COLORADO DEPARTMENT OF REGULATORY AGENCIES
OFFICE OF POLICY AND RESEARCH

NURSE AIDE CERTIFICATION PROGRAM

2002 SUNSET REVIEW

STATE OF COLORADO

DEPARTMENT OF REGULATORY AGENCIES
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Bill Owens
Governor

October 15, 2002

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 Colorado Department of Regulatory Agencies has completed the evaluation of the State Board of Nursing's nurse aide certification program. I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2003 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 38.1 of Title 12, C.R.S. The report also discusses the effectiveness of the State Board of Nursing and its 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,

M. Michael Cooke

M. Michael Cooke
Executive Director

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Background

The Sunset Process

The regulatory functions of the State Board of Nursing's (Board) nurse aide certification program (Program), in accordance with Article 38.1 of Title 12 of the Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2003, unless continued by the General Assembly. During the year prior to this date, it is the duty of the Department of Regulatory Agencies (DORA) to conduct an analysis and evaluation of the Program pursuant to section 24-34-104(9)(b), C.R.S.

The purpose of this review is to determine whether the Program should be continued for the protection of the public, and to evaluate the performance of the Board and the staff of the Department of Regulatory Agencies, Division of Registrations (Division). During this review, the Board must demonstrate that there is still a need for the Program, and that the regulation is the least restrictive form of regulation that is consistent with the public interest. DORA's findings and recommendations are submitted via this report to the legislative committee of reference of the Colorado General Assembly. Statutory criteria used in sunset reviews may be found in Appendix A on page 81.

Methodology

As part of this review, DORA staff conducted a literature review; attended meetings of the Nurse Aide Advisory Committee, the Medication Administration Advisory Committee and the Board; interviewed Board staff; reviewed Board records and minutes, including complaint and disciplinary actions; interviewed officials with state and national professional associations; interviewed health care providers and consumers; reviewed Colorado statutes and Board rules and reviewed the laws of other states.

Profile of the Profession

Nurse aides help care for physically or mentally ill, injured, disabled or infirm individuals by assisting them with activities of daily living, such as bathing, personal grooming, dressing, toileting and eating. While nurse aides may work in a variety of health care settings, only certified nurse aides (CNAs) are permitted to work in long-term care facilities and home health care agencies.

Long-term care facilities, such as nursing homes, provide round-the-clock care for patients, often referred to as residents, who may suffer from acute illnesses or injuries, or who are simply no longer able to care for themselves. Home health care agencies, on the other hand, provide care to patients in the patients' homes by sending CNAs and other health care providers for visits. The frequency and duration of these visits depends upon the patients' needs.

The educational and training prerequisites to become a CNA are minimal. To obtain certification, an individual need not have graduated from high school or obtained a general equivalency diploma, though individual employers may impose such requirements. State and federally mandated training courses must contain at least 75 clock hours of classroom and clinical training, which includes communication skills, documentation of patient status and care provided, reading and recording vital signs, basic infection control procedures, basic body functions, maintenance of a healthy environment, emergency procedures, personal hygiene and grooming, safe transfer techniques, normal range of motion and positioning and basic nutrition.

CNAs perform routine tasks under the supervision of licensed health care providers. Depending upon the setting, CNAs answer patients' call bells, deliver messages, assist with meals and eating, make beds, assist with dressing and bathing, provide skin care, assist with personal grooming and toileting, take temperatures and blood pressure, assist with getting into and out of bed and assist with walking. In addition, CNAs are often called upon to empty bedpans, change soiled bed linens and perform bowel programs. They frequently care for disoriented, irritable or uncooperative patients. Because of this continual, often day-to-day interaction with patients, the role of the CNA cannot be understated.

CNAs perform a variety of intimate and routine services for some of society's most vulnerable populations – the elderly and the disabled. However, CNAs are not compensated accordingly. According to the U.S. Bureau of Labor Statistics, the median hourly wage for a CNA working in a nursing home was $8.89 in 2000, and $8.23 for a CNA working in the home health care setting.[1] According to data available from the Colorado Department of Labor and Employment (DOLE), the average hourly wage for a CNA working in a nursing home in Colorado in 1998 was $8.41, and $8.11 for a CNA working in the home health care setting.[2] Both sets of figures, when annualized, provide incomes of less than $20,000 per year. By way of contrast, DOLE's website reports that refuse collectors are paid an average of $12.52 per hour.[3]

With such low wages, it is no surprise that, until recently, there was a statewide shortage of CNAs. However, with the nationwide economic downturn, this situation has now reversed itself, at least in urban areas.

History of Regulation

In 1987, the U.S. Congress passed the Omnibus Budget Reconciliation Act of 1987, which mandated that all nurse aides who work in nursing homes and other long-term care facilities that receive funds from Medicare and/or Medicaid receive certain minimal training and testing. Shortly thereafter, Congress imposed similar, though not identical, requirements on home health aides.

[1] *2002-2003 Occupational Outlook Handbook*, U.S. Bureau of Labor Statistics, p. 319.
[2] *Colorado Occupational Employment Outlook 1998-2008 - Top 50 Occupations by Average Annual Wage*, Colorado Department of Labor and Employment, as downloaded from www.coworkforce.com/LMI/oeo/Top50AAW.htm on June 13, 2002.
[3] *2000-2001 Occupational Wages, Table 3 – Hourly*, Colorado Department of Labor and Employment, as downloaded from www.coworkforce.com/LMI/wages/Table3h.htm on June 18, 2002.

The Colorado General Assembly passed the nurse aide practice act (Act), effective July 1, 1989. Following a prolonged debate over whether to place the new program in the Colorado Department of Public Health and Environment (CDPHE), which regulates long-term care facilities and home health care agencies, or with the Board, which regulates registered nurses, licensed psychiatric technicians and licensed practical nurses, the Act placed the new program under the auspices of the Board.

The Act and the rules promulgated by the Board synthesize the training, testing and registry requirements of the multiple federal mandates, thus allowing a Colorado-certified nurse aide to work in either or both long-term care facilities or home health care agencies without having to acquire separate certifications depending on employment setting.

In 1989, the Board promulgated rules regarding certification requirements and requirements for nurse aide-training programs. In 1999, the Board promulgated new rules establishing the federally mandated Nurse Aide Registry, which contains certification and disciplinary information on all CNAs certified by the Board. In addition, the Nurse Aide Registry contains notations for those CNAs who have been disciplined for misappropriating patient or facility property, and for those who have been disciplined for abusing or neglecting the patients in their care. Under the federal mandates, a CNA who has received such discipline may not, in general, continue to work as a CNA anywhere in the U.S.

During the 2002 regular legislative session, the General Assembly passed two bills that directly relate to CNAs. House Bill 02-1090 created the Medication Administration Advisory Committee and tasked that committee with providing input to DORA for this sunset report regarding whether and under what conditions CNAs should be permitted to administer medications.

The second bill, House Bill 02-1447, created the Direct Care Provider Career Path Pilot Program. The purpose of this program is to bring together, among others, educators, job-training professionals, individuals seeking entry-level employment, county departments of social services and potential employers to develop a system of improved recruitment and retention of CNAs. This program, which is to be implemented in southwest Colorado, creates three tiers of CNA employment, where each tier represents increased educational requirements and concomitant wage earning and prestige potential.

Legal Framework

A multitude of federal laws and regulations directly impact Colorado's nurse aide certification program (Program). For example, the regulations governing home health care agencies (HHAs) and long-term care facilities that participate the Medicare and Medicaid programs mandate different training and testing requirements, depending upon the setting in which the nurse aide works. In addition, the federal regulations pertaining to hospice specifically adopt the standards and regulations pertaining to HHAs.[1]

Under the federal nursing home regulations, a nurse aide is an individual who provides nursing or nursing-related services to residents. Exempted from this definition are licensed health professionals, registered dieticians or anyone who volunteers to provide such services without pay.[2]

Under the HHA/hospice regulations, a nurse aide provides hands-on personal care, performance of simple procedures, assistance in ambulation or exercises and assistance in administering medications that are ordinarily self-administered.[3]

Nursing homes can only employ nurse aides who, within four months of hire, have completed a training and competency evaluation or who are otherwise deemed competent to deliver nurse aide services.[4] Additionally, the nursing home, but not an HHA/hospice, must verify that the individual has not been disciplined for abuse, neglect or misappropriation of facility or patient property, and has met competency evaluation requirements by checking with every state's Nurse Aide Registry.[5]

However, a nurse aide who works for an HHA or hospice cannot begin work as such until he/she has successfully completed a state-approved, or state-operated, training program and competency evaluation, or has simply passed a competency evaluation.[6] One caveat to this rule is that a nurse aide who works as a personal care attendant need only pass those sections of the competency evaluation pertaining to the services that aide will provide.[7]

Under both the nursing home regulations and the HHA/hospice regulations, a certified nurse aide (CNA) who has not provided nurse aide services for compensation during the previous 24 months, must receive retraining and/or retake the competency evaluation.[8]

Nurse aide training programs in nursing homes must consist of at least 75 clock hours, 16 of which must include supervised practical training with patients.[9] An additional 16 hours of pre-clinical training must cover communication and interpersonal skills, infection control, safety/emergency procedures, promoting residents' independence and respecting residents' rights.[10] The remainder of the training must cover basic nursing skills, personal care skills (i.e., bathing, grooming and eating), mental health and social service needs of residents, care of cognitively impaired residents, basic restorative services and residents' rights.[11]

The regulations governing HHA/hospice nurse aide training programs are slightly different. Like the nursing home programs, they must consist of at least 75 clock hours, 16 of which must be in the classroom and completed prior to the time the student begins any supervised practical training with patients. At least another 16 hours must be devoted to supervised practical training.[12] Pursuant to Title 42, Part 484, Sections 36(a)(1) and (b)(2)(i) of the Code of Federal Regulations (CFR), the nurse aide-training course and competency evaluation must address:

- Communicating with patients and others.
- Observing, reporting and documenting patient status and the care or service furnished.
- Reading and recording temperature, pulse and respiration.
- Practicing basic infection control procedures.
- Recognizing basic elements of body function and changes in body function that must be reported to the aide's supervisor.
- Maintaining a clean, safe and healthy environment.
- Recognizing emergencies and practicing basic emergency procedures.
- Recognizing the physical, emotional and developmental needs of patients and knowing ways to work with the populations served by the HHA, including the need to respect the patient and his/her privacy and property.
- Practicing appropriate and safe techniques in personal hygiene and grooming that include bathing, nail and skin care, oral hygiene, toileting and elimination.

- Practicing safe transfer techniques and ambulation.
- Assisting with normal range of motion and positioning.
- Providing adequate nutrition and fluid intake.

A CNA who receives an "unsatisfactory" score in any of these required areas on the competency evaluation, is deemed to be "not competent" in that area.[13]

Under both sets of regulations, nurse aide training programs must be conducted by, or under the supervision of, a registered nurse who has at least two years nursing experience. For HHA/hospice instructors, at least one of these years must be in the home health care setting.[14] For nursing home instructors, at least one of these years must be in the nursing home setting.[15] In addition, nursing home instructors must have experience or training in adult education.[16]

Under both sets of regulations, a CNA's performance must be evaluated every 12 months.[17]

Nursing homes are required to provide a CNA with at least 12 hours of in-service training each year to ensure continued competence and to address areas of weakness as determined by performance reviews.[18] Noticeably, a nursing home is only required to provide the in-service training; there is no requirement that the CNA actually receive it. In the HHA/hospice setting, however, a CNA must receive at least 12 hours of in-service training each year.[19]

Whereas the regulations for HHA/hospice are silent as to the actual competency evaluation, the nursing home regulations are not. Candidates for certification must pass both a standardized written/oral examination and a standardized practical/skills examination. The candidate must be given the choice between a written and oral examination, the questions for which must be drawn from a pool of questions covering the mandatory training topics.[20] The practical/skills examination must consist of a demonstration of randomly selected items drawn from a pool consisting of the tasks generally performed by nurse aides, including the mandatory training topics discussed above.[21] Candidates must be given at least three opportunities to pass the competency evaluation and must be advised of the areas that were failed.[22]

Importantly, the nursing home regulations mandate that the competency evaluation be administered either directly by the state, or by a state-approved entity that does not receive Medicare and/or Medicaid payments.[23]

The nursing home and HHA/hospice regulations also differ in that a nurse aide who is employed by a nursing home, or has received an offer of employment from a nursing home, cannot be charged for any portion of the training and/or competency evaluation program.[24] Similarly, if a candidate is not employed at the time he/she completes training and/or completes the competency evaluation, but becomes employed by a nursing home within 12 months of such completion, the state must reimburse the CNA, on a *pro rata* basis, for any costs incurred in completing the training program and/or competency evaluation.[25] The HHA/hospice regulations contain no provisions for the reimbursement of training and evaluation costs; the CNA bears these costs.

Finally, the nursing home regulations mandate that the state establish and maintain a registry of nurse aides certified by that state.[26] The registry must include, for each CNA: full name and other identifying information, as necessary; date of eligibility to be placed on the registry; information regarding any findings that the CNA engaged in the neglect and/or abuse of a resident and information regarding any findings that the CNA misappropriated resident property.[27] Any CNA who has not provided CNA services, for pay, during the preceding 24 months, must be removed from the registry unless that CNA was found to have abused and/or neglected a resident or misappropriated resident property, in which case the registry must note such facts and provide relevant information.[28] The state is prohibited from imposing any charges on registrants for listing them on the registry.[29] CNAs who work in home health care may be included on the registry.[30]

The state is responsible for establishing the standard for a passing score on the competency evaluation, but such standard must involve satisfactory completion of both the written/oral and practical/skills portion of the examination.[31] A nurse aide who passes the competency evaluation must be listed on the registry within 30 days of passing the examination.[32]

Rather than develop two separate programs to comply with these diverse, though intimately related, federal mandates, Colorado has developed a nurse aide certification program that combines these federal requirements so that a nurse aide who is approved to work in a nursing home may also, without additional training or certifications, go to work for an HHA or hospice, and *vice versa*.

Only those individuals who currently hold a certificate to practice as a nurse aide, as issued by the State Board of Nursing (Board), have the right to use the title "Certified Nurse Aide" or "C.N.A."[33]

Nurse aide practice includes performing the services that require the education, training and skills specified in Article 38.1, Title 12, C.R.S., under the supervision of a dentist, physician, podiatrist, professional nurse, licensed practical nurse, or other licensed or certified health care professional.[34]

Any person who practices as a CNA and is not a CNA or fraudulently obtains or furnishes a certificate to practice as a CNA, or aides or abets someone doing so, is guilty of a Class 2 misdemeanor.[35]

Pursuant to section 12-38.1-117, Colorado Revised Statutes (C.R.S.), one need not obtain certification as a nurse aide to:

- Gratuitously care for friends or family members.
- Hold oneself out for hire as a nurse aide, but not as a certified nurse aide.
- Provide nursing assistance in an emergency.
- Act within the scope and course of employment as a CNA for the first four months of a person's employment as such, if that person is pursuing certification as a nurse aide and is directly employed by a nursing home or home health care agency.
- Act within the scope of a license, certificate or registration issued by the State of Colorado, provided such person is so licensed, certified or registered.

The Board has the ultimate authority to certify nurse aides to practice in Colorado and is responsible for implementing the provisions of Article 38.1 of Title 12, C.R.S.[36] However, the Board has the authority, which has been exercised, to appoint the Nurse Aide Advisory Committee (Advisory Committee), which is composed of five members: one CNA, one member of the Board, one member to represent professional associations of home health care agencies, one member to represent the concerns of senior citizens and one member to represent professional associations of nursing homes. In addition, an employee of the Colorado Department of Public Health and Environment serves in an *ex officio* capacity.[37] Advisory Committee members receive a $50-*per diem* and reimbursement of any related, actual costs.[38] Members of the Advisory Committee may serve no more than two, three-year terms.

Additionally, the Medication Administration Advisory Committee (MAAC) was created by the General Assembly in 2002.[39] Appointed by the Executive Director of the Department of Regulatory Agencies (DORA), the MAAC comprises eleven members: one geriatric physician; one pharmacist who is experienced in the delivery of pharmaceutical products in a health care-based setting; one advocate who represents residents of nursing homes; one home health care nurse; one director of a home health care agency; one professional nurse who is a director of a nursing home in an urban area and one who is a director of a nursing home in a rural area; one registered nurse who has experience teaching medication administration; one registered nurse who has experience teaching in a nurse aide-training program; one clinical researcher who has studied care delivery in long-term care settings and one member of the staff of the Board.[40] MAAC members do not receive any compensation or reimbursement for their service.[41]

The MAAC's sole task is to provide input to DORA for this sunset review regarding the benefits and risks associated with certified nurse aides serving as medication aides; the effect of the use of medication aides on the level of patient care; the level of experience a CNA must have in order to be considered for training as a medication aide; the extent and content of classroom training and education required to become a medication aide; the extent and limit to the scope of practice of a medication aide; and the requirements for supervision of a medication aide.[42]

The findings of the MAAC may be found in Appendix C on page 83. The MAAC has no functions other than those listed above.

Pursuant to sections 12-38.1-111(1) and (3), C.R.S., the Board may issue a letter of admonition or suspend, revoke or deny any certification to practice as a CNA upon proof that such CNA has:

- Procured or attempted to procure a certificate by fraud, deceit, misrepresentation, misleading omission or material misstatement of fact.
- Been convicted of a felony or has pleaded guilty or *nolo contendere* to a felony.
- Willfully or negligently acted in a manner inconsistent with the health or safety of a person under his/her care.
- Had a certification to practice as a nurse aide or license to practice any other health care occupation suspended or revoked in any jurisdiction.
- Violated any provision of Article 38.1 of Title 12, C.R.S, or has aided or knowingly permitted any person to violate any provision of such article.
- Negligently or willfully practiced as a nurse aide in a manner that fails to meet generally accepted standards of such practice.
- Negligently or willfully violated any order, rule or regulation of the Board pertaining to practice or certification as a nurse aide.
- Abused, neglected or otherwise harmed a person under his/her care.
- Misused, or habitually or excessively used any habit-forming drug as defined in section 12-22-102(13), C.R.S., or any controlled substance as defined in section 12-22-303(7), C.R.S.
- A physical or mental disability, which renders him/her unable to practice as a CNA with reasonable skill and safety and which may endanger the health or safety of persons under his/her care.
- Violated the confidentiality of information or knowledge as prescribed by law concerning any patient.

- Misappropriated patient or facility property.
- Engaged in any conduct that would constitute a crime if such conduct relates to the person's ability to practice as a nurse aide.

Except as otherwise noted, the Board need not determine intent when considering the basis for disciplinary action, but it may consider it when determining the sanctions to be imposed.[43]

A letter of admonition is appropriate when the Board finds that misconduct occurred, but, in the opinion of the Board, such conduct does not warrant formal discipline. A letter of admonition must be mailed to the CNA via certified mail. Within 20 days of proven receipt of the letter, the CNA may request that the letter be vacated and that formal disciplinary proceedings be instituted to afford the CNA a hearing in accordance with the State Administrative Procedure Act.[44]

In addition, the Board must automatically suspend a CNA's certification if a court of competent jurisdiction finds that CNA to be mentally ill. Similarly, the Board may require a CNA to submit to a mental or physical examination if the Board has reasonable cause to believe that the physical or mental condition of the CNA has resulted in the CNA being unable to practice with reasonable care, or that the CNA is a threat to the safety of his/her patients. Failure of a CNA to comply with such a requirement may result in the summary suspension of the certificate to practice.[45]

The Board may conduct disciplinary hearings itself or may employ hearing officers.[46] The Colorado Court of Appeals has initial jurisdiction to review final actions and orders of the Board.[47]

A CNA may voluntarily surrender his/her certificate to practice prior to the initiation of an investigation or hearing, but he/she must wait one year before reapplying for certification and then must meet all of the eligibility requirements for initial, not renewal, certification.[48]

A nurse aide may obtain certification either by endorsement or by passing the Board-approved competency evaluation.[49] Regardless of the way in which a nurse aide seeks certification, the nurse aide must submit the application on forms provided by the Board and the required, Board-established fees.[50] However, if a nurse aide seeks certification by taking the competency evaluation, the nurse aide must have graduated from a Board-approved training program, which may include, but is not limited to, training/education received in practical and professional nurse training programs.[51] The nurse aide must pass both the written and clinical performance portions of the competency evaluation.[52]

An applicant for certification by endorsement must demonstrate, in writing, that he/she is certified to practice as a nurse aide in another state whose requirements for certification are essentially similar to those of Colorado; has not committed any act or omission that would be grounds for discipline or denial of certification under Colorado law; has successfully completed an education training program approved by the Board or a program that meets the standards for such programs under Colorado law and has no record of abuse, neglect or misappropriation of residents' property or any disciplinary action taken or pending in another state.[53]

An applicant for certification by competency evaluation must pay the required fee and demonstrate, in writing, that he/she has not committed any act or omission that would be grounds for discipline or denial of certification under Colorado law and has successfully completed an approved training program.[54]

In addition, the nurse aide, regardless of the method by which certification is sought, must submit to a criminal history background check conducted within 90 days of submittal of the application for certification.[55] Companies approved by the Board to conduct the background checks must be able to provide information relating to any convictions.[56] The report must include the name of the nurse aide applicant, social security number, date of birth, other names and aliases, dates of guilty or *nolo contedere* pleas and convictions, jurisdictions of convictions, descriptions of offenses, dispositions, classes and types of convictions, sentencing information, arrest reports, sources utilized in conducting the background check, timeframes checked and a written explanation as to any difficulties encountered in obtaining the required information.[57]

Criminal history background checks may only be performed by criminal history background check companies that have been approved by the Board.[58] Approvals are renewed every two years.[59] To obtain initial approval, the company need only demonstrate to the Board that it is able to perform criminal history background checks.[60]

If the criminal history background check reveals that the applicant has been convicted of a felony or has had a court accept a plea of guilty or *nolo contendere* to a felony, the Board may deny certification to the applicant.[61]

Competency evaluations must evaluate the candidate's basic nursing skills, personal care skills, recognition of mental health and social services needs, basic restorative services and resident/patient rights.[62] In addition, the competency evaluation must be offered, at a minimum, on a quarterly basis.[63]

A CNA certification is valid for two years, at the end of which time the CNA must apply for renewal.[64] A certification is considered a "renewal" when the CNA maintains continued certification prior to the expiration of the certificate.[65] The CNA must pay a renewal fee and demonstrate that he/she has provided nurse aide services, for pay, within the preceding 24 months, or that he/she has completed a new Board-approved training program within the same time frame.[66]

A certificate that is not renewed is subject to reinstatement.[67] To reinstate the certificate, the nurse aide must provide evidence that the CNA has successfully completed a Board-approved nurse aide-training program within the previous 24 months and submit to a criminal history background check.[68]

The Board may deny initial certification to a nurse aide who does not posses the minimum qualifications as demonstrated on the application for certification or if there is reasonable cause to believe that the applicant has committed any of the acts that serve as grounds for discipline. If the Board denies an application, it must so notify the applicant, who may request a hearing.[69]

Once certified, the CNA is required to notify the Board within 30 days of any name or address change.[70]

Nurse aide-training programs must be approved by the Board, which conducts on-site surveys every two years to ensure compliance with the various rules, regulations and statutes governing the nurse aide certification program.[71]

The Board may approve any nurse aide-training program offered by or held in a nursing home, home health care agency or other facility, so long as the training provider has not explicitly been disapproved by the Colorado Department of Public Health and Environment.[72] Any institution, agency or individual desiring approval of a nurse aide-training program must submit an application to the Board and may consult with the Board regarding compliance with the rules and regulations for approval.[73] In addition, the applicant must designate a program coordinator who is responsible for ensuring that the training program complies with the Board's requirements.[74]

When reviewing a training program for approval, the Board evaluates the program's governing body to determine its general policies and to ensure that it will provide adequate funding to the training program. The Board also ensures that the program has a qualified coordinator and that it has sufficient instructors to provide effective assistance and supervision to trainees.[75] In addition, the training program must ensure that students perform services under the supervision of a registered nurse, and that they only provide services for which they have been trained.[76] Finally, a nursing home or HHA that has been terminated from participating in either the Medicare or Medicaid programs is prohibited from conducting a nurse aide-training program.[77]

A program coordinator of a nurse aide-training program must hold an active license, in good standing, as a registered nurse in Colorado, have at least two years of nursing experience in caring for the elderly and/or chronically ill and attend a "train the trainer" program approved by the Board or demonstrate competency in adult education.[78] The primary instructor of a nurse-aide training program must hold an active license, in good standing, as a registered nurse or licensed practical nurse, have at least one year of nursing experience in caring for the elderly and/or chronically ill and attend a "train the trainer" program approved by the Board or demonstrate competency in adult education.[79] All other instructors must have a minimum of one year of current experience in their respective fields.[80]

A nurse aide-training program must include material that will provide a basic level of knowledge and demonstrable skills, and be presented in a manner that will take into consideration individuals with limited literacy skills.[81] Training program objectives must include producing nurse aides who are able to form a relationship, communicate and competently interact with patients; demonstrate sensitivity to residents' emotional, social and mental health needs; assist residents in attaining and maintaining independence; support patients' rights and demonstrate observational and documenting skills needed in the assessment of patients' health, physical condition and well-being.[82]

The course curriculum must include instruction regarding communication and interpersonal skills, infection control procedures, safety and emergency procedures, promoting resident/patient rights, basic nursing skills, personal care skills, recognition of mental health and social services needs and basic restorative services.[83] The training course must consist of at least 75 clock hours, 16 of which must include pre-clinical instruction. An additional 16 hours must include clinical instruction under the direct supervision of a registered nurse or licensed practical nurse.[84]

Once a nurse aide is certified as a CNA, his/her name is placed on the registry of CNAs (Nurse Aide Registry).[85] The Nurse Aide Registry contains the CNA's full name; last known address; date of birth; date of original Colorado certification; status of certification (including date of expiration of current certificate); certification number; name and address of entity that administered the CNA's competency evaluation; information regarding any finding of abuse, neglect or misappropriation of property; and information regarding any disciplinary action taken against the CNA.[86] Designation of abuse, neglect or misappropriation of property must occur within ten days after such a finding has been made by the Board or upon conviction by a court of law for such an offense.[87] A finding of abuse, neglect or misappropriation of patient property must be removed from the Nurse Aide Registry if the finding is determined to be in error, the CNA was found not guilty of such an offense in a court of law (if that conviction was the sole reason for including the designation on the registry), or if the Board is notified and provided proof of the CNA's death.[88]

Additionally, such a designation may be removed upon request of the CNA.[89] Except for cases of error, a not guilty verdict or death, the CNA may request the removal after five years of the date of the final finding in cases of neglect in which harm to the patient occurred, or after three years of the date of the final finding in cases of verbal abuse or neglect where no harm occurred.[90]

The Board may remove the designation upon submission of proof of a "not guilty" judgment or a determination that the incident was not part of a pattern of behavior, or a determination that similar behavior will not be repeated, or a determination that the individual has been rehabilitated.[91]

Although the Direct Care Provider Career Path Pilot Program created in section 12-38.1-201, et seq., C.R.S. (Pilot Program), is not directly related to the Program or this sunset review, it does represent a potential new direction for the CNA Program in the years ahead. Created by House Bill 02-1447, the Pilot Program will be implemented, if at all, in southwestern Colorado.[92] It is scheduled to be implemented on January 1 of the year following receipt by the Department of Health Care Policy and Financing and the Department of Public Health and Environment of the necessary federal waivers.[93]

Regardless of whether and when such waivers are obtained, the Pilot Program shall be repealed by operation of law on July 1, 2008.[94] Within two months of the completion of the Pilot Program, the Board and the Direct Care Advisory Committee created under the Pilot Program, are required to present a report to the General Assembly and the Governor that addresses the efficacy of the Pilot Program.[95]

The Pilot Program creates a three-tier CNA program. The first tier envisions a Certified Personal Care Provider, who possesses some of the training and performs a limited number of the tasks of a traditional CNA. The second tier envisions the creation of a CNA Level I, who is a traditional CNA. The third tier envisions the creation of a CNA Level II, who has all the training of a traditional CNA, but who also meets mentor or preceptor standards or any other specialty or advanced training requirements specified by the Board.[96]

The enabling legislation of the Pilot Program became effective July 1, 2002, so as of this writing, implementation of the Pilot Program has been limited.

[1] 42 CFR §418.94
[2] 42 CFR §483.75(e)
[3] 42 CFR §484.36(c)(2)
[4] 42 CFR §483.75(e)(2)
[5] 42 CFR §§483.75(e)(5) and (6)
[6] 42 CFR §§484.36(b)(1) and 484.4
[7] 42 CFR §484.36(e)(2)
[8] 42 CFR §§483.75(e)(7) and 484.4
[9] 42 CFR §483.152(a)
[10] 42 CFR §483.152(b)(1)
[11] 42 CFR §§483.152(b)(2)-(7)
[12] 42 CFR §484.36(a)(1)
[13] 42 CFR §484.36(b)(4)(ii)
[14] 42 CFR §484.36(a)(2)(ii)
[15] 42 CFR §483.152(a)(5)(i)
[16] 42 CFR §483.152(a)(5)(ii)
[17] 42 CFR §§483.75(e)(8) and 484.36(b)(2)(iii)
[18] 42 CFR §§ 483.75(e)(8)(i) and (ii)
[19] 42 CFR §484.36(b)(2)(iii)
[20] 42 CFR §483.154(b)(1)(i)
[21] 42 CFR §483.154(b)(2)
[22] 42 CFR §483.154(f)
[23] 42 CFR §483.154(c)(1)
[24] 42 CFR §483.154(c)(2)
[25] 42 CFR §483.154(c)(4)
[26] 42 CFR §483.156(a)
[27] 42 CFR §483.156(c)(1)
[28] 42 CFR §483.156(c)(2)
[29] 42 CFR §483.156(b)(4)
[30] 42 CFR §483.156(a)(3)
[31] 42 CFR §483.154(e)(1)
[32] 42 CFR §483.154(e)(2)
[33] §12-38.1-102(3), C.R.S.
[34] §12-38.1-102(5), C.R.S.
[35] §12-38.1-118, C.R.S.
[36] §12-38.1-103(1), C.R.S.
[37] §12-38.1-110, C.R.S.
[38] §24-34-102(13), C.R.S.
[39] §12-38.1-110.3, C.R.S.
[40] §§12-38.1-110.3(1) and (2), C.R.S.
[41] §12-38.1-110.3(3), C.R.S.
[42] §12-38.1-110.3(4), C.R.S.
[43] §12-38.1-111(2), C.R.S.
[44] §12-38.1-111(3), C.R.S.
[45] §§12-38.1-113(1) and (2), C.R.S.
[46] §12-38.1-114(1), C.R.S.
[47] §12-38.1-116, C.R.S.
[48] §12-38.1-115, C.R.S.
[49] Board Rule Chp. X, §§3 and 4
[50] §§12-38.1-104(1) and (2), C.R.S.
[51] Board Rule Chp. X, §§ 3.7 and 3.8
[52] Board Rule Chp. X, §3.11
[53] §12-38.1-106, C.R.S., Board Rule Chp. X, §4
[54] §12-38.1-105, C.R.S.

[55] §§12-38.1-104(3)(a), 12-38.1-105, 12-38.1-106(1)(e), C.R.S., Board Rule Chp. X, §§3.10(D) and 4.1(D)
[56] §12-38.1-104(3)(b), C.R.S.
[57] Board Rule Chp. XVI, §3.7
[58] Board Rule Chp. XVI, §5
[59] Board Rule Chp. XVI, §6
[60] Board Rule Chp. XVI, §5.6
[61] §12-38.1-111(1)(b), C.R.S.
[62] §12-38.1-107, C.R.S.
[63] §12-38.1-107, C.R.S., Board Rule Chp. X, §3.3.
[64] §12-38.1-109, C.R.S.
[65] Board Rule Chp. X, §5.1(A)
[66] §12-38.1-109, C.R.S., Board Rule Chp. X, §§5.2, 5.3 and 5.5(A)
[67] Board Rule Chp. X, §5.1(B)
[68] Board Rule Chp. X, §5.5(B)
[69] §§12-38.1-112, 24-4-104(9), C.R.S.
[70] Board Rule Chp. X, §6.3
[71] Board Rule Chp. XI, §9.2.
[72] §12-38.1-108(1), C.R.S.
[73] Board Rule Chp. XI, §§3.1(A) and (C)
[74] Board Rule Chp. XI, §3.1(B)
[75] Board Rule Chp. XI, §§4.1(C) and (D)
[76] Board Rule Chp. XI, §4.3
[77] Board Rule Chp. XI, §10.1
[78] Board Rule Chp. XI, §6.5(A)
[79] Board Rule Chp. XI, §6.5(B)
[80] Board Rule Chp. XI, §6.5(C)
[81] §12-38.1-108(2), C.R.S.
[82] Board Rule Chp. XI, §5.2(B)
[83] §§12-38.1-108(3) and (4), C.R.S., Board Rule Chp. XI, §5.2(A)(1)
[84] Board Rule Chp. XI, §5.2(A)
[85] §12-38.1-103(4), C.R.S.
[86] Board Rule Chp. XVII, §1
[87] Board Rule Chp. XVII, §3
[88] Board Rule Chp. XVII, §4
[89] Id.
[90] Board Rule Chp. XVII, §5
[91] Board Rule Chp. XVII, §7.3
[92] §12-38.1-203(1), C.R.S.
[93] §12-38.1-203(4), C.R.S.
[94] §12-38.1-208, C.R.S.
[95] §12-38.1-206, C.R.S.
[96] §12-38.1-204(1), C.R.S.

Program Description and Administration

Although the State Board of Nursing (Board) has the ultimate regulatory authority over the nurse aide certification program (Program), it has delegated most of its regulatory functions to the Nurse Aide Advisory Committee (Advisory Committee).

The five-member Advisory Committee meets monthly, typically for one or two hours. While the public is invited to attend, and notices of the meetings are posted on the Board's Internet homepage, no members of the public have recently attended an Advisory Committee meeting.

Technically, the Advisory Committee makes recommendations to the Board regarding certification and disciplinary issues. In practice, however, the Chair of the Board accepts these recommendations as a matter of course. In fact, the full Board does not discuss the Advisory Committee's recommendations. Rather, a memorandum regarding recent certification and disciplinary matters is provided to the Board's chair, who simply signs it on behalf of the Board, thus effecting Board action.

License/Registration

The Board receives funding for the Program through a variety of fees, as well as from Medicare and Medicaid. The Department of Regulatory Agencies (DORA) contracts with the Colorado Department of Public Health and Environment (CDPHE) for Medicare funds and with the Department of Health Care Policy and Financing (HCPF) for Medicaid funds. Medicaid funding is provided through a 50/50, federal fund/state general fund match. Medicare funding, however, is entirely federally funded.

Table 1 illustrates the funding provided through these three funding sources.

Table 1
Funding Information

	FY96-97	FY97-98	FY98-99	FY99-00	FY00-01
Fees	$284,196	$315,740	$279,870	$350,329	$306,437
Medicare	$174,397	$168,924	$161,224	$188,349	$197,766
Medicaid	$220,526	$223,171	$227,754	$250,841	$267,332
Total	$679,119	$707,835	$668,848	$789,519	$771,535

The Board collects a variety of fees. However, due to federal prohibitions on charging nurse aides a certification fee, the Board does not charge a fee for initial certification, but does charge fees for certification by endorsement, certification renewals and certification reinstatements.

Table 2 illustrates the fee schedules and the types of fees assessed for the last five fiscal years. Although the Board does not directly charge a fee for initial certification by examination, the vendor with which the Board has contracted to administer the examination collects examination and re-examination fees to cover the costs of administering the examination.

Table 2
Program Fees

	FY96-97	FY97-98	FY98-99	FY99-00	FY00-01
Examination	$95	$95	$95	$95	$105
Re-Examination: Written	$50	$50	$50	$50	$40
Re-Examination: Manual	$45	$45	$45	$45	$45
Certification by Examination	$0	$0	$0	$0	$0
Certification by Endorsement	$20	$15	$15	$35	$35
Certification Renewal	$20	$15	$15	$35	$35
Certification Reinstatement	$30	$25	$25	$50	$35
Late Fees	$10	$10	$0	$15	$15
Duplicate Certificate	$5	$5	$5	$5	$5

Prior to January 30, 2000, certified nurse aide (CNA) certificates expired every January 30, but they are now valid for two years and still expire on January 30 of the renewal year. If a CNA fails to renew by this date but renews subsequently, the CNA is charged the late fee plus the renewal fee. These two fees comprise the reinstatement fee. A CNA in this situation is not charged all three fees, but rather is simply charged the reinstatement fee.

Table 3 illustrates the manner in which the Board expends these various revenues. Note that for each of the last five fiscal years, total Program revenues have exceeded Program expenditures by a considerable sum. These excess funds were transferred to the Program's fund balance. Because revenues exceeded expenditures by such a considerable sum, the Board reduced the various fees charged to CNAs beginning in fiscal year 01-02. As a result, the program's fund balance has returned to more normal, acceptable levels.

The Board regularly employs temporary employees to assist with clerical duties on certification renewals as well as various other *ad hoc* tasks. Additionally, the Board contracts with a nurse practice consultant, who assists staff in conducting nurse aide training program survey visits.

Table 3
Program Expenditures

Fiscal Year	Total Board Expenditure	FTE	Consultants	Temporary Employees
96-97	$489,622	3.5	$21,761	$0
97-98	$518,629	3.5	$19,989	$1,378
98-99	$562,272	3.5	$19,999	$809
99-00	$555,913	3.75	$8,126	$0
00-01	$618,747	3.75	$14,826	$8,030

The Board expends funds to administer a program that regulates approximately 20,000 CNAs. To accomplish this task, the Board employs 3.75 full-time equivalent (FTE) employees to run the Program, which comprises 11 people who perform the following tasks:

- 0.10 FTE Program Administrator – Responsible for operation of the Program
- 0.80 FTE Nurse Practice Consultant – Approves nurse aide training programs
- 0.30 FTE Nurse Practice Consultant – Handles CNA disciplinary matters and provides staff services to the Advisory Committee
- 0.25 FTE General Professional IV – Screens all complaints related to the Program
- 0.10 FTE Office Manager II – Supervises FTE assigned to the Program
- 0.80 FTE Office Manager I – Processes CNA applications that indicate prior criminal convictions and administers the contract with the examination vendor

- 0.05 FTE Program Assistant II – Updates policies, provides assistance to rules hearings and administers the Program's budget
- 0.10 FTE Administrative Assistant III – Deposits cash and pays invoices
- 0.15 FTE Administrative Assistant III – Maintains licensing and disciplinary databases
- 0.80 FTE Administrative Assistant II – Handles CNA endorsements and provides staff services to the Advisory Committee
- 0.30 FTE Administrative Assistant II – Answers telephonic and written inquiries

It is important to note that all 11 of these employees also provide services to the Board in its capacity as the regulatory authority over registered nurses, licensed psychiatric technicians and licensed practical nurses. All four programs share the same pool of staff.

CNAs may become certified either by examination or by endorsement. As Table 4 illustrates, the vast majority of CNAs receive Colorado certification by examination.

Table 4
Certification Information

Fiscal Year	Number of Licenses			
	Exam	Endorsement	Renewal	TOTAL
96-97	3,565	545	13,473	17,569
97-98	3,500	631	14,284	17,500
98-99	2,286	518	14,040	17,652
99-00	2,180	494	14,859	16,538
00-01	2,167	461	0	19,595

Effective January 30, 2000, the Board ceased renewing certifications on an annual basis and began renewing all certificates on a biennial basis. A certification must be renewed by February 1 of the renewal year or a reinstatement fee is assessed.

When a CNA applies for Colorado certification by endorsement, the Board verifies that the CNA is indeed certified by the state claimed, and it ensures that the CNA's entry on that state's Nurse Aide Registry does not indicate discipline for abuse, neglect or misappropriation of facility or patient property. In addition, the Board requires a criminal history background check that complies with the same procedures as those required of candidates for certification by examination.

Examination

The CNA competency evaluation consists of two segments: a written examination and a manual skills examination. The Board has contracted with Promissor, Inc. (Promissor) to directly receive examination applications, conduct initial application screening, administer both segments of the examination and mail examination results to applicants. The examination that Promissor administers in Colorado is the same standard, examination that is administered in several other states.

Although Promissor will mail application packets to nurse aide candidates upon request, most candidates obtain these packets directly from their nurse aide-training program, which often assists the candidates in the application process. Promissor encourages nurse aides and the training programs to initiate the required criminal history background checks approximately one month prior to the time the candidate plans to sit for the examination.

Before a candidate is allowed to sit for the examination, he/she must submit to Promissor, a complete application. This includes, but is not limited to, the results of a criminal history background check conducted by a Board-approved criminal history background check company and a certificate of completion from a Board-approved nurse-aide training program.

Information regarding a candidate's criminal history is obtained by two methods: 1) a question on the application asking whether the candidate has ever been convicted of a crime, and 2) a criminal history background check.

If the application question regarding past criminal convictions is answered affirmatively, the candidate must provide documentation regarding disposition.

In addition, the Board has approved 17 private companies to conduct criminal history background checks of applicants. The applicant provides the company with a Board-approved form, a copy of which may be found in Appendix B on page 82, that solicits information on any names used by the applicant, the applicant's social security number and the addresses of every place the applicant has ever lived. The company then searches a variety of databases in the relevant jurisdictions to ascertain the applicant's criminal history.

As Table 5 illustrates, the costs and timeframes involved in this process vary widely. The cost of a criminal history background check on an applicant who has resided only in Colorado can range from $18.00 to $45.00. These costs increase by $6.00 to $55.00 for each alias or other name ever used by the applicant. The cost to search other jurisdictions ranges from $5.00 up to $27.00 for each name and address. While Board staff estimates the average criminal history background check to cost anywhere from $75 to $100, anecdotal evidence suggests that these costs occasionally reach the $1,000 level.

Table 5
Background Check Information

Company	Completion Time Range Colorado Resident to Other State	Cost to Colorado Resident	Cost to Colorado Resident w / Maiden Name	Cost to Applicant per Additional State Search
A	Within hours to 1-3 days	$25.00	$25.00+	$25.00 per name/per state
B	1 day to 72 hours	$25.00	$5.95+	$15.00/per county/per name
C	48 hours to 72 hours	$18.00	$18.00+	$15.00/per county/per name
D	1 day to 7 days	$45.00	$55.00	$5-10/per county/per name
E	1 day to 3 days	$28.50	$23.50+	$12.00/per county/per name
F	1 day to 3-4 days	$20.00	$30.00	$20.00/per county/per name
G	2 days to 2 months	$30.00	$0-12.50+	$12.50/per county/per name
H	3-4 days/Colorado and Other State	$35.00	$27.00+	+$27.00/per county/per name
I	1-3 days to 1 week	$25.00	$10.00+	$10.00/per county/per name
J	10 days to 1 month	$20.00	$20.00+	$20.00/per county/per name
K	2 days to 2 months	$30.00	$0-12.50+	$12.50/per county/per name
L	2 weeks to 2 days-2 months	$25.00	$18.00+	$9-16/per county/per name
M	Less than 1 day to 1-3 days	$27.00	27.00+	$1-16.00/per county/per name

The length of time it takes to complete a criminal history background check also varies widely, depending on the company and the number of jurisdictions and names that need to be searched. It can take anywhere from one day to two months to complete a criminal history background check.

If either the criminal history background check or the application indicate a prior criminal conviction, the application and criminal history background check documentation are forwarded to the Board. The Board has authorized staff to screen certain types of offenses depending upon the nature of the offense and how long ago it occurred. In these cases, the Board's staff may approve the application and return it to Promissor.

If the applicant was convicted of an offense that the staff is not authorized to screen, or if the staff is unsure of a certain situation, the application is reviewed by the Advisory Committee, which may recommend approval or denial of the application.

The application also offers the applicant a variety of testing sites around the state. Depending on the test site, the examination may be offered several times per week or only several times per month. The applicant is asked to select and rank, in order of preference, three sites. Once the application is complete, Promissor mails an admission ticket to the applicant, which includes the date and test site for the applicant. Promissor makes every effort to schedule the applicant for the earliest test date at the applicant's first choice test site.

Both the written and manual skills examinations are administered on the same day. The candidate must pass both examinations in order to pass the competency evaluation. If one examination is not passed, the candidate may retake that segment only. Within a two-year period, there is no limit to the number of times a candidate may retest. However, after two years, the candidate must reapply before taking the examination again.

The written examination is a 60-question, multiple-choice examination that includes ten "test" questions, so only 50 questions are counted in the scoring of the examination. The applicant has two hours in which to complete the written examination.

In addition, Promissor also offers the "written" segment in Spanish. The Spanish-language version of the examination is read aloud to the applicant via audiotape. It also consists of 60 questions, but rather than 10 "test" questions, it has ten questions that address English-language skills. These English-language skills questions are counted in determining a passing score.

Regardless of the language in which the written examination is taken, the candidate must answer approximately 75 percent of the questions correctly to pass this segment of the competency evaluation.

The 25-minute manual skills examination tests the applicant on five skills. Each skill has up to 23 steps, one to three of which may be deemed to be essential steps. The applicant must successfully complete all essential steps in order to pass the particular skill being tested. The applicant must pass all five skills in order to pass the manual skills examination.

The manual skills that are tested are selected from a published pool of 21 skills:

- Washing hands
- Measuring and recording the weight of an ambulatory patient
- Brushing a patient's teeth
- Dressing a patient
- Transferring a patient from a bed to a wheelchair
- Assisting a patient with ambulation
- Cleaning and storing dentures
- Performing passive range of motion exercises for one knee and one ankle
- Measuring and recording urinary output
- Assisting a patient with the use of a bedpan
- Providing perineal care for an incontinent patient
- Providing catheter care
- Counting and recording radial pulse and respirations
- Taking and recording blood pressure
- Placing a knee-high, elastic stocking on a patient
- Making a bed that is occupied
- Washing feet
- Providing fingernail care
- Feeding a patient who cannot feed himself/herself
- Positioning a patient on his/her side
- Giving a patient a modified bed bath (face, one arm, hand and underarm)

Nurse aide training programs prepare students for the examination. In addition, the application packet provided by Promissor also contains a Promissor-developed and published "Certification Program Candidate Handbook." The handbook lists the pool of skills that may be tested and includes, for each skill, the necessary steps and essential steps.

The figures provided in Table 6 are for first-time examinees only. The number of candidates who pass the written examination has remained relatively constant over the last five years. However, the number of candidates who pass the manual skills examination declined considerably beginning in 2000.

Table 6
Examination Information

Calendar Year	Number of Written Examinations Given	Pass	Fail	Number of Manual Skills Examinations Given	Pass	Fail
1997	3,382	88%	12%	3,283	94%	6%
1998	2,668	88%	12%	2,774	94%	6%
1999	2,595	83%	17%	2,605	94%	6%
2000	2,052	85%	15%	3,355	57%	43%
2001	3,446	86%	14%	3,873	61%	39%

Prior to 2000, Colorado utilized a competency examination that had been developed by the National Council of State Nursing Boards and one of Promissor's predecessors, Psychological Corporation. In that examination, which was also administered in other states, a candidate was required to successfully complete three of the five skills being tested. However, a concern arose that the examination did not adequately ensure competency. To resolve this concern, a new examination was developed towards the end of 1999, which is now administered in approximately 30 states, including Colorado. The new examination requires candidates to pass all five skills being tested, which helps to explain the decline in the pass-rate in 2000.

The Board's contract with Promissor requires Promissor to mail candidate score reports within ten business days after the examination is administered. Representatives from Promissor report that this is usually accomplished within three to five days.

Complaints/Disciplinary Actions

As Table 7 indicates, the Board receives approximately 200 to 300 complaints regarding CNAs each year.

Table 7
Complaint Information

Complaints by Type	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02
Abuse of patient (physical)	40	24	31	27	16	25
Abuse of patient (sexual)	7	6	9	5	9	3
Abuse of patient (verbal)	35	23	16	11	15	24
Patient abandonment	41	32	29	30	14	26
Misappropriation of property	9	11	2	2	3	4
Alcohol addiction/dependence	4	4	7	8	14	16
Felony conviction	7	10	4	6	1	1
Conduct constituting a crime	6	15	12	14	13	17
Fraudulent application for certification	1	6	3	0	0	0
Discipline by other state	1	1	0	0	1	0
Practitioner/patient boundary violation	0	0	2	3	1	3
Substandard practice	134	109	146	119	86	62
Practicing beyond the scope of training/competence	1	7	5	4	3	2
Misrepresentation	1	1	0	5	1	2
Violation of Board order/rule	2	0	3	4	2	3
Violation of patient confidentiality	1	2	2	1	0	0
Physical/mental disability	1	0	0	0	1	0
Medication administration error/omission	1	1	1	0	0	0
Charting errors/omissions	0	1	1	1	0	0
Miscellaneous	2	0	0	2	1	1
TOTAL	**294**	**253**	**273**	**242**	**181**	**189**

Complaints are often filed by nursing supervisors who allegedly feel compelled to complain about many minor issues because of their respective facilities' certification requirements imposed by the Department of Public Health and Environment, Health Facilities Division (HFD). HFD annually surveys all of the facilities it certifies for Medicare and Medicaid purposes. If these surveys reveal that a facility failed to take action against a CNA (or any other employee) for violations, the facility may be cited with a deficiency. Thus, to be on the safe side, nursing supervisors would be motivated to file complaints with the Board so as to protect the facility. This may explain, in large part, the large number of complaints regarding substandard practice.

Regardless of the reason, when the Board receives a complaint regarding a CNA, staff mails a letter of acknowledgement to the complainant within three to five days. Staff then conducts an initial screening of the complaint.

First, the staff must determine whether the respondent is a CNA, to establish the Board's jurisdiction. Some complaints are filed against CNA-candidates who are still in their four-month grace period and have not yet applied to Promissor to sit for the competency evaluation or who have applied for certification by endorsement and have not yet been certified. In such cases, the staff creates a file and works with Promissor to flag the application when it is received. If Promissor does not receive an application within one year, the staff administratively closes the case and informs the complainant. This happens rarely.

If the respondent is already a CNA, or has filed an application with Promissor, the Board has jurisdiction. The staff then reviews the complaint to determine subject matter jurisdiction. In cases alleging patient abandonment, the Board's staff first reviews the complaint to determine whether the alleged abandonment occurred in a long-term care facility or in a home health care setting. The setting in which the alleged abandonment occurred helps to determine the manner in which the complaint is processed. If it occurred in a long-term care facility, staff determines whether it appears that patient abandonment truly occurred.

Pursuant to Board policy, abandonment occurs when a CNA has accepted a patient assignment (thus establishing a relationship with the patient) and then severs that relationship without giving reasonable notice to the appropriate person (such as the supervisor or the patient) so that arrangements can be made for continuation of care by others.

If the allegation of abandonment pertains to conduct in a long-term care facility and that conduct appears to conform to the Board's definition of abandonment, or if the allegation pertains to a situation in a home health care setting, the complaint is processed in the same manner as other complaints. However, if an allegation of abandonment does not conform to this definition and it pertains to a long-term care facility, staff sends a letter to the complainant and the CNA to inform them of the Board's policy. These letters are referred to as letters of abandonment.

These situations are treated differently because it is easier for staff to determine whether patient abandonment occurred in a long-term care facility by the face of the complaint, whereas such is not the case in allegations relating to home health care.

Occasionally, complaints regarding other issues do not contain sufficient information for the staff to determine whether, if the allegations were proven to be true, a violation occurred. In these cases, the staff writes to the complainant and requests additional information and documentation.

Once the staff has determined that the Board has jurisdiction over the respondent and it has gathered sufficient information, the staff determines whether, if true, the alleged conduct constitutes a violation of the nurse aide practice act (Act). If not, the case is referred to a nurse practice consultant for a second opinion. If the nurse practice consultant also finds that no violation occurred, the staff administratively closes the complaint.

If either the staff or the nurse practice consultant find that, if true, the alleged conduct would constitute a violation of the Act, the staff refers the case to the Division of Registration's Complaints and Investigations Unit (C&I).

If the staff is unsure as to whether the alleged conduct constitutes a violation, the case goes to the Advisory Committee for review. The Advisory Committee may either recommend dismissing the case or it can recommend pursuing the case by referring it to C&I.

Once the case is assigned to an investigator in C&I, a letter is sent to the respondent, advising the CNA that a complaint has been filed, the nature of the complaint, and requesting a response from the CNA within 20 days. This is the first time that the CNA is informed of the complaint.

Many CNAs fail to respond to this letter, which is commonly referred to as a "20-day letter." Staff attributes this to the fact that CNAs frequently move without informing the Board of the new address. As a result, the CNA never receives the letter.

Regardless, C&I conducts a cursory criminal history background check on the respondent, interviews witnesses and otherwise conducts its investigation. At the conclusion of the investigation, the investigator drafts a report and forwards the case, with the report, to the Advisory Committee.

The Advisory Committee may recommend dismissing the case, refer the case back to C&I for additional investigation or recommend disciplinary action. If disciplinary action is recommended, a memorandum is prepared by staff and forwarded to the Chair of the Board for signature, thus effecting the discipline. Staff then prepares a letter to notify the CNA of the action taken and of the time period in which appeals may be filed.

As Table 8 illustrates, many complaints that are filed with the Board are eventually dismissed.

Table 8
Disciplinary Information

Closure Actions by Type	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01
Revocations	16	48	82	57	53
Suspensions	17	62	35	45	34
Relinquishments	1	2	0	6	0
Letters of Admonition	13	22	13	23	16
Injunctions	0	1	1	0	1
Letters of Abandonment	24	26	13	24	13
Administrative Closures	2	1	2	0	0
Dismissals without Prejudice	1	1	0	0	0
Dismissals	43	79	60	98	72
TOTAL	**117**	**242**	**206**	**253**	**189**
Average Number of Days to Resolution*	241/279	215/291	255/262	208/217	187/187

*The latter averages include cases taking over 1,000 days to resolve

These figures regarding disciplinary actions reflect that the Advisory Committee and the Board take proven violations relatively seriously. The Board is more likely to revoke or suspend a certification than it is to issue a letter of admonition.

Most suspensions are for relatively short periods, several weeks to a few months. Such short periods may appear to be inadequate at first blush. However, considering the socio-economic status of many CNAs, two to three weeks of lost income represents a significant loss, as well as the possible loss of employment.

Until 2002, the Advisory Committee routinely required continuing education be obtained during the suspension period. However, it ceased this practice on the advice of the Board's staff because it can be difficult, if not impossible, for CNAs to obtain continuing education units because it is not generally available, and because the Board has no basis for determining competency as a result of the additional training.

As discussed earlier, letters of abandonment are typically issued to CNAs who work in long-term care facilities when the Board's staff is able to determine, on the face of the complaint, that the alleged conduct does not conform to the Board's definition of patient abandonment.

Regardless of the disciplinary action imposed, the staff has 30 days in which to mail notification of whatever action is taken, including dismissals, to the complainant and the respondent. If a letter of admonition is issued, the CNA has 20 days from the date the CNA receives the letter in which to request formal disciplinary proceedings. If the CNA's certification is suspended or revoked, the CNA has 30 days in which to request a hearing.

If the CNA does not contest the disciplinary action within the allotted timelines, the action becomes final and the CNA's entry on the Nurse Aide Registry is amended appropriately. However, if the CNA appeals the disciplinary action, nothing is noted on the Nurse Aide Registry, and the case is referred to the Attorney General's Office (AGO). The AGO initially attempts to settle the case with a stipulation. In addition, the AGO may return the case to the Board if the AGO determines that action other than what the Board is seeking is warranted.

If the AGO retains the case and is unable to settle it, the AGO issues a Notice of Charges and proceeds with a hearing before an administrative law judge (ALJ). CNAs typically appear, if at all, without an attorney.

At the conclusion of the hearing, the ALJ issues findings of fact, conclusions of law and recommended sanctions. If exceptions to the ALJ decision are filed, the case is then referred to one of the Board's hearing panels, not the Advisory Committee. This has happened only twice and in both instances, the hearing panel imposed the discipline that the Advisory Committee had originally recommended.

Some members of the Board's staff report that it is awkward for the Board's hearing panel to conduct an exceptions hearing, rather than the Advisory Committee. They argue that the Advisory Committee retains the expertise regarding CNAs and that by referring such cases to the Board, the Advisory Committee is not apprised of how a particular case is resolved, even though this is a function the Board's staff could easily perform.

On the other hand, referring such cases to the Board provides an additional opportunity for objective analysis of the case. The Board has nothing invested in the case, so it looks at it with fresh eyes and can be more objective.

A CNA may appeal the hearing panel's decision to the Colorado Court of Appeals, though no CNA has ever done so. Not until all appeals are exhausted does the action become the Board's final agency action, which warrants amending the CNA's entry on the Nurse Aide Registry appropriately.

Unfortunately, the protections that are in place to ensure the rights of the CNA throughout this process produce a significant time lag between the time a complaint is received and the time final disciplinary action is taken. On average, 204 days, approximately seven months, pass before final action is taken. To make matters worse, and also skewing the average number of days to take final action, a surprisingly large number of cases remain open for periods exceeding 1,000 days. In the last five fiscal years, five cases remained open for more than 2,000 days, and 17 cases took between 1,000 and 2,000 days to close.

The Board's staff explains that the primary factor in these delays was a backlog of cases at the AGO. In 1998, the General Assembly funded a decision item that granted additional funds to the AGO to eliminate this backlog. As Table 8 indicates, the average time to closure declined to a considerable degree in fiscal year 00-01, compared to prior years.

Analysis and Recommendations

Recommendation 1 - Continue the Colorado Nurse Aide Certification Program until 2010.

The key question in any sunset review is whether the program under review is necessary to protect the health, safety or welfare of the public. While federal regulations mandate minimum levels of training for nurse aides who work in either long-term care facilities or home health care, those regulations are inconsistent regarding competency examinations. Colorado law, however, mandates the same training and the same competency examination for both settings, regardless of the actual duties to be performed, thus ensuring a minimum level of competency in basic skills that is consistent across health care settings.

Additionally, the Colorado nurse aide certification program was originally enacted, in part, to assist Colorado's home health care agencies and long-term care facilities to more easily comply with federal regulations. A nurse aide who is certified to work in home health care can also work in long-term care without having to obtain additional training and/or certification, thus providing both types of health care providers and their patients with a larger pool of certified nurse aides (CNAs) from which to hire.

Some, particularly in the disabled community, argue that the state's regulation of CNAs who work in home health care has actually hindered their ability to hire CNAs. They argue that many people are unable to obtain certification as a CNA because they do not test well. This is particularly problematic in situations in which a parent seeks to obtain certification in order to obtain Medicare and/or Medicaid reimbursement for caring for a disabled child. These parents know what their children need and how to perform the functions required to satisfy those needs, but because the state-mandated training and competency examination requires the demonstration of skills that are not pertinent to their situation, they are unable to pass the examination. This is an issue because the federal regulations allow for a personal care attendant to work as such by demonstrating competency only in those skills such aide will perform, rather than all the skills normally required for certification.

However, the competency examination is designed to ensure a minimal level of competency in basic skills. Arguably, if a parent is unable to pass such an examination, that parent may need additional training or may need to consider obtaining the assistance of an outside CNA. As a practical matter, however, these situations are more the exception than the rule, and as Table 4 on page 23 illustrates, most examinees pass the competency examination.

Some in the home health care industry also argue that the training programs and competency examination are geared more towards long-term care facilities than home health care. This is problematic because a nurse aide can pass the competency examination, yet still not be prepared to work in the home health care setting where on-site supervision is rare. As a practical matter, however, very few training and testing programs ensure that a person who progresses through them is automatically ready to begin work. Orientation and on the job training are often required and desirable. The state-mandated training and examination simply seek to provide nurse aides with basic skills that are, for the most part, equally applicable in both settings, and then ensure that those basic skills have been mastered. It remains the responsibility of the employer to train the CNA on its preferred way of doing things.

Although federal regulations regarding CNAs go to considerable lengths to protect the health, safety and welfare of the public, Colorado's CNA program adds additional public protection aspects.

The Direct Care Provider Career Path Pilot Program (Pilot Program) created by House Bill 02-1447 and codified at section 12-38.1-201, et seq., C.R.S., is scheduled for repeal on July 1, 2008, by operation of law. Within two months of the Pilot Program's completion, the Board is required to submit to the General Assembly and to the Governor a report outlining the efficacy of the Pilot Program. By scheduling the CNA program to sunset following the conclusion of the Pilot Program, the General Assembly will be assured that the results of the Pilot Program will play a role in the sunset review of the CNA program.

For these reasons, the General Assembly should continue the CNA program until 2010.

Recommendation 2 - Create the occupation of Medication Aide within the nurse aide practice act. Amend section 12-38.1-110.3(4), C.R.S., as follows:

Medication administration advisory committee – created ~~– department of regulatory agencies report~~.

(4) For the purposes of the PROMULGATION OF RULES AND REGULATIONS AND THE ESTABLISHMENT OF POLICIES REGARDING MEDICATION AIDES, ~~review provided in sections 12-38.1-120 and 24-34-104, C.R.S.,~~ the advisory committee shall provide input to the BOARD. SUCH INPUT ~~department of regulatory agencies regarding the issue of allowing certified nurse aides to administer medications in nursing facilities and through home health agencies. After such review, the report by the department of regulatory agencies required pursuant to 24-34-104(8), C.R.S.,~~ shall include, but not be limited to, the following:

~~(a) The benefits and risks associated with certified nurse aides serving as medication aides;~~

~~(b) The effect of the use of medication aides on the level of patient care;~~

(c) The level of experience a certified nurse aide must have in order to be considered for training as a medication aide;

(d) The extent and content of classroom training and education required to be a medication aide;

(e) The extent and limit to the scope of practice of a certified nurse aide who has completed training as a medication aide; and

(f) The requirements for supervision for medication aides.

During the 2002 regular legislative session, the General Assembly passed House Bill 02-1090, which directed the Executive Director of the Department of Regulatory Agencies (DORA) to appoint an 11-member Medication Administration Advisory Committee (MAAC) to provide input to DORA for this sunset report regarding the issue of allowing CNAs to administer medications in long-term care facilities and through home health care agencies. More specifically, the MAAC provided input on:

- The extent and limit to the scope of practice of a CNA who has completed training as a medication aide.
- The level of experience a certified nurse aide must have in order to be considered for training as a medication aide.
- The extent and content of classroom training and education required to be a medication aide.
- The requirements for supervision of medication aides.
- The benefits and risks associated with CNAs serving as medication aides.
- The effect of the use of medication aides on the level of patient care.

In addition to soliciting input from the MAAC, whose final report may be found in Appendix C on page 83, DORA also reviewed the laws of all 50 states and contacted those whose statutes indicated that they currently utilize medication aides. Additionally, for those states whose statutes did not reflect the use of medication aides, DORA attempted to confirm this information. However, not all states that DORA contacted responded to telephonic and email inquiries. Where comparative information is provided in this sunset report, the parameters for including such information are provided.

The extent and limit to the scope of practice of a CNA who has completed training as a medication aide.

At least 21 states have medication aide programs. Only four of these states have incorporated such programs into their CNA programs. Of these four states, three restrict the use of medication aides to long-term care facilities; only one allows CNAs who are medication aides to work as such in home health care.

Of the 21 states that have medication aides, including the four that include such programs in their CNA programs, 11 restrict medication aides to working in long-term care facilities, five allow medication aides to work in both long-term care and home health care and six either did not report the settings in which their medication aides may work or they prohibit medication aides from working in these settings, but allow them to work in other facilities, such as facilities for the developmentally disabled, adult day care facilities, correctional facilities, assisted living facilities, hospitals and in hospice settings.

In addition to restricting the setting or facilities in which medication aides may work, 15 of the 21 states that have medication aides provided DORA with the types of medications that medication aides may administer and the routes by which those medications may be administered. The MAAC, too, devoted considerable time to exploring these same issues.

In addition to the scope of practice of a CNA, the MAAC determined that the following tasks could be safely performed by a properly trained medication aide:

- Measurement and documentation of vital signs prior to administering any medications. At least 13 of the 15 states that provided information on what medication aides may do, allow them to do this.

- Observation and reporting any abnormalities or side effects after medication is administered. At least 12 of the 15 states that provided information on what medication aides may do, allow them to do this.

- Administration of routinely prescribed medications that the medication aide has personally prepared. At least 14 of the 15 states that provided information on what medication aides may do, allow them to do this, although DORA did not inquire as to whether the medication aide must personally prepare the medications. Personal preparation entails removing the proper dosage of medication from the medication bottle and placing it into a cup for administration to the patient.

- Administration of routinely prescribed medications via oral, ophthalmic, otic, nasal, vaginal and rectal routes. At least 12 of the 15 states that provided information on what medication aides may do, allow them to do this.

- Administration of medication via metered dose inhaler. At least 12 of the 15 states that provided information on what medication aides may do, allow them to do this.

- Documentation of any medications personally administered by the medication aide. At least 14 of the 15 states that provided information on what medication aides may do, allow them to do this.

- Crushing and administering medications if such preparation is appropriate according to the manufacturers instructions and the physician's order. At least 13 of the 15 states that provided information on what medication aides may do, allow them to do this.

- Count and document controlled substances with a licensed nurse. At least 10 of the 15 states that provided information on what medication aides may do, allow them to do this.

- Administer previously ordered *pro re nata* medications (medications that are taken on an "as needed" basis) only if authorized by the nurse on duty. At least 12 of the 15 states that provided information on what medication aides may do, allow them to do this.

The MAAC also determined that medication aides should not be permitted to engage in the following tasks:

- Administration of medication via injection routes, including intramuscular, intravenous, subcutaneous or intradermal routes. Only two of the 15 states that provided information on what medication aides may do, allow medication aides to administer medication via these routes.

- Administration of medication used for intermittent positive pressure breathing (IPPD) or any form of medication inhalation treatments other than metered dose inhalers. Only two of the 15 states that provided information on what medication aides may do, allow medication aides to administer medication used for IPPD.

- Instillation of medication, irrigation or flushing of foley or super pubic catheters, ears, nasogastric tubes, jejunostomy tubes, gastrostomy tubes or intravenous catheters. Only two of the 15 states that provided information on what medication aides may do, allow medication aides to instill medication into, irrigate or flush these types of catheters and tubes.

- Assumption of responsibility for receiving verbal orders. Only two of the 15 states that provided information on what medication aides may do allow medication aides to assume responsibility for receiving verbal, as opposed to written, orders.

- Administration of any treatment that involves advanced skin conditions, including stage II, III and IV decubitus ulcers. Only one of the 15 states that provided information on what medication aides may do, allows medication aides to administer this type of treatment.

- Administration of Coumadin or chemotherapeutic agents. None of the states that provided information to DORA reported whether their medication aides work under similar restrictions.

- Administration of scheduled drugs, including oral, transdermal and rectal routes. None of the states that provided information to DORA reported whether their medication aides work under similar restrictions.

- Administration of *pro re nata* medications unless a nurse has assessed the patient. None of the states that provided information to DORA reported whether their medication aides work under similar restrictions.

- Administration of medications to a ventilator patient. None of the states that provided information to DORA reported whether their medication aides work under similar restrictions.

- Administration of medications to any patient 15 years of age or younger. None of the states that provided information to DORA reported whether their medication aides work under similar restrictions.

In addition to the types and routes of medications that medication aides should be allowed to administer, DORA's research of the laws of other states revealed that four states allow medication aides to conduct finger-stick blood glucose testing, four allow diabetic urine testing and two allow medication aides to transcribe physician orders into patient charts.

The scope of practice recommended by the MAAC, as well as the limitations to that scope of practice, are remarkably similar to those instituted in the other states DORA was able to identify. If the General Assembly elects to move forward with implementing a medication aide program, it should consider this data when developing the scope of practice for such individuals.

The level of experience a certified nurse aide must have in order to be considered for training as a medication aide.

While addressing the issue of the level of experience a CNA must possess before obtaining training as a medication aide, the MAAC was primarily concerned with establishing that medication aide candidates demonstrate a commitment to their work. The MAAC determined that this was best accomplished by examining how long a CNA worked as such at a particular facility.

The MAAC identified five prerequisites to a CNA obtaining training as a medication aide. In addition, 16 states provided information to DORA as to their prerequisites:

- Possession of a high school diploma or a general equivalency diploma. At least eight states reported a similar requirement.
- Attainment of the age of 18 years. At least eight states reported a similar requirement.
- The ability to read and comprehend English. At least seven states reported a similar requirement.
- At least 2,000 hours of working experience as a CNA in the same facility. At least seven states reported a similar requirement, although the period of work experience varied from between three months and one year.

- Letters of recommendation from a director of nursing and two charge nurses. At least two other states reported similar requirements. One state requires a letter of recommendation from a current employing-facility and the second state requires letters from the aide's director of nursing, agency administrator and two charge nurses.

Additionally, six states reported that they require medication aide candidates to first obtain certification as a nurse aide, but do not require that the candidate work as such for any specific period of time.

By comparing the prerequisites of established programs in other states to those developed by the MAAC, it becomes clear that the MAAC developed prerequisites that are substantially similar to those found in many other states. If the General Assembly elects to establish a medication aide program, it should develop it according to the MAAC's recommendations regarding training prerequisites.

The extent and content of classroom training and education required to be a medication aide.

The MAAC devoted considerable time and effort to determining how much and what type of training a CNA would require in order to become a safe and effective medication aide. The MAAC determined that a total of 140 hours is optimal: 100 classroom hours, 20 hours of return skills demonstration and 20 hours of clinical experience. This is significantly more training than what is required in most other states.

However, at least two other states require 100 or more hours of training. Texas requires 100 classroom hours and 40 hours of practical training, and Wisconsin requires 60 classroom hours and 40 hours of practical training.

At least six states require between 40 and 80 hours of training. Most of these states require that two-thirds of the training be classroom training, with the remaining third devoted to practical clinical work. Only four states require less than 32 hours of training, with one requiring only 20 hours.

In addition to determining the number of hours of training that should be required, the MAAC also considered what that training should comprise. The MAAC determined that a medication aide-training course should address the following topics:

- Fundamentals of the gastrointestinal, musculoskeletal, skin and sensor, urinary, cardiovascular, respiratory, endocrine, reproductive and nervous systems and the medications effecting each system
- Psychotherapeutic medications
- Inflammation, infection, immunity and malignant disease
- Pain management
- Basic principles of administering medications, infection control and handwashing
- Documentation of medication administration
- Patients rights and ability to refuse medication
- Behavioral interventions with medication administration
- Position of patients in preparation for medication administration
- Measurement of vital signs, including pulse, respiratory rate and blood pressure
- Administration of medications via gastrostomy and jejunostomy tubes
- Administration of medications via inhaled media

Based on the number of recommended hours of training and the content of that training, it becomes clear that the MAAC intended that medication aides enjoy a broad scope of practice. However, without knowing exactly what medication aides would be responsible for performing and the circumstances under which they would be able to perform such duties, the MAAC was not clear as to the level of education that a medication aide should have. As a result, the MAAC's final document favored a more conservative approach, and would require that medication aides receive a considerable amount of in-depth training.

If the General Assembly elects to implement a medication aide program, it seems as though, based on comparative data alone, 140 hours may be too much. The comparative data suggest that a training course of between 80 and 100 hours might be sufficient.

The requirements for supervision for medication aides.

In addition to current state and federal regulations regarding nurse-staffing levels, the MAAC determined that facilities that utilize medication aides should have additional staffing requirements. Specifically, a licensed nurse should supervise no more than two medication aides.

The MAAC also explored whether supervisory levels should be determined based on patient acuity, number of patients, or other factors. However, in the end it determined that since current regulations require facilities to have sufficient staff to ensure a safe environment, there was no need to limit the number of patients to which a medication aide could administer medications. Such issues should be left to the discretion of the facilities that utilize medication aides.

DORA did not solicit from other states information regarding this issue.

The benefits and risks associated with CNAs serving as medication aides.

There appear to be numerous benefits and risks associated with utilizing CNAs as medication aides. One of the main benefits identified by the MAAC is the idea that the use of medication aides would allow registered nurses to spend more time with patients because they would be required to spend less time administering routine medications. The MAAC anticipated that nurses would have more direct contact with patients, allowing them to conduct assessments, administer other treatments, tend to wounds, assess medication orders, tend to care plans and be able to telephone physicians, family members and support personnel in a more timely manner as circumstances warrant.

Additionally, the MAAC assumed that a medication aide's only duties would be to administer medications, rather than performing CNA duties in addition to medication aide duties. Given this, the MAAC anticipated that the medication aide would be more focused on administering the medications than registered nurses currently are, because registered nurses are frequently interrupted while administering medications, which can lead to errors. This process would also better ensure that patients receive their medications in a more timely manner because facilities would be able to employ more medication aides than they are currently able to employ registered nurses.

On a related matter, the MAAC also speculated that the utilization of medication aides would enhance facilities' abilities to recruit and retain registered nurses because those nurses would be better able to more routinely utilize their professional assessment skills, rather than administer routine medications, which can currently account for half of a nurse's time. Having more nurses and medication aides would improve overall patient care and would maximize the state's nurse force to provide more professional care.

Finally, the MAAC anticipated that creating the occupation of medication aide would provide for greater upward mobility for CNAs by creating a career ladder for what otherwise amounts to a dead-end job. Such an occupation would allow a CNA who does not desire to, or is not able to attain the level of education required of licensed practical nurses and registered nurses to advance in the health care field, leading to greater job satisfaction for, and retention of these individuals.

Although the MAAC stated that the use of medication aides in home health care is not appropriate, it did determine that if home health care agencies were to use medication aides, fewer visits by registered nurses and/or licensed practical nurses may be necessary, thus potentially lowering the cost of such care.

As part of this sunset review, representatives from seven other states provided DORA with input on the benefits and risks realized in those states. Not surprisingly, there is a great deal of overlap between what these representatives reported and the findings of the MAAC. Representatives from four states reported to DORA that their respective medication aide programs have allowed their nurses to spend more time with patients.

Additionally, one representative stated that medication aides tend to be more focused on administering medication because that is all that they do. This representative and another also reported that the medication aide program provides a career ladder for CNAs.

Representatives from three states simply reported that they had no position regarding the benefits realized by their medication aide programs.

There are, however, risks associated with permitting CNAs to serve as medication aides. The first such risk identified by the MAAC counters one of the benefits identified: nurses may spend less time with patients and more time on administrative matters. Since nurses currently administer medications, they have some interaction with the patients under their care. The use of medication aides, however, could serve to compartmentalize care and further remove nurses from patient care.

Similarly, the MAAC expressed concern that medication aides could replace licensed nurses because medication aides would be less expensive to a facility in terms of salary, though they could be more expensive in terms of liability insurance premiums.

The MAAC was also concerned that some facilities may require medication aides to work as such in addition to working as a CNA. This could lead to increased medication errors, lower levels of job satisfaction and employee-retention problems.

Finally, and most importantly, the MAAC identified increased medication errors as a potential risk. Since CNAs have less education and less experience with medications than licensed nurses, there is a greater likelihood that the wrong medication or the wrong dosage will be administered by a medication aide than by a nurse. This is particularly a concern with patients who take multiple medications at various times throughout the day, a common situation among the populations served by long-term care facilities and home health care agencies.

Lack of adequate supervision could compound this problem. A medication aide would need someone with pharmacological training to answer questions. This is a particular concern in home health care, where the medication aide would be working with little or no on-site supervision.

Representatives from 11 other states provided DORA with input regarding the risks they have identified in using medication aides. Comments that were program-specific are not included here.

Two of these representatives stated that the utilization of medication aides had removed nurses from patient care to a certain degree. Where medication aides are used, the nurses do not necessarily know which medications patients are on and they have less opportunity to assess patients because they no longer see patients while administering medications.

Additionally, one representative indicated that there tend to be more problems with medication aides when they are given assignments other than administering medication. When this happens, complex tasks are interrupted and the medication aide loses focus of the task at hand, which leads to errors.

A second representative echoed the problem of medication errors. However, that individual stated that medication errors occur in any process and that the solution is increased supervision of the medication aide.

Finally, one representative reported to DORA that most of the complaints they receive regarding medication aides involve drug diversion.

It is clear that there are many benefits and risks involved in allowing CNAs to be used as medication aides. Interestingly, the MAAC's speculations tracked very closely with the information provided by states that have medication aide programs in place.

To summarize, both the MAAC and information from other states identified the following issues as potential benefits:

- Nurses may have more time to spend assessing patients because less time will be devoted to administering routine medications.
- Developing a medication aide program could provide a career ladder for CNAs.

Risks identified by both groups include:

- Nurses may spend less time with patients because they will no longer have routine interaction with patients while administering medications.
- The frequency of medication errors could increase when medications are administered by medication aides, who lack the experience and pharmacology background of nurses.
- Medication aides who also work as CNAs may be more easily distracted, leading to increased medication errors.

The effect of the use of medication aides on the level of patient care.

In the final analysis, the best way to determine whether to enable CNAs to administer medications is to determine the effect of medication aides on the level of patient care.

The MAAC determined that the use of medication aides in home health care would be inappropriate because, unlike long-term care facilities, the home health care setting lacks the constant oversight of all levels of care by nurses. The MAAC speculated that due to this decreased monitoring by a nurse, the use of medication aides in home health care could lead to increased instances of medication errors and delays in the early detection of medication side effects.

However, the MAAC held a different view of using medication aides in long-term care facilities, such as nursing homes. In such facilities, the MAAC determined that overall care could improve because nurses would have more time to conduct patient assessments, discuss patient needs with family members and physicians, and participate in direct patient care. Additionally, the MAAC speculated that if a medication aide's duties were restricted to administering medications, patients would receive their medications in a more timely manner and that, given time, the medication aide would learn to recognize side effects, thus improving the level of patient care.

During this sunset review, representatives from 15 other states provided information to DORA regarding this issue. Of these, six reported that their medication aide programs had a relatively neutral effect on the level of patient care. That is, the level of patient care neither improved nor declined significantly. Five of the states that provided information to DORA reported a general improvement in the level of patient care.

Representatives from three states reported that their medication aide programs enhanced patient care by helping to alleviate the nursing shortages that those states were experiencing. Medication aides were able to fulfill a necessary role in the health care system, which relieved some of the pressure faced by nurses and CNAs. Thus, as a whole, the level of patient care increased.

Finally, one representative stated that medication aides improved the level of patient care as long as administering medications was the only task assigned to the medication aide.

During the course of this sunset review, DORA also interviewed numerous individuals in the long-term care and home health care industries, including CNAs, patients, nurses, employers and patient family members. Most of these individuals demonstrated extreme discomfort at the suggestion of allowing CNAs to administer medications, though very few could articulate why. Those that could identify the source of their adverse reaction typically stated that the potential for medication errors is too risky and that this risk alone would lead to an overall decrease in the level of patient care.

However, the conclusions of the MAAC and the comments provided by other states tend to take the opposite view. Overall, the MAAC found that medication aides could, given the proper training and employment situations, improve the level of patient care. This sentiment was echoed by at least half of the states that provided information to DORA on this issue.

A major concern, of course, is the potential risk for medication errors. Medication errors can take the form of prescription errors, dispensing the incorrect medication in the pharmacy and administering an incorrect medication or an incorrect dose to a particular patient. A 2000 study by the Institute of Medicine reported that in 1993, medication errors, which were defined broadly, accounted for approximately 7,000 hospital deaths in the U.S. This accounted for approximately one out of every 854 in-patient deaths.[4]

A more recent study, published in the September 9, 2002, issue of *The Archives of Internal Medicine*[5] (AMA Study) is, perhaps, more relevant to the issue of medication aides. The AME study defined "medication error" as a dose administered differently than as ordered on the patient's medical record.

The AMA Study examined medication administration passes in 36 accredited hospitals, non-accredited hospitals and skilled nursing facilities in Colorado and Georgia. The study concluded that error rates were higher in Colorado than in Georgia.[6]

The AMA Study found that 19 percent, or nearly one in five, of the doses observed were in error.[7] As a percentage of all errors, the results included wrong time (43 percent), omission (30 percent), wrong dose (17 percent) and unauthorized drug (four percent). Seven percent of these errors resulted in actual or potential adverse drug events.[8]

Interestingly, two of these findings, "wrong time" and "omission," were cited by the MAAC as potential benefits of using medication aides in Colorado. The MAAC speculated that if a facility were to utilize medication aides appropriately, residents would receive their medications in a timely manner. This could potentially reduce the "wrong time" and "omission" error rates in such a facility.

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[4] *To Err is Human: Building a Safer Health System*, L. Kohn, J. Corrigan and M. Donaldson, eds. National Academy Press, 2000, p. 27.
[5] *Medication Errors Observed in 36 Health Care Facilities*, K. Barker, E. Flynn, G. Pepper, D. Bates and R. Mikeal. American Medication Association 2002: *Archives of Internal Medicine*, Vol. 162, September 9, 2002, page 1897.
[6] Id.
[7] Id. at 1900.
[8] Id.

As a result of DORA's research into the laws of other states and the proceedings of the MAAC, DORA recommends that the General Assembly pursue the creation of the occupation of medication aide. However, given the fact that the MAAC had insufficient time to thoroughly explore the details of creating such a program, DORA cannot recommend how such a regulatory program should be structured.

In December 2001, the Board convened a special task force to review its licensed psychiatric technician (LPT) program. LPTs receive approximately 140 hours of classroom, laboratory and clinical training relating to the administration of medications. Once licensed, LPTs are authorized to administer psychotropic medications to the mentally ill and the developmentally disabled and the LPT license specifies which of these populations a particular LPT is licensed to work with. One of the main focuses of the Board's task force, which is scheduled to complete its work by the end of 2003, is to explore combining the two licenses because many of the patients served by LPTs are both mentally ill and suffer from developmental disabilities. During the course of these meetings, the task force has also realized that many of these populations are aging, so geriatrics is becoming an issue for LPTs as well.

Because the Board's task force has devoted considerable time and effort to more thoroughly exploring the administration of medication by individuals other than nurses and physicians and is addressing many of the same issues as the MAAC, DORA recommends that the General Assembly allow the MAAC to continue and further recommends that the Board combine the MAAC and LPT task force to more thoroughly address this issue and to develop comprehensive training protocols, testing requirements and a scope of practice that satisfies the needs of long-term care facilities without unduly jeopardizing the health and safety of the residents of such facilities.

Recommendation 3 - Require that the mandatory criminal history background checks required of certification applicants be conducted based on the applicant's fingerprints, rather than the applicant's name and social security number. Amend section 12-38.1-104(3), C.R.S., to read as follows:

> **(a) Every applicant seeking certification pursuant to this section shall submit TO a criminal history background check conducted within the ninety-day period prior to submittal of the application ~~from a company approved by the board~~.**
>
> **(b) ~~Companies approved by the board to conduct criminal history background checks must be able to include information on convictions~~ EVERY APPLICANT SHALL SUBMIT TO THE BOARD A SET OF THE APPLICANT'S FINGERPRINTS AND MAKE ARRANGEMENTS IN SUCH MANNER AS THE BOARD MAY PRESCRIBE FOR THE PAYMENT OF THE ACTUAL COSTS OF THE CRIMINAL HISTORY RECORD CHECK PROVIDED FOR IN THIS SUBSECTION (3). UPON RECEIPT OF THE FINGERPRINTS AND PROOF THAT ADEQUATE PAYMENT ARRANGEMENTS HAVE BEEN MADE, THE BOARD SHALL FORWARD SUCH FINGERPRINTS TO THE COLORADO BUREAU OF INVESTIGATION WHICH SHALL CONDUCT A STATE AND NATIONAL FINGERPRINT-BASED CRIMINAL HISTORY RECORD CHECK UTILIZING RECORDS OF THE COLORADO BUREAU OF INVESTIGATION AND THE FEDERAL BUREAU OF INVESTIGATION.**
>
> **(C) THE APPLICANT MUST BE ABLE TO PROVIDE INFORMATION ON CONVICTIONS.**

CNAs work primarily with the disabled and the elderly, either in a home health care setting or in a long-term care facility. This often requires CNAs to work with these vulnerable populations under little or no supervision, thus increasing the risk that a CNA will abuse the patient, either physically, sexually or emotionally; commit a crime of violence against the patient; neglect the patient; commit a property offense, such as theft, fraud or arson; or work while under the influence of a controlled substance.

To better protect the health, safety and welfare of these vulnerable populations from these risks, the General Assembly passed House Bill 95-1266, which requires nurse aide certification applicants to submit to criminal history background checks prior to certification. While criminal history background checks in no way guaranty that such offenses will not be committed against these vulnerable populations, they at least provide information as to whether the CNA has committed such offenses in the past.

Currently, criminal history background checks are required for all nurse aide certification applicants. There is a two-fold process for conducting these checks. First, applicants must self-report any criminal history they may have. Second, an actual criminal history background check must be performed by a company that has been approved by the Board. However, there are a number of fundamental problems with this system.

The Board is required to approve a list of private companies to perform the criminal history background checks, which are currently conducted based upon the applicant's name and social security number. This system requires considerable self-disclosure and is inherently unreliable.

In order to initiate a background check under the current system, the certification applicant completes a form developed by the Board and provides this form to one of the approved background check companies. This form, which may be found in Appendix B on page 82, requires the applicant to disclose all names ever used by the applicant, including maiden names and aliases, and all states in which the applicant has ever lived. The background check company then proceeds to search a variety of databases for the names disclosed by the applicant in the states disclosed by the applicant to gather the required arrest and disposition information.

Each state maintains and provides access to the required information in a different manner. Some states report only arrest information, requiring the background check company to conduct additional research at the local level to determine case disposition. Thus, a great deal depends upon the type of information that the background check company is able to access and the type of information the background check company actually makes an effort to uncover.

A more fundamental problem, however, is that this system is based on self-disclosure. Because the background check company will only check the names and states provided by the applicant, information can be missed. For example, a CNA applicant who is a lifetime resident of Colorado could be arrested and convicted for assault while vacationing in California. Because the background check company only checks the states in which the applicant discloses he/she lived, California is not checked and the applicant would appear to have no criminal record because the record in Colorado, the only state searched, would be clean.

Additionally, the Board has no way to verify the reliability of the company performing the background check. Until a few years ago, the Board provided background check companies with the names of individuals known to have criminal backgrounds in order to determine whether the company located and reported all criminal records. The results were disappointing. In many instances, the background check companies failed to report known criminal activity.

Indeed, these types of results were confirmed in November 2001, when the State Auditor conducted a performance audit of the Board. The State Auditor reported six instances in which the nurse aide applicant self-reported prior criminal history, but the criminal history background check failed to detect and/or report it.[9]

However, the Board learned that it had to cease its practice of checking the quality of criminal history background checks because it is unlawful to conduct such a check on an individual without that individual's permission. While the Board has been gathering such permissions and will soon have permission from enough individuals to perform tests with an adequate pool, it has not yet done so. As a result, the Board continues to have serious doubts as to the quality of the background checks being performed. These concerns are so severe, in fact, that many call the current system "useless."

[9] *The Colorado Board of Medical Examiners and the Colorado Nursing Board: Performance Audit, November 2001,* at page 21. Submitted to The Office of the Colorado State Auditor by Sjoberg Evanshenk Consulting, LLC.

Finally, a background check under the current system can become quite expensive quite quickly. Table 5 on page 26 and reproduced below, illustrates the rates charged by the Board-approved background check companies for a variety of services. The information is provided in a random order to better protect the proprietary and competition-related concerns of these companies.

Table 5
Background Check Information

Company	Completion Time Range Colorado Resident to Other State	Cost to Colorado Resident	Cost to Colorado Resident w / Maiden Name	Cost to Applicant per Additional State Search
A	Within hours to 1-3 days	$25.00	$25.00+	$25.00 per name/per state
B	1 day to 72 hours	$25.00	$5.95+	$15.00/per county/per name
C	48 hours to 72 hours	$18.00	$18.00+	$15.00/per county/per name
D	1 day to 7 days	$45.00	$55.00	$5-10/per county/per name
E	1 day to 3 days	$28.50	$23.50+	$12.00/per county/per name
F	1 day to 3-4 days	$20.00	$30.00	$20.00/per county/per name
G	2 days to 2 months	$30.00	$0-12.50+	$12.50/per county/per name
H	3-4 days/Colorado and Other State	$35.00	$27.00+	$27.00+/per county/per name
I	1-3 days to 1 week	$25.00	$10.00+	$10.00/per county/per name
J	10 days to 1 month	$20.00	$20.00+	$20.00/per county/per name
K	2 days to 2 months	$30.00	$0-12.50+	$12.50/per county/per name
L	2 weeks to 2 days-2 months	$25.00	$18.00+	$9-16/per county/per name
M	Less than 1 day to 1-3 days	$27.00	27.00+	$1-16.00/per county/per name

The cost and time to complete a criminal history background check depends on several factors, including the number of names the applicant has used and the number of states, and potentially counties, the applicant has lived in. According to the data in Table 5, the least expensive background check would be provided by Company C for $18 for an applicant who never changed names and lived his/her entire life in Colorado. The most expensive background check for the same applicant would be $45 from Company D. Unless this individual contacted all Board-approved companies to compare price, the applicant could easily pay more than double what the least expensive company charges.

Table 5 also illustrates how quickly the cost of a criminal history background check can escalate. For example, an applicant who has changed names only once, but has lived in two states under both names would pay at least $90 for a criminal history background check performed by Company F.

Although the Board does not track the cost of individual background checks, the Board's staff reports that several nurse aide applicants have complained to the Board that costs of their background checks were exorbitant. This is troubling when one recalls that, on average, CNAs only earn nine to ten dollars per hour. In addition, there is no guaranty that someone with a criminal record will violate the law in the future, or, conversely, that someone who does not have a criminal record will not violate the law at some future point.

The current system of background checks does have one positive feature. Table 5 indicates that most criminal history background checks are completed within a matter of days, though those that require more in-depth out of state inquiries, can take as long as several months.

Overall, however, the current system of conducting criminal history background checks on nurse aide applicants is severely flawed. They can be quite costly and they are so inherently unreliable and questionable that they are of little value and tend to give employers, patients and the public a false sense of security.

Assuming criminal history background checks are necessary in order to better protect the vulnerable populations with whom CNAs work, a better system must be found. Indeed, the State Auditor reached the same conclusion in 2001, stating,

> While it appears that under the current system in Colorado, self-reporting for nurse aides is more accurate than the contractor-produced lifetime background checks, the Nursing Board still runs the risk that candidates will not honestly disclose criminal histories. A more effective alternative, according to the Colorado Bureau of Investigations, is fingerprint cards for applicants that allow searches of statewide databases.[10]

[10] Id.

In response to a September 2001, Criminal History Checks Performance Audit conducted by the State Auditor, the Colorado Department of Health Care Policy and Financing, Department of Human Services and Department of Public Health and Environment prepared a report (Joint Report). This report provided several low-cost and higher-cost options for attaining the goal of protecting vulnerable populations. Among the Joint Report's low-cost options were abuse prevention training, self-reporting by applicants of criminal history, reference checks and state name checks.[11]

Unfortunately, the Board already requires applicants to self-report and conducts statewide and nationwide name checks. These are the very processes that have been found to be unreliable.

The Joint Report also included two higher-cost options: state fingerprint checks through the Colorado Bureau of Investigations (CBI) and national fingerprint checks through the Federal Bureau of Investigations (FBI).[12] While these higher-cost options provide more reliable results, they, too, fall short of perfection.

The discussion that follows focuses considerable attention on arrest information and disposition information. Arrest information simply indicates whether an individual was arrested and the basis for that arrest. Disposition information, however, addresses whether charges were filed and whether the individual was acquitted or convicted of the crime alleged. Thus, disposition information is critical because it is the more accurate measure of criminal activity. Anyone can be arrested, but only guilty parties are, theoretically, convicted.

To obtain fingerprint checks from both the CBI and FBI, a nurse aide applicant would take a Board-provided fingerprint card to a local law enforcement agency to be fingerprinted. Most local police stations maintain schedules for the times and days upon which they will do fingerprinting for these types of purposes. A nominal charge of $5 to $10 is typical for this service.

[11] *Response to the Criminal History Checks Performance Audit Dated September 2001*, at page 7. Submitted to the Colorado General Assembly by the Colorado Departments of Public Health and Environment, Human Services and Health Care Policy and Financing on March 31, 2002.
[12] Id. at 9.

Once the fingerprinting is completed, the fingerprint card would be returned to the applicant, who would then submit it to the Board. The Board would provide certain information on the fingerprint card, including its name, address and statutory citation(s) authorizing the fingerprint check, and then forward it to the CBI.

The CBI runs fingerprints through two separate databases, the Colorado Crime Information Computer (CCIC) and the Integrated Colorado On-Line Network (ICON). The CCIC is a repository of criminal history information, which provides both arrest and disposition information for criminal activity that occurred in Colorado within the last ten years. The CCIC contains only Colorado arrest information for dates earlier than ten years ago.

Additionally, the CBI runs the fingerprints through ICON, which provides only case disposition information. Like the CCIC, ICON only contains Colorado criminal information. Unlike the CCIC, however, ICON depends upon the state's various courts to report information to it and then to update that information. Not all courts report to ICON and not all courts update that information on a timely basis. Notably, Denver's courts do not report to ICON.

Regardless of their shortcomings, the databases through which the CBI runs fingerprints will detect arrest information and, possibly, disposition information.

Under the system proposed here, the CBI would also forward the fingerprints to the FBI for a national fingerprint check. The FBI also runs fingerprints through two databases: the Interstate Identification Index (III) and the National Crime Information Computer (NCIC). Both the NCIC and the III are dependent upon the information reported to them by the several states. Although the states are required to report serious crimes and the fingerprints of the offenders to the FBI, some states report disposition information and some do not. Similarly, some states update arrest and disposition information and some do not, or do not do so in a timely manner. Additionally, the FBI's databases do not provide information regarding sealed or juvenile records.

The FBI would then forward the report to the CBI, who would then forward the FBI and CBI reports to the Board. Since it is illegal for the Board to reproduce these reports, the Board could simply notify Promissor, the nurse aide-testing contractor, whether a particular nurse aide could take the examination. Alternatively, the nurse aide applicant could be allowed to take the examination, but the Board could withhold certification until the criminal history background check is completed.

Although the CBI and FBI systems have drawbacks, the dual fingerprint check system is a far more accurate way for the Board to, at a minimum, identify and locate arrest information. It is not unreasonable to place the burden of providing disposition information, to the extent it is necessary, on the nurse aide applicant.

Additionally, the combined CBI/FBI fingerprint checks would be relatively inexpensive. The CBI charges $14, and the FBI charges $22. Assuming a CNA candidate must pay $10 to a local law enforcement agency to be fingerprinted, the total cost for this type of background check would be $46. While this is slightly more expensive than the most expensive, basic, criminal history background check available under the current system, it is far less expensive than the costs a nurse aide applicant could expect to pay if the applicant has had more than one name or has lived in more than one state. It is also more predictable and equitable -- every nurse aide applicant would pay the same fee for the criminal history background check and could budget accordingly.

A major drawback to this proposal, however, is timeliness. Most of the background check companies listed in Table 5 reported that they report results, for the most part, within a matter of days. While the CBI is required to report results within three days, the FBI typically takes 30-60 days to report results. However, this is within the 90-day time limit established by the General Assembly in section 12-38.1-104(3)(a), C.R.S., and there is no reason why a nurse aide candidate could not submit the fingerprint card prior to completing a nurse aide-training course, thus allowing sufficient time to complete the background check prior to taking the competency examination.

In time, this may become moot. Technology currently exists that enables law enforcement agencies to take fingerprints electronically. These fingerprints are digitized and can be run through the databases discussed above in a matter of minutes, thus reducing the time it takes to generate a report. At present, most law enforcement agencies that have the required equipment, however, have housed it in their jails and are, understandably, reluctant to take applicants into their jails to be fingerprinted. Additionally, the FBI does not yet have the capacity to run digitized fingerprints for applicants, though it does so in criminal investigations. In time, though, this technology will become more widespread and the Board and/or Promissor may consider purchasing its own equipment to expedite the process.

If the General Assembly enacts this recommendation, it is important to note that the FBI requires that a statute mandate the FBI-fingerprint check. It will not perform fingerprint checks without either a federal or state statute that requires it.

Another shortcoming of both the current system and the one proposed here is the fact that criminal activity perpetrated outside of the U.S. is virtually impossible to detect without self-disclosure. This is particularly problematic with CNAs because, according to industry representatives, a great number of them are immigrants. Unfortunately, neither the Board nor Promissor tracks whether CNAs or applicants are immigrants.

However, as part of this sunset review, DORA contacted a representative of the U.S. Department of State, the federal agency responsible for issuing visas to foreign nationals seeking to enter the U.S. As part of the visa-application process, an applicant must provide the State Department a police certificate from every country in which that person has lived for six months or longer.

Although a clean police certificate is no guaranty that the applicant lacks a criminal record (because of poor record keeping or corruption), the process at least affords a modicum of protection to the public. This process also helps to alleviate some of the fears that foreign nationals with extensive criminal records can come to the U.S. and obtain CNA certification because their criminal histories will not be detected. The federal government at least makes an attempt to prevent such individuals from legally entering the country.

Because the current system of self-reporting criminal histories and conducting nationwide criminal history background checks based on name, social security number and the states in which the nurse aide applicant declares to have lived is inherently unreliable and potentially very expensive, and because the combined CBI/FBI fingerprint checks are considerably more reliable and accurate and, potentially, less expensive, the General Assembly should require nurse aide certification applicants to obtain criminal history background checks based on CBI and FBI fingerprint checks.

Recommendation 4 - Include the habitual or excessive use, or misuse of cocaine, marihuana or marihuana concentrate as possible grounds for discipline. Amend section 12-38.1-111, C.R.S., to read as follows:

> **(1) The board may suspend, revoke, or deny any certification to practice as a nurse aide or issue a letter of admonition to a certified nurse aide upon proof that such person:**
>
> **(i) Has habitually abused or excessively used any habit-forming drug as defined in section 12-22-102(13), or any controlled substance as defined in section ~~12-22-303(7)~~ 18-18-102(5);**
>
> **(j) Has misused any drug or controlled substance as defined in section ~~12-22-303(7)~~ 18-18-102(5);**

Section 12-22-303(7), C.R.S., a section of the Drugs and Druggists Act (Drug Act), defines a controlled substance as "a drug, substance, or immediate precursor included in Schedules I to IV of Part 2 of Article 18 of Title 18, C.R.S."

Section 18-18-102(5), C.R.S., a section of the Colorado Criminal Code (Criminal Code) defines a controlled substance in an identical manner except that it goes on to state, "including cocaine, marihuana, and marihuana concentrate."

Tetrahydrocannabinols, commonly referred to as "THC", is listed as a Schedule I Controlled Substance at section 18-18-203(2)(c)(XXIII), C.R.S. The Drug Act, at section 12-22-303(32)(a), C.R.S., defines "THC" as,

> synthetic equivalents or the substances contained in the plant, or in the resinous extractives of, cannabis, sp., or synthetic substances, derivatives, and their isomers with similar chemical structure and pharmacological activity . . .

Thus, THC is a part of the marihuana plant, but an individual could potentially test positive for marihuana and not THC, which is the controlled substance under the Drug Act.

In 2001, the Board sought to take disciplinary action against a CNA who reported to work in an intoxicated state and tested positive for cocaine, alcohol and marihuana. Because the nurse aide practice act references the Drug Act, which includes THC as a controlled substance, but not marihuana specifically, the administrative law judge (ALJ) requested the Board's Assistant Attorney General, to establish the relationship between THC and marihuana in order to proceed to hearing whether the marihuana in the CNA's system was grounds for disciplinary action. This involved research, legal analysis of the relevant statutes and obtaining an affidavit from a pharmacist.

Since THC is listed as a Schedule I Controlled Substance, and the Criminal Code specifically includes marihuana in its definition of a controlled substance, it is clear that the General Assembly intended that a CNA who is found to have abused or excessively or habitually used marihuana be subject to disciplinary action. The recommended amendment will more clearly state the General Assembly's intention.

Two other points are worth noting in relation to this issue. First, most, if not all, of Colorado's professional practice acts contain language similar to that at issue here – they reference the Drug Act. In order to impose consistency across the practice acts, Recommendation 8 in the Colorado State Board of Pharmacy Sunset Report that is being presented during the current legislative session recommends that the Drug Act's definition of "controlled substance" be amended to conform to the Criminal Code's definition.

Finally, in 2000, the Colorado Constitution was amended to legalize the use of marihuana for people suffering from debilitating medical conditions. Colo.Const. art. XVIII, §14. This recommendation will not infringe upon an individual's opportunity to exercise the rights granted under this constitutional provision so long as the CNA does not report to work while under the influence of marihuana, just as a CNA could receive discipline for reporting to work while under the influence of alcohol. For an individual who has obtained the necessary approvals and permissions to use marihuana for medicinal purposes, a showing of abuse, or habitual or excessive use would be similar to such a showing for alcohol.

Recommendation 5 - Revise the grounds for discipline of certified nurse aides to make "abuse" and "neglect" of patients, two separate grounds for discipline. Amend section 12-38.1-111, C.R.S., as follows:

> **(1) The board may suspend, revoke, or deny any certification to practice as a nurse aide or issue a letter of admonition to a certified nurse aide upon proof that such person:**
>
> **(h) Has VERBALLY OR PHYSICALLY abused~~,~~ ~~neglected, or otherwise harmed~~ a person under ~~his~~ THE care OF THE CERTIFIED NURSE AIDE;**
>
> **(o) HAS NEGLECTED A PERSON UNDER THE CARE OF THE CERTIFIED NURSE AIDE.**

This language is intended to simplify the manner in which the Board cites the grounds for the disciplinary action it takes. Currently, the Board may take disciplinary action for abuse or neglect of a patient, but disciplinary documents simply refer to subsection (h), which includes both grounds.

This is an important distinction to make because any disciplinary action taken against a CNA based on the abuse or neglect of a patient must be, according to federal regulations, noted on the Nurse Aide Registry. Unlike disciplinary action taken on other grounds, such a notation on the Nurse Aide Registry serves as a legal bar to the CNA's future employment as such – a CNA who is found to have abused or neglected a patient may not continue to work as a CNA.

However, a process exists whereby a CNA who is disciplined for neglecting a patient and has such a notation on the Nurse Aide Registry, may petition the Board to have such notation removed after three years if the neglect did not result in harm to the patient, or after five years if the neglect resulted in harm to the patient. No such provision exists for the removal of the notation for abuse.

Because the offenses of abuse and neglect currently reside in the same statutory citation, the Nurse Aide Registry simply reports that the CNA was found to have "abused, neglected or otherwise harmed" a patient and the Board is restricted to imposing administrative penalties based on the entire section, not just abuse or neglect, as may be appropriate.

The proposed language will simplify the removal process for those CNAs who perform the necessary actions to have the notation of neglect removed from the Nurse Aide Registry and will allow the Board to more precisely inform the CNA involved, as well as the public, as to the reason for any disciplinary action taken.

In addition, the Division of Registrations' computerized disciplinary system is unable to report data in any format other than statutory citation. Thus, under the current system, the record of a CNA who is found to have either neglected or abused a patient simply reflects that the CNA abused, neglected or otherwise harmed the patient. However, by separating the two grounds for discipline, the computer system can more accurately report the grounds for discipline. This will assist the Board when it receives petitions to remove the "neglect" notation from the registry, as well as assist the Board in its statistical reporting obligations to the federal government. Additionally, it will provide more accurate disciplinary information to the public and CNA employers.

For these reasons, the General Assembly should make "abuse" and "neglect" separate grounds for discipline.

Recommendation 6 - More clearly define the circumstances under which a nurse aide may work as such without having obtained certification. Amend section 12-38.1-117(1)(d), C.R.S., to read as follows:

> **(1) This article shall not be construed to affect or apply to:**
>
> **(d) A person who is directly employed by a medical facility while acting within the scope and course of such employment for the first four months of such person's employment at such medical facility if such person is pursuing INITIAL certification as a nurse aide. A person may utilize this exclusion only once in any twelve-month period. This exclusion shall not apply to any person who has ALLOWED HIS/HER CERTIFICATION TO LAPSE, HAS had his/HER certification as a nurse aide suspended or revoked, or his/HER application for such certification denied.**

The state and federal laws and regulations implementing the CNA program (Program) allow a nurse aide to work as such for up to four months prior to obtaining certification, provided the nurse aide has completed an approved training course and is pursuing certification. Discussions with the Board's staff indicate that this initial four-month grace period was initially intended to allow nurse aides to begin working as such while the Board processed the nurse aide's application for competency evaluation and certification.

However, the law, as currently drafted, allows a CNA who allows his/her certification to lapse to work for an additional four months without obtaining recertification.

The recommended language would eliminate this loophole in the law and prevent a nurse aide whose certification has lapsed from working as a CNA. This, in turn, will provide incentive to CNAs and their employers to ensure that recertification is obtained in a timely manner.

For these reasons, the General Assembly should specify that the four-month grace period applies only to initial certification.

Recommendation 7 - Revise the composition of the Nurse Aide Advisory Committee to include greater representation by certified nurse aides or health care providers who work directly with them. Amend section 12-38.1-110, C.R.S., to read as follows:

> **. . . One member shall be a certified nurse aide, one member shall be a member of the state board of nursing WHO IS A LICENSED PROFESSIONAL NURSE, one member shall ~~represent professional associations composed of home health agencies~~ BE A CERTIFIED NURSE AIDE WHO WORKS IN A HOME HEALTH CARE AGENCY OR A LICENSED PROFESSIONAL NURSE WHO WORKS IN A HOME HEALTH CARE AGENCY AND SUPERVISES CERTIFIED NURSE AIDES, one member shall be ~~from a group representing the concerns of senior citizens~~ A MEMBER OF THE GENERAL PUBLIC, and one member shall ~~represent professional association composed of nursing homes~~ BE A CERTIFIED NURSE AIDE WHO WORKS IN A NURSING HOME OR A LICENSED PROFESSIONAL NURSE WHO WORKS IN A NURSING HOME AND SUPERVISES CERTIFIED NURSE AIDES. A department of public health and environment employee shall serve as an ex officio member. . .**

This recommendation does not alter the number of members serving on the Advisory Committee. Rather, it delineates the professional and employment backgrounds of those who serve on it.

Currently, the Board appoints one of its own members to serve on the Advisory Committee. This is logical in the sense that the Board appoints all of the members of the Advisory Committee and it exists under the auspices of the Board. By requiring a member of the Board to serve on the Advisory Committee, the Board is able to contribute to the Advisory Committee's deliberations and is able to ensure a modicum of consistency in the policies of both bodies.

The first part of this recommendation simply delineates that the Board's representative be a licensed professional nurse. The Board comprises licensed professional nurses, licensed practical nurses, nursing administrators, nursing educators and members of the public, any one of whom could be appointed by the Board to serve on the Advisory Committee. This recommendation merely seeks to ensure that a licensed professional nurse serves on the Advisory Committee.

In addition, the current composition of the Advisory Committee includes only one CNA, the profession the Advisory Committee purports to regulate. Thus, non-CNAs make policy, disciplinary and certification recommendations to the Board. Furthermore, unlike any other board or advisory committee in the Division of Registrations, the Advisory Committee has two members of professional associations that comprise CNA employers.

The recommended language would increase the number of CNAs on the Advisory Committee to a maximum of three, but retain the minimum of one. Two arguments have been presented to counter this recommendation. First, many feel that the average CNA is not sufficiently aware of the laws and rules governing CNAs, thus the Advisory Committee should comprise individuals who possess sufficient understanding, presumably CNA employers. However, aside from stereotyping CNAs as low-income individuals with poor educations, nothing has been presented to support this argument. In addition, it is reasonable to assume that the Board would make every effort to find and appoint two CNAs, from the thousands who are certified, who exhibit some understanding of the laws and regulations governing the profession. In addition, it is reasonable to ask how many professionals serve on other boards and advisory committees who do not fully understand the laws and regulations governing their own professions until having served in such a capacity for a period of time.

Second, CNAs are typically at the bottom of the hierarchy in most health care facilities, whether they work in a nursing home or home health care agency. Thus, they are in a relatively weak position to request time off from work to serve on the Advisory Committee. This is a reasonable argument, even though it can be countered by the fact that many employers are likely to find it prestigious to have one of their employees serving in such a capacity.

Nevertheless, to accommodate these arguments, the recommended language also allows the Board to appoint a registered nurse in the place of a CNA. Registered nurses provide the most direct form of supervision to CNAs, placing them in a better position to serve on the Advisory Committee than representatives from professional associations.

The final alteration to the composition of the Advisory Committee includes language to allow the Board to appoint a member of the general public. With rare exceptions, all boards, whether advisory committees or policy autonomous boards, contain representation of the general public. This is generally done to ensure that consumers, those that regulation is intended to protect, have a voice on the regulatory body.

The Advisory Committee's current composition includes someone to represent the concerns of senior citizens. However, senior citizens are but one subsection of the general public and only one of the groups with whom CNAs work. In addition to senior citizens, CNAs frequently work with the disabled and the chronically ill. By including a representative of the general public, there is a greater likelihood that the Board will appoint someone who can bring a wider perspective to the Advisory Committee than can an individual whose sole task is to represent the concerns of senior citizens.

The recommended language retains the level of representation afforded to the two employment settings of CNAs – long-term care facilities and home health care agencies. Since CNAs who work in these two settings are likely to encounter different and unique issues, it is only logical to retain this diversity on the Advisory Committee. The recommended language also expands the representation of consumers from an individual who represents only the interests of the elderly, to also include, at least potentially, the interests of the disabled.

For these reasons, the General Assembly should revise the composition of the Advisory Committee to more adequately include representation of CNAs, the populations with whom CNAs work and the public.

Recommendation 8 - Comply with federal regulations and require a certified nurse aide who has not worked as such for twenty-four months to retake the competency evaluation. Amend section 12-38.1-109, C.R.S., to read as follows:

> **. . . At the time of such renewal, the nurse aide shall submit proof to the board, as required by federal law or regulation, of either having performed nurse aide services, or the equivalent, as defined in rules and regulations, for pay during the preceding twenty-four-month period or having ~~completed a new training program approved under the provisions of this article~~ PASSED A COMPETENCY EVALUATION during the preceding twenty-four months.**

Federal regulations governing CNAs who work in long-term care facilities require a CNA who has not performed CNA services within the preceding 24 months to "complete a new training program and competency evaluation program or a new competency evaluation program." 42 CFR §483.75(e)(7).

Section 12-38.1-109, C.R.S., does not currently comply with this federal requirement in that it does not require retesting after 24 months of inactivity. Rather, it merely requires the nurse aide to submit proof of attending a training program.

While Colorado's current statutory language requiring retraining may have helped to ensure greater competency years ago, when the Board held less confidence in its nurse aide competency evaluation, this is no longer the case. The current nurse aide competency evaluation provides adequate assurances of competency.

In addition to complying with federal law, this recommendation will also assist a nurse aide who has allowed his/her certification to lapse. Rather than having to retake 75 hours of training, the nurse aide may simply retake the competency evaluation. This will require a less substantial investment of time and money for both the nurse aide and the facility that intends to employ him/her.

For these reasons, the General Assembly should require a nurse aide to re-test in order to reinstate a certification, rather than simply re-train, if the nurse aide has not worked as such during the preceding 24-month period.

Recommendation 9 - Change the timelines for appealing a letter of admonition to 30 days from the date of mailing, rather than 20 days from the date of proven receipt. Amend section 12-38.1-111(3), C.R.S., to read as follows:

> **. . . a letter of admonition may be sent by certified mail to the nurse aide against whom a complaint was made and a copy thereof to the person making the complaint. When the letter of admonition is mailed by certified mail by the board to the nurse aide complained against, such nurse aide shall be advised that such person has the right to request in writing within ~~twenty~~ THIRTY days after ~~proven receipt of~~ the DATE ON WHICH THE letter WAS MAILED, that formal disciplinary proceedings be initiated to adjudicate the propriety of the complaint on which the letter of admonition is based . . .**

In practice, the current statutory provision requires a letter of admonition to be mailed via certified mail, return receipt requested. This is the only verifiable way to prove the date on which such letter is received.

However, it is not uncommon for letters of admonition to be returned to the Board as undeliverable or unclaimed. One reason for this is the CNA having moved and not notified the Board of the CNA's new address as required. An additional consideration here is that state mail is not forwarded, it is returned to the Board as undeliverable.

A more pessimistic explanation is that the CNA simply refuses to sign for the letter, thus preventing the tolling period from beginning.

The Colorado Court of Appeals recently addressed this issue in *Colorado State Board of Medical Examiners v. Roberts*, 42 P.3d 70 (Colo. App. 2001). In *Roberts*, the court reviewed a provision in the Medical Practice Act that is substantially similar to the statute under discussion here. The Board of Medical Examiners issued a letter of admonition to Dr. Roberts and mailed it to him at his place of business via certified mail, return receipt requested. However, Dr. Roberts and his staff refused to sign for the letter on two separate occasions. Three months later, Dr. Roberts requested that the Board of Medical Examiners vacate

the letter of admonition and institute formal disciplinary proceedings against him. The Board of Medical Examiners refused, stating that two notices of attempted delivery by the U.S. Postal Service was sufficient to constitute receipt and begin the 20-day tolling period for requesting formal disciplinary proceedings.

Dr. Roberts and the Court of Appeals disagreed. In focusing on the plain language of the statute, the court held that "receipt" in the statute requires actual receipt.

Since the nurse aide practice act contains language that is substantially similar to the statutory provision reviewed in *Roberts*, it is not unreasonable to believe that at some point, the Board will encounter a similar problem.

The recommended language attempts to expedite the disciplinary process while protecting the rights of the CNA. By requiring the letter of admonition to be mailed by certified mail, the Board will be able to establish the date on which it is mailed. To allow for delivery time, and to be consistent with other appeals timelines, the time in which a CNA may request formal disciplinary proceedings is extended from 20 days to 30 days.

This recommendation neither restricts nor expands the powers of the Board or the rights of the CNA. Rather, it attempts to correct a procedural problem that may be exacerbated by the *Roberts* decision.

Administrative Recommendation 1 - The State Board of Nursing should promulgate rules that require nurse aide-training courses provide specific training on how to deal with difficult patients.

Training is one of the most contentious issues surrounding the CNA program. Throughout this sunset review, DORA asked whether 75 hours of training was adequate to prepare a CNA to work with patients. The responses to this question were anything but uniform.

Some argue that the amount of training is not the problem, but rather the problem lies with the type of training that is provided within those 75 hours. Others argue that 75 hours is woefully inadequate and that substantially more training is required. Invariably, however, those who advocate for more training are unable to articulate how much more training should be required or why. Additionally, many, if not most, training programs include more than 75 hours of training.

One commonality among those arguing on both sides of this issue, however, is the theme that CNAs are not adequately prepared to work with patients who may be difficult, for whatever reason. A CNA's patients may have dementia or Alzheimer's disease, may be frustrated with trying to live with a disability, may be frustrated with simply not being able to care for themselves, or they may just be irritable. A CNA must work with each of these types of patients and not allow that patient's psychological dispositions to interfere with the provision of care or to provoke the CNA to respond in an inappropriate manner.

It is unfortunate that, as the system currently exists, CNAs receive a minimal amount of training, are thrust into situations in which they are expected to work with some of society's most difficult and vulnerable populations, and when they react instinctively, which often includes a physical reaction, they are designated on the Nurse Aide Registry as abusive, and are subsequently prohibited from working as a CNA anywhere in the country ever again.

Both the federal government and the General Assembly have mandated that nurse aide training courses consist of at least 75 hours and that included in those 75 hours must be training on communication and interpersonal skills. However, nothing in the federal statutes or regulations or Colorado's statutes or the Board's rules specify that the communication and interpersonal skills training include training on how to deal with difficult patients or what that training should entail.

Since it is not clear whether or how many additional hours need to be added to the minimum training program, but it is clear that CNAs need training in how to deal with difficult patients, the Board should revise its rules, particularly Chapter XI: Rules and Regulations For Approval Of Nurse Aide Training Programs, to specify that training programs include such training as part of the communication and interpersonal skills training and what that training should entail.

Administrative Recommendation 2 - The State Board of Nursing should revise the manner in which it processes complaints relating to certified nurse aides to conform with the process it currently uses to process complaints relating to registered nurses, licensed practical nurses and licensed psychiatric technicians.

The Board regulates registered nurses, licensed practical nurses, licensed psychiatric technicians and CNAs. However, it currently maintains two systems for processing complaints: one for CNAs and one for all other licensees that it regulates. A comparison of these two systems indicates that the Board should change the manner in which it processes complaints relating to CNAs to mirror that used to process complaints against the other licensees that it regulates.

When the Board receives a complaint against a CNA, the Board's staff makes an initial determination as to whether the Board has jurisdiction over the complaint. If the staff decides that jurisdiction is proper, the complaint is forwarded to the Division of Registration's Complaints and Investigations Unit (C&I). C&I then mails a copy of the complaint to the CNA-respondent requesting that the CNA provide a written response within 20 days. This request is commonly referred to as "the 20-day letter."

Regardless of whether the CNA responds to the 20-day letter, C&I begins to investigate the allegations in the complaint. Once the investigation is completed, the C&I investigator drafts a report and forwards the file to the Advisory Committee so that it may make a determination as to whether and what disciplinary action is warranted.

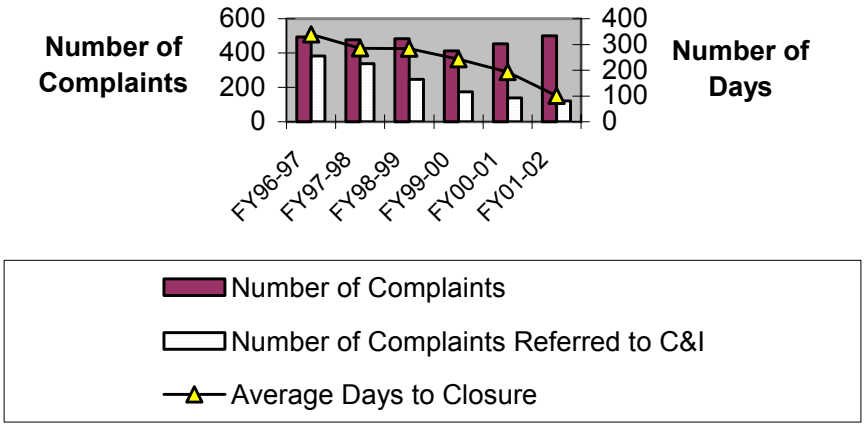
Following this process and utilizing the data contained in Table 7 on page 30, an average of 204 days pass from the time a complaint is filed until the time it is resolved. This means that a CNA whose case is ultimately dismissed may have to work under the pressure of possible disciplinary action for almost seven months. More importantly, however, it also means that a CNA who has violated the CNA Practice Act may continue to practice, possibly jeopardizing his/her patients, for an additional seven months while the CNA's case winds its way through the Board's complaint handling process.

Until July 1, 1999, the Board used this same procedure to process complaints relating to the other licensees it regulates. Faced with a similar dilemma regarding lengthy processing time (an average of 302 days), the Board sought and obtained statutory language that changed the manner in which it processes complaints. Beginning in fiscal year 99-00, when the Board receives a complaint relating to a registered nurse, licensed practical nurse or licensed psychiatric technician, the Board's staff sends the nurse-respondent a 30-day letter. The Board's staff then forwards the complaint and response, if one is received, to one of the Board's disciplinary panels that meet monthly. The panel then determines whether to dismiss the complaint or whether to refer it to C&I for investigation.

As Graph 1 illustrates, the Board has managed to close more cases more quickly than before the implementation of this new system in fiscal year 99-00, from an average of 302 days (approximately ten months) for the three years immediately preceding the change, to an average of 179 days (approximately 6 months) for the three years immediately following the change. This represents a decrease of approximately 40 percent.

Graph 1

Number of Nursing Complaints vs. Average Days to Closure



Significantly, the reduction in time to closure came at a time when the number of complaints received by the Board remained relatively constant over the six-year period reflected in Graph 1. Therefore, despite the fact that the Board had just as many complaints to process in fiscal year 01-02 as it did in fiscal year 96-97, it resolved them in almost half the time, thus affording licensees with speedy resolution and better protecting the public from licensees who should be disciplined.

If the Board implements the same complaint handling system for CNAs as it has for the other licensees it regulates, it can anticipate reducing the time to closure for complaints from the current 204 days (approximately seven months) to 123 days (approximately four months). Thus, cases will be resolved in 81 fewer days (approximately three months) under the proposed system than under the current system. As with the other licensees it regulates, this will enable the Board to remove from practice those CNAs who pose a risk to the public in a much more timely manner without jeopardizing the due process rights of those CNAs.

However, the manner in which this system is implemented for CNAs could be the subject of debate. The Board's process is codified in the Nurse Practice Act at section 12-38-116.5(3), C.R.S., which specifically states that this process shall apply to registered nurses, licensed practical nurses and licensed psychiatric technicians. It does not include CNAs. Additionally, the Medical Practice Act contains a similar provision at section 12-36-118(4)(a), C.R.S., for physicians.

An argument could be made that since this process is codified in statute for the Board and the State Board of Medical Examiners, the General Assembly did not intend for this process to be used by any program that does not have it in its statute.

On the other hand, nothing in the State Administrative Procedure Act or the Nurse Practice Act delineates how an agency is to process complaints. Such issues are typically left to the discretion of the agency. Indeed, the State Mental Health Grievance Board currently processes complaints in the manner recommended in this sunset report and it does so pursuant to rule, as opposed to statute.

For these reasons, the Board should implement for CNAs the same complaint handling processes it uses for registered nurses, licensed practical nurses and licensed psychiatric technicians.

Administrative Recommendation 3 - The State Board of Nursing should update its website to include, on a monthly basis, the names and certification numbers of those certified nurse aides that are subjected to disciplinary action so as to assist certified nurse aide employers in verifying the continued certification and employability of their certified nurse aides.

Before either a long-term care facility or a home health care agency may legally employ a CNA as such, that facility must verify the status of the CNA's certification. To facilitate this process, the Board has implemented a web tool that allows a member of the public to enter a CNA's name or certification number and receive disciplinary information on that CNA.

However, as Table 7 on page 30 illustrates, it can take a long time between when a complaint is filed against a CNA and the final disposition of that case. The Board cannot legally report that a complaint has been filed against a CNA until final disciplinary action, if any, is taken. Thus, there is a considerable time lag between when a complaint is filed and the time that final disciplinary action is reported by the Board on the Nurse Aide Registry.

Employers file many complaints against CNAs. In many instances, the CNA is terminated on the very grounds that serve as the basis for the complaint. A problem arises when the CNA then seeks employment elsewhere.

When the CNA applies for employment at another facility, that facility utilizes the Board’s web tool to verify the status of the CNA's certification. Because the complaint is still being investigated, the Board’s web tool reports that the certification is in good standing.

Additionally, the potential employer may check the CNA's references, but due to liability concerns, most former employers limit references to verification of dates of employment. Most refuse to discuss why the employment relationship was terminated.

With nothing more than verification of the certification to go on, the new facility hires the CNA. Subsequently, the Board revokes, suspends or takes some other disciplinary action against the CNA's certification and the CNA fails to so notify his/her employer.

Because CNAs are required to recertify every two years, rather than annually, unless the facility constantly reverifies the certification status of all employees, it will not become aware of the revocation until it is time for the CNA to recertify. In the meantime, that facility has violated numerous state and federal laws by employing a nurse aide who is no longer certified.

While there is no way to legally inform potential employers or any one else of pending complaints, the Board can take steps to make it easier for employers to regularly verify the status of certifications.

The Board should update its website to include monthly announcements that include the names and certification numbers of those CNAs against whom disciplinary action has been taken since the last such announcement. Employers can then examine this monthly announcement and search this limited list for the names of its employees, rather than having to enter the names of all of its CNAs into the Board's web tool every month to verify certification status.

Administrative Recommendation 4 - The State Board of Nursing should cease dismissing complaints without prejudice.

Between fiscal years 96-97 and 00-01, the Board dismissed two cases without prejudice. It dismissed two more complaints without prejudice in fiscal year 01-02.

When a complaint is dismissed without prejudice, that complaint may be revived at a later time, as long as any applicable statutes of limitation have not expired. However, in administrative proceedings that have not progressed to the hearing stage, all dismissals are dismissals without prejudice. Thus, it may cause confusion among respondent-CNAs to have multiple complaints filed against them where one complaint is dismissed without prejudice and a second is simply dismissed. Both dismissals have the same practical effect, but may create a different expectation.

Finally, by designating some dismissals as dismissals without prejudice and others as simple dismissals, it is not unreasonable to conclude that at some point an attorney will attempt to argue that since the Board specifically dismisses some complaints without prejudice and others it simply dismisses, it must intend that those that are not dismissed without prejudice must be dismissals with prejudice, which would preclude the Board from re-asserting the allegations contained in those complaints.

For these reasons, the Board should immediately cease its occasional practice of dismissing cases without prejudice.

Appendix A - Sunset Statutory Evaluation Criteria

(I) 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;

(II) 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;

(III) 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;

(IV) Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;

(V) 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;

(VI) The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;

(VII) 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;

(VIII) Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action; and

(IX) Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Appendix B – Authorization to Perform Criminal History Background Checks

COLORADO BOARD OF NURSING
AUTHORIZATION TO PERFORM CRIMINAL BACKGROUND CHECKS

INSTRUCTIONS: *PLEASE PRINT ALL INFORMATION CLEARLY AND SUBMIT TO AN APPROVED CRIMINAL CONVICTION AGENCY. THERE IS A FEE FOR THIS – PLEASE CONTACT THE AGENCY FOR INFORMATION.*

1. Are you applying for the Nurse Aide Examination? _____ Yes _____ No

2. Are you applying for certification by endorsement from another state? _____Yes _____ No

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Legal Last name: _____ Legal First: _____ Middle: _____

Social Security Number: _____ Birth date: _____

Drivers License Number: _____ State: _____Exp. date: _____

Previous names (Maiden/Marriage/Alias etc.): _____

Present address: _____ Phone: _____

Previous addresses: **(Must list for lifetime. Please list city, state, zip code, dates of residence and names used.** Attach additional sheet if necessary)

_____ (Name Used) _____ Dates: _____
_____ (Name Used) _____ Dates: _____
_____ (Name Used) _____ Dates: _____

How long have you lived in Colorado?: _____Have you lived outside the United States?_____
If yes, please complete the "Attestation Regarding Criminal Convictions" and submit with your criminal background check.

The Criminal Background Agency should submit your report to: (Pick one)

_____**Nurse Aide Training Program** (For all aides who are in or just completed a training program in Colorado)

Name:
Contact:
Address:
Phone:

_____ **Assessment Systems, Inc. (ASI)** (For all others applying for examination)

OR

_____**Colorado Board of Nursing** (Endorsing from another state ONLY)

I request and authorize agencies approved to perform criminal background checks for the Board of Nursing to conduct a social security number verification and a criminal background check for the purpose of my obtaining nurse aide certification. I voluntarily agree to have my social security number and other identifying information released to companies applying for Board approval to perform background checks. This process shall cover only the time period previously checked in connection with my CNA certification.

Signature: _____ Date: _____

ASI# 0706-07 6/01

Appendix C – Final Report of the Medication Administration Advisory Committee

House Bill 02-1090
Advisory Committee to Study:
Administration of Medications by Certified Nurse Aides

August 2002

A. Benefits and risks associated with Certified Nurse Aides serving as Medication Aides

Benefits

- Aide is focused on administering medications.
- Nurses would have more time for direct contact with residents including assessments, treatments, and wound care. The nurse would also have increased time for documentation and keeping the care plan current.
- Residents would receive their routine medications in a more timely manner, as a facility could employ more medication aides, than they can find nurses now.
- Residents physical and psychosocial care would improve, as the nurses would be freed up to call physicians, families, support personnel when the residents care level changed.
- Nurses would have more time to assess medication orders and review these critical areas of the chart for adverse interactions. This would also free up the LPN/RN in regard to home health to make more visits to those who are more critical.
- A great career ladder for those who have worked successfully as a Certified Nurse Aide, but has chosen or is not able to go to nursