-129(7)(e), 12-32-108.3(12), and 12-33-119(10), C.R.S., respectively.

Recommendation 14 – Clarify the wording that permits nurses to perform medical functions delegated by physician assistants.

Section 12-38-103(4), C.R.S., defines a "delegated medical function" as an aspect of care which implements and is consistent with a medical plan as prescribed by a licensed or otherwise legally authorized physician, podiatrist, or dentist.

The section goes on to authorize physician assistants (PAs) to delegate medical functions to nurses, provided that a physician appropriately delegated that medical function to the PA. The current wording states that:

> Subject to the provisions of section 12-36-106(5), a physician may delegate authority to a physician assistant who has passed a national certifying examination to implement any act under the medical plan, including the initiation of medical directives to any nurse licensed under section 12-38-111 or 12-38-112. Any such delegation to a physician assistant shall be made pursuant to the written or oral directions of a physician or written protocol.

The purpose of this provision is to establish that it is appropriate for nurses to perform medical functions delegated by PAs, but as written the passage implies that it is the nurse's responsibility to 1) verify that a PA has passed the national certifying examination, and 2) assure that the physician appropriately delegated the medical function to the PA, before accepting the delegated task.

The specific procedure for delegation from a physician to a PA is appropriately housed in section 12-36-106(5), C.R.S. Deleting the above wording would in no way affect the physician-to-PA delegation procedures or the PA scope of practice. Therefore, the wording above should be repealed, and section 12-38-103(4), C.R.S., rewritten to state simply that nurses may perform medical functions delegated by PAs.

Recommendation 15 – Clarify that nurse applicants may be charged a fee for the nursing peer health assistance or nurse alternative to discipline program.

By law, the Board may require applicants for initial licensure or reinstatement of a lapsed license, as well as renewing nurses, to pay a fee to support the nursing peer health assistance or nurse alternative to discipline program.

Section 12-38-131(1), C.R.S., states that:

> As a condition of licensure and for the purpose of supporting a nursing peer health assistance program or a nurse alternative to discipline program, every renewal applicant shall pay to the administering entity {…}

This language should be clarified to establish that the fee may be charged to both new applicants and to nurses renewing their licenses.

Recommendation 16 – Effective July 1, 2010, require all new applicants for placement on the advanced practice registry to have national certification.

As of July 1, 2008, all new applicants for advanced practice nurse (APN) designation must hold a graduate degree in the appropriate specialty.[107] Beyond this, the exact requirements for placement on the advanced practice registry vary depending on the type of APN designation. Most notably, to qualify for designation as a certified nurse midwife (CNM) or a certified registered nurse anesthetist (CRNA), applicants are required to have passed a national certifying examination,[108] while applicants for designation as a nurse practitioner (NP) or clinical nurse specialist (CNS) do not have to secure national certification.

According to data from the National Council of State Boards of Nursing (NCSBN), most nursing boards require the passage of a national certification examination as a condition for placement on the registry.

Table 13 shows the percentage of states currently requiring national certification for each type of APN designation.

Table 13
States Requiring National Certification for Advanced Practice Nurses

Type of APN	Percentage of States Requiring National Certification
Certified Registered Nurse Anesthetist (CRNA)	94.1
Certified Nurse Midwife (CNM)	86.3
Clinical Nurse Specialist (CNS)	74.5
Nurse Practitioner (NP)	88.2

These data reflect a clear national trend toward requiring all APNs to secure national certification.

Requiring national certification is also an important step toward standardizing the requirements for APN designation from state to state. The NCSBN has already developed an Advanced Practice Registered Nursing Compact (APRN Compact) that establishes national certification as the standard for APNs. Similar to the Compact that was implemented in Colorado in October 2007, the APRN Compact would allow states a mechanism for mutual recognition of APN authority. Although no date has been set for the implementation of the APRN Compact, it is likely to become a reality eventually given the general movement toward standardization of preparation and scope of practice of APNs.

[107] § 12-38-111.5(4)(c), C.R.S.
[108] Board Rule XIV, § 2.

Because Colorado CNMs and CRNAs must currently hold national certification, it is certain that over 600 of the approximately 4,000 APNs currently listed on the registry are already certified. Although the Board does not specifically collect this information for NPs and CNSs, it is very likely that the majority of these APNs hold national certification as well. That said, the intent of this requirement is not to exclude those uncertified APNs who have been safely practicing for years. Therefore, individuals already listed on the registry as of June 30, 2010, should be permitted to remain on the registry.

Requiring national certification for all APNs would bring Colorado into line with a majority of the states, preparing for the likely transition to mutual recognition of APNs from state to state. Therefore, all APNs should be required to obtain national certification to qualify for placement on the registry.

Recommendation 17 – Modify the collaborative agreement requirement for advanced practice nurses with prescriptive authority, and remove the limitations on the types of medication that such nurses may prescribe.

As a result of the 1994 sunset review of the Board, APNs were granted the ability to prescribe medications under certain limited circumstances.

At the time, specific legislation codifying a formal process whereby nurses could prescribe was a relatively new concept. Although many states allowed nurses to prescribe at the time of the sunset review, there was significant variation among the states, and there was little published research to either specifically support or undermine an argument to extend prescriptive privileges to nurses. There was, however, growing support for the practice of APNs. The sunset report cited one study conducted by the Office of Technology Assessment. That study, which evaluated the results of over 268 published studies dealing with practice outcomes of mid-level practitioners, including NPs and CNMs, found that the care provided by NPs was generally equivalent to and in some cases superior to that provided by physicians.[109]

However, the dearth of data specifically addressing prescriptive authority led stakeholders to be cautious in crafting the new legislation.

[109] Colorado Department of Regulatory Agencies, *Sunset Review of the Colorado Board of Nursing* (1994), p.10.

The current law places two important conditions on prescriptive authority:

- The APN may only prescribe controlled substances and prescription drugs to treat patients requiring:[110]
    - Routine health maintenance or routine preventive care;
    - Care for an acute, self-limiting[111] condition;
    - Care for a chronic condition that has stabilized; or
    - Terminal comfort care.
- The APN holding the authority must enter into a written collaborative agreement with a Colorado-licensed physician whose education and practice experience corresponds to that of the APN.

As of July 2008, 1,936 APNs held prescriptive authority.

There is no published research comparing patient outcomes before and after prescriptive authority was introduced in Colorado. In the absence of such evidence, the second sunset criterion requires DORA to evaluate whether the existing regulatory mechanisms establish the least restrictive form of regulation consistent with the public interest.

APNs with prescriptive authority play an extremely important role in Colorado's health care system, particularly in rural and inner-city areas. More and more APNs are acting as primary caregivers. In an effort to use an evidence-based approach to determine appropriate scopes of practice, Governor Ritter created the Collaborative Scopes of Care Advisory Committee to examine the roles mid-level providers could play in meeting Colorado's health care needs.

With the seemingly inexhaustible demand for health care services, as well as the declining numbers of physicians electing to go into primary care, the question becomes whether these restrictions on prescriptive authority serve the public interest.

Sections 12-38-111.6(3)(a) and (b), C.R.S., limit the types of medication an APN may prescribe. These provisions exclude the prescribing of certain medications from the scope of practice of all APNs.

[110] §§ 12-38-111.6(3)(a) and (b), C.R.S.
[111] § 12-38-111.6(3)(c), C.R.S., defines "self-limiting" as a condition that has a defined diagnosis and a predictable outcome and is not threatening to life or limb.

Colorado has historically taken an elastic approach to the nursing scope of practice. Instead of creating an itemized laundry list of acceptable tasks for nurses to perform, the Board expects nurses to perform only those jobs/tasks for which they possess the specialized knowledge, judgment and skill required to complete such job/task. The Board developed an algorithm to assist RNs in determining whether a task is within their scope of practice.[112] The algorithm guides the RN through a series of questions, including:

- Was the skill/task either taught in your basic nursing program, OR, if it was not included in your basic nursing education, have you since completed a comprehensive training program, which included clinical experience?
- Has this task become so routine in the nursing literature and in nursing practice (e.g., sharp wound debridement) it can be reasonably and prudently assumed within scope?
- Is the skill/task in your hiring agency policy and procedure manual?
- Does carrying out the duty pass the "reasonable and prudent" standard for nursing?

If an RN can answer "yes" to all the above questions, the task is within the RN's scope of practice. This algorithm is included in its entirety as Appendix A on page 60.

Although the document does not specifically address advanced practice nursing, the message is clear: professional nurses are responsible for 1) knowing their scope of practice, and 2) performing only those skills and tasks within their scope of practice. Considered in this context, prescribing the medications beyond those enumerated in sections 12-38-111.6(3)(a) and (b), C.R.S., could reasonably be part of an APN's scope of practice, as long as that APN has the knowledge, skills and judgment to do so.

The public would benefit from access to a greater number of health care providers trained to prescribe medications. If an APN with prescriptive authority has the knowledge, judgment and skill to prescribe the medications beyond those enumerated in sections 12-38-111.6(3)(a) and (b), C.R.S., but is prevented from doing so, this is not consistent with the requirement set forth in the second sunset criterion that regulation should establish the least restrictive form of regulation consistent with the public interest.

Section 12-38-111.6(8)(c)(I), C.R.S., states:

> Prescriptive authority by an advanced practice nurse shall be limited to those patients appropriate to such nurse's scope of practice. Prescriptive authority may be limited or withdrawn and the advanced practice nurse may be subject to further disciplinary action in accordance with this article if such nurse has prescribed outside such nurse's scope of practice or for other than a therapeutic purpose.

[112] Colorado Board of Nursing. *Scope of Practice.* Retrieved on August 6, 2008, from http://www.dora.state.co.us/nursing/scope/scope.htm

This provision clearly establishes that APNs who prescribe beyond their scope of practice are in violation of the NPA, and may be subject to disciplinary action. If the specific restrictions upon medications they can prescribe are deleted, APNs will still be held to this standard.

In a 2007 study of scope of practice models in the United States and Canada conducted by the Center for the Health Professions, at the University of California, San Francisco, the authors concluded:

> Inefficiencies occur when health care practitioners are not utilized to their full capacity in terms of their education, training, and competence. These inefficiencies may manifest as higher costs, limited access to care, and concerns over quality and safety.[113]

Given the desperate need for qualified providers, Colorado cannot afford to arbitrarily limit the scope of practice of its APNs.

The current restriction upon the medications that APNs may prescribe is inconsistent with the way the Board has traditionally interpreted scope of practice. There is no evidence that the public has benefited from these restrictions. There is, however, the potential for this restriction to compromise patient care by prohibiting qualified APNs from prescribing medications within their scope of practice.

The second restriction on APN prescriptive authority is that the APN must enter into a collaborative agreement with a Colorado-licensed physician whose education and practice experience corresponds to that of the APN.[114]

Representatives of the medical and nursing communities agree that collaboration is good for patients. The question is whether the collaborative agreement requirement ensures meaningful collaboration.

By law, the collaborative agreement must include the duties and responsibilities of each party, provisions regarding consultation and referral, and a mechanism designed by the APN to assure appropriate prescriptive practice.[115] Section 12-38-111.6(4)(d)(IV), C.R.S., directs that collaborative agreements must not be construed as:

- Permitting the independent practice of medicine;
- Limiting the ability of the APN to make an independent judgment;
- Requiring supervision by a physician; or
- Requiring the APN to use methods for prescribing medication that prevent the use of professional judgment or variation according to the needs of the patient.

[113] Catherine Dower, JD, Sharon Christian, JD, Edward O'Neil, PhD, MPA, FAAN, *Promising Scope of Practice Models for the Health Professions*, Center for the Health Professions, University of California, San Francisco (2007), p. 20.
[114] § 12-38-111.6(4)(d)(I), C.R.S.
[115] § 12-38-111.6(4)(d)(II), C.R.S.

In other words, collaborative agreements must respect the independence of the APN, while drawing a clear line between the practice of nursing and the practice of medicine.

The actual agreement itself does not need to be filed with the Board. The APN simply files a form with the Board with the name of the collaborating physician, and the Board assumes based on this form that the nurse is engaged in an appropriate collaborative relationship. An APN must inform the Board within 30 days of the commencement or termination of any collaborative agreement.[116]

For APNs practicing in large medical centers, it is not difficult to find a collaborating physician in the appropriate specialty area. For APNs in rural or underserved areas, however, it is another story. Anecdotal evidence gathered over the course of this review indicates that in some cases, APNs were unable to find a physician in the appropriate specialty area, or if they could, the physician might be located in another city. In the end, the collaborative agreement requirement can create barriers to health care in the geographic areas that need APNs' services the most. The collaborative agreement, rather than an effective regulatory tool, becomes an administrative hurdle.

The fact is that the collaborative agreement process has operated largely on the "honor system": by submitting the form to the Board, the APN is essentially attesting that he or she has a collaborative agreement as required by section 12-38-111.6, C.R.S. The NPA does not require the Board to review the agreement, visit the practice location, or perform periodic audits to assure the agreement is being implemented appropriately. It is the actual collaboration among health care providers that assures patient safety, not the fact that a particular piece of paper is on file with the Board.

With the passage of House Bill 08-1061, the following wording was added to the NPA:

> An advanced practice nurse shall practice in accordance with the standards of the appropriate national professional nursing organization and have a safe mechanism for consultation or collaboration with a physician or, when appropriate, referral to a physician. Advanced practice nursing also includes, when appropriate, referral to other health care providers.[117]

This provision underscores the critical role collaboration plays in health care. It is the duty of all APNs to have established appropriate mechanisms for consultation and referral: in other words, they are required to collaborate. Nurses are not physicians, and in the interest of their patients, they must forge and maintain powerful, meaningful collaborative relationships with physicians and other health care providers.

Although collaboration is critical, the collaborative agreement requirement as set out in law is currently flawed. As the first step in improving the framework for collaborative agreements, the General Assembly should make the following statutory changes.

[116] Board Rule XV, § III, A3.
[117] § 12-38-111.5(6), C.R.S.

1. **Remove the specific requirements for collaborating physicians from the NPA.**

   The current law requires that an APN:

   > (Execute) a written collaborative agreement with physician *licensed in Colorado whose medical education, training, experience, and active practice correspond with that of the advanced practice nurse*. {Emphasis added}

   The italicized text makes it difficult for some APNs, particularly those in rural or underserved areas, to find qualified physicians with whom to collaborate. There may be other equally valid approaches that would simultaneously assure patient safety and expand access to health care. Therefore, the specific requirements for collaborating physicians should be removed from the NPA.

2. **Harmonize sections 12-38-111.6(4)(d) and 12-36-106.3, C.R.S.** The exact requirements for collaborating physicians and collaborative agreements differ between the NPA and the Medical Practice Act. For the sake of clarity, the wording in these statutes should be harmonized.

3. **Add a provision exempting collaborating physicians from liability**. Liability concerns can make physicians reluctant to enter into collaborative agreements with APNs. To create an incentive for physicians to enter into such agreements, the NPA should state that a collaborating physician will not be held liable for an APN's practice purely on the basis of the signed agreement. A new statutory provision should be added that specifically exempts physicians from liability under these circumstances.

It is in the best interest of Coloradans to promote allowing APNs to practice within the full the scope of their knowledge, judgment and skills. Therefore, the restrictions on the types of medication APNs can prescribe should be eliminated, and the statutory wording regarding collaborative agreements should be revised as described above.

Recommendation 18 – Direct both the Board and the Board of Medical Examiners to promulgate joint rules regarding collaborative agreements by April 1, 2010.

As established in Recommendation 17 above, the current requirements regarding the collaborative agreements that APNs with prescriptive authority must enter into with physicians are flawed. Although the statutory changes recommended above will allow greater flexibility in the selection of collaborating physicians, further changes are required.

Therefore, the General Assembly should amend both the NPA and the Medical Practice Act to direct the Board and the Board of Medical Examiners to promulgate joint collaborative agreement rules. In promulgating these rules, the boards should assure patient safety while promoting access to health care services.

These joint rules should address among others, the following areas:

- Further elimination of restrictions by establishing standards for remote consultation;
- Requirements for consultation and referral if the collaborating physician cannot be reached; and
- Collaborative agreement requirements that encourage participation by reducing costs to APNs.

The promulgation of rules that address these areas would move forward the creation of a meaningful new framework for collaborative agreements. As part of their collaboration, the boards could discuss and offer additional guidance on malpractice requirements, liability and incentives for participation.

The statutory language should require that these rules be promulgated by April 1, 2010, otherwise the Division Director should be granted the power to promulgate such rules.

Recommendation 19 – Repeal the Nursing Shortage Alleviation Act of 2002.

The Nursing Shortage Alleviation Act of 2002 (Act), located at section 12-38-201, *et seq*., C.R.S., suggests that the Board collaborate with the Department of Public Health and Environment to identify and encourage remedies for Colorado's nursing shortage.

This legislation was originally introduced as Senate Bill 02-134. In addition to establishing the Act, the bill sought to make numerous changes throughout the statutes, including:

- Limiting the number of hours nurses could be permitted to work, specifically, eliminating mandatory overtime;
- Requiring insurers to reimburse nurses at the same rates as physicians for performing similar procedures;
- Directing the Colorado Commission on Higher Education to establish a two-year professional nursing program; and
- Placing numerous provisions throughout the statutes establishing the General Assembly's awareness of the nursing shortage, and its support of any efforts to develop workforce development.

The bill's fiscal note called for an appropriation of $137,810 and one full-time equivalent (FTE) employee in order for the Department of Regulatory Agencies (DORA) to implement the Act. The fiscal note also assumed that two advisory committees would be formed to implement the Act: one to develop recommendations for legislative changes and a public education-awareness program, and the second to examine nursing educational barriers, develop rules and policies regarding nursing education, and prepare a report for the General Assembly.

By the time the legislation passed—as part of House Bill 02-1003—it had undergone substantial changes. The most controversial provision, limiting the hours nurses could work, was ultimately stripped, as was the appropriation.

The Act contains no mandates. It "encourages" the collection and analysis of nursing workforce data, but does not require the Board to meet any specific goals or timelines. The Act does not grant the Board any additional powers to those delineated in section 12-38-108, C.R.S. In fact, the law effectively curtails the Board's powers by expressly forbidding it from forming an advisory committee to assist in implementing the law.[118]

Although no funding or resources were provided to help implement the Act, the Act authorizes the Board to seek grants and donations to a "Nursing Shortage Fund." To date, no revenues have been deposited in this fund.

Lacking funding and resources, the Board has not spearheaded any efforts to meet the objectives outlined in the Act.

The primary objective of the Board is public protection. The Board has numerous legislative mandates to fulfill, and cannot neglect its public protection activities in order to pursue the worthy—but ultimately optional—objectives outlined in the Act. The Board is a cash funded agency, meaning its administrative costs are covered by licensing fees. Lacking additional funding and resources, the Board cannot be reasonably expected to implement the Act. Should the Board wish to pursue efforts to address the nursing shortage in the future, there is nothing preventing it from convening advisory committees or recommending legislation to do so.

Therefore, the Act should be repealed.

[118] § 12-38-202(7), C.R.S.

Recommendation 20 – Require APNs in independent practice to maintain professional liability insurance, and authorize the Board to promulgate rules establishing exemptions to this requirement.

Professional liability insurance provides a means by which consumers may be made financially whole in the event that they have to file a malpractice claim against a health care professional. Many health care providers, including chiropractors,[119] podiatrists,[120] optometrists,[121] dentists,[122] and physicians,[123] are required to maintain such insurance coverage.

The vast majority of nurses work in settings where their employers provide this kind of coverage. Some APNs, however, are engaged in independent practice.

According to stakeholders interviewed for this report, most APNs currently in independent practice already hold professional liability insurance. Although these practitioners may elect to purchase liability insurance, there is no requirement that they do so. This places the patients under their care at risk, in the event they have cause to pursue legal action.

Professional liability insurance appears to be available for each type of APN designation. APNs may currently obtain insurance via their professional associations, American Nurses Association for NPs and CNSs, the American Association of Nurse Anesthetists for CRNAs, and the American College of Nurse Midwives for CNMs.

The costs of such policies vary depending on the type of practice, whether the APN works full-time or part-time, and whether the nurse has prescriptive authority. DORA reviewed the cost of liability insurance for APNs with CNS and NP designation, who comprise the majority of Colorado APNs. Annual premiums for a policy that provides coverage of $1 million per occurrence and $6 million annual aggregate can range from $303 per year for an NP or CNS working part-time in adult care, to $1,617 for an NP or CNS working in obstetrical labor and delivery.[124] These premiums are reasonable enough that requiring such insurance would not impose an undue financial burden on APNs.

[119] § 12-33-116.5, C.R.S., Board of Chiropractic Examiners *Rule 3, Professional Liability*.
[120] § 12-32-102(2), C.R.S., and Colorado Podiatry Board Rule 220, Rules and Regulations Regarding Financial Responsibility Standards.
[121] § 12-40-126, C.R.S.
[122] § 13-64-301, C.R.S., and Board of Dental Examiners *Rule XXI, Financial Liability Requirement*.
[123] § 13-64-301, C.R.S., and Colorado State Board of Medical Examiners Rule 220, Rules and Regulations Regarding Financial Responsibility Standards.
[124] Professional Liability Insurance Application, Employed Nurse Professionals, American Nurses Association, p. 2.

Because APNs practicing independently without professional liability insurance could place the public at risk, and because such insurance coverage appears to be available and reasonably priced, the General Assembly should require APNs practicing independently to secure professional liability insurance. With the exception of chiropractors,[125] health care professionals must currently secure a policy that provides coverage of at least $500,000 per claim and $1.5 million aggregate per year. The General Assembly should hold APNs engaged in independent practice to the same standard.

The Podiatry Board, the Optometry Board, the Board of Medical Examiners, and Board of Chiropractic Examiners have established lesser financial responsibility requirements for practitioners meeting certain criteria, i.e., podiatrists who do not perform surgical procedures,[126] optometrists engaged primarily in non-clinical duties,[127] or physicians whose practice is confined to a federal or military agency.[128] These boards may also exempt certain practitioners from the financial responsibility requirements. The Board should be granted similar authority to promulgate rules establishing such exemptions or lesser requirements as appropriate.

Administrative Recommendation 1 – Increase the percentage of clinical hours that may be performed in a clinical simulation laboratory from 15 percent to 25 percent in any given course.

Nursing education programs often include clinical laboratory and simulation components to help teach students clinical skills.

Board rule defines a clinical laboratory as a laboratory setting for practice of specific basic clinical skills.[129]

Clinical laboratory experiences allow students to learn and practice routine skills before performing the skills on real patients. Nursing students interviewed for this report expressed that the more opportunities they have to practice a nursing task—such as venipuncture—in a clinical simulation setting, the more effectively and confidently they are able to perform the task on real patients during their clinical rotations.

Board rule defines a clinical simulation laboratory as:

> (A) care setting utilizing human simulation experience to create realistic, life-like scenarios where students engage in the practice of nursing skills and theory application under the direction of licensed nursing faculty.[130]

[125] Pursuant to section 12-33-116.5, C.R.S., chiropractors must secure coverage for $100,000 per claim with a $300,000 aggregate per year.
[126] § 12-32-102(2)(b), C.R.S.
[127] § 12-40-126(2), C.R.S.
[128] Colorado State Board of Medical Examiners Rule 220, Rules and Regulations Regarding Financial Responsibility Standards, § 2a.
[129] Board Rule II, § 1.6.
[130] Board Rule II, § 1.9.

Clinical simulation laboratories can be used to allow the students to experience low-frequency, high-acuity scenarios which they might not otherwise encounter in a real clinical setting. Simulation laboratories typically feature computerized mannequins that can be programmed to demonstrate a range of medical experiences, including sepsis, allergic reactions, heart attacks, and broken bones.[131]

At the Work, Education, and Lifelong Learning Simulation (WELLS) Center at Fitzsimons Medical Campus, a representative of DORA observed nursing and medical students working through a complex, high-acuity scenario. After the scenario was completed, students had an opportunity to debrief with an instructor, identify areas for improvement, then run through the same scenario again. The contrast between the first and second run-throughs was remarkable. This process gives the students an opportunity they will never have in a real clinical experience: to learn from their mistakes and immediately put that knowledge into practice.

The National League for Nursing (NLN) conducted a three-year study to evaluate the efficacy of simulation experiences for nursing students. The study concluded:

> While more research is needed, it appears that immersion in a simulation provides the opportunity to apply and synthesize knowledge in a realistic but non-threatening environment. Active involvement and the opportunity to apply observational, assessment, and problem-solving skills, followed by a reflective thinking experience, leads to increased self-confidence in students. In addition, when students are more active and immersed in a learning situation, the feedback they receive regarding what they did correctly and incorrectly can greatly facilitate their learning. It is expected that the expanded use of simulation in nursing education will facilitate increased learning and skill transfer when students care for patients in today's complex, health care environment.[132]

All laboratory and simulation experiences are not equal. The NLN study found that the most realistic simulated scenarios provide the most rewarding educational experiences for students, and realistic simulation technology can be costly. Also, there is no substitute for traditional clinical experiences, which offer students the opportunity to work with real patients in real health care settings. However, clinical laboratories and simulation, when used properly, can complement and enhance traditional clinical experiences.

[131] *Annual Report for Calendar Year 2006*, Colorado Center for Nursing Excellence (2007), p. 7.
[132] Pamela Jeffries, Mary Anne Rizzolo (2006), "Summary Report: Designing and Implementing Models for the Innovative Use of Simulation to Teach Nursing Care of Ill Adults and Children: A National, Multi-Site, Multi-Method Study," National League for Nursing, p.12.

Securing traditional clinical experiences is one of the ongoing challenges in nursing education. Nursing education programs can only admit as many students as there are available clinical resources, which can result in long waiting lists. For example, according to data from the Colorado Community College System (CCCS), Pikes Peak Community College offers 140 slots in its RN program: there are currently 300 students on the waiting list. The Larimer campus of Front Range Community College offers 50 slots in its RN program: there are currently 400 students on the waiting list. The difficulty of securing clinical placements contributes to the bottleneck in Colorado's nursing education system, and consequently, to the ongoing nursing shortage. Increasing the number of clinical hours performed in clinical laboratories and clinical simulation laboratories could help move students through the nursing education system more efficiently.

Access to sophisticated clinical simulation laboratories appears to be relatively widespread. CCCS, which educates more than half of Colorado's nurses, has established considerable simulation resources at its campuses across the state, including mobile units that serve rural areas. This suggests that Colorado's nursing education programs are already providing the kind of high-fidelity simulation experiences that are most useful for students.

Currently, Board rules state that for any one clinical course, no more than 15 percent of clinical hours can be delivered utilizing clinical laboratory and/or clinical simulation.[133] Given the advances in laboratory and simulation technology, the specific benefits of using these teaching methods in tandem with traditional clinicals, and the ongoing struggle to secure sufficient clinical resources for Colorado's nursing students, the Board should increase the allowable percentage of simulated/laboratory hours to 25 percent.

To assure that clinical simulation laboratories are sufficiently sophisticated to offer students an optimal experience, the Board should require programs to seek Board approval before substantially changing their clinical simulation laboratories.

Administrative Recommendation 2 – Grant continuing approval to nursing education programs demonstrating ongoing national accreditation.

In addition to securing Board approval, Board rule requires nursing education programs to seek accreditation from either the Commission on Collegiate Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLN-AC).[134] Programs accredited by CCNE or NLN-AC must undergo an evaluation every five years to maintain accreditation.

[133] Board Rule II, § 3.13 C.4.c.
[134] Board Rule II, § 3.2.

To maintain Board approval, programs are subject to review at least every five years. Although Board rules specify that such site visits should be coordinated with the national nursing accrediting body,[135] requiring nursing education programs to be reviewed by two different entities every five years can create an administrative burden for the Board as well as the faculty and staff of the nursing education program.

Although both CCNE and NLN-AC require Board approval as a condition of accreditation, Colorado is only one of seven states that require national accreditation. According to a representative of the CCCS, a 2006 study estimated that obtaining and maintaining national accreditation for all the community colleges in the system would cost CCCS more than $10 million annually. Given the expense of securing and maintaining national accreditation the Board should examine whether this requirement is necessary.

If the Board does continue to require national accreditation, it should do everything in its power to streamline the ongoing approval process and eliminate duplicative efforts both for nursing programs and for Board staff. At a minimum, the Board should grant continuing approval to nursing education programs that can provide evidence of ongoing national accreditation.

Administrative Recommendation 3 – The Board should actively pursue implementation of continuing competency requirements in conjunction with DORA's implementation plan.

DORA is currently undertaking a collaborative effort with professional associations to create a regulatory culture of continuing competency for regulated professions. Continuing education has long been the regulatory standard because of its ease of implementation by administrative staff and acceptance by licensees and trade/occupational associations. In fact, section 12-38-127, C.R.S., currently authorizes the Board to require continuing education; however, since 1991 the Board has chosen not to require mandatory continuing education, because it has many shortcomings. Consequently, efforts are underway across the country to develop and implement new models of assuring that practitioners continue to be competent when their licenses are renewed.

DORA's model for continuing competence is one that establishes a goal that a licensee assess his or her current knowledge and skills, execute a learning plan based on the assessment and demonstration of knowledge and skills necessary to ensure a minimal ability to safely practice the profession. While continuing education is expected to play a role in the continuing competency model, the education received will be targeted and retention measured.

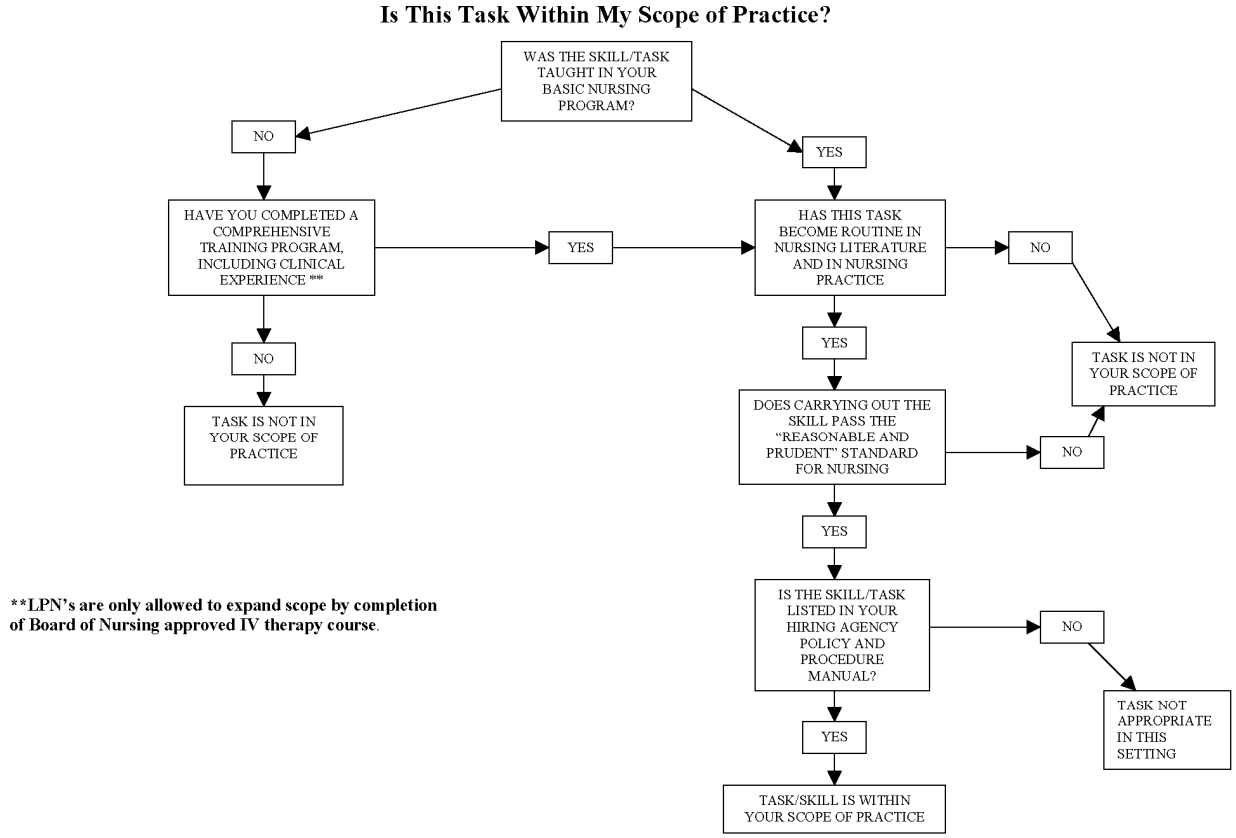
[135] Board Rule II, § 5.3.

In general, a continuing professional competency program is envisioned as including at a minimum, the following elements:

(I) Assessment of the knowledge and skills of a licensee seeking to renew a license;
(II) Development, execution of a learning plan based on the assessment; and
(III) Periodic demonstration of the knowledge and skills necessary to ensure a minimal ability to safely practice practical or professional nursing.

It is the conclusion of this sunset review that the Board should actively participate in DORA's efforts to implement continuing competency provisions in licensing boards.

Appendix A – Scope of Practice Algorithm for Registered Nurses (RNs)



****LPN's are only allowed to expand scope by completion of Board of Nursing approved IV therapy course**.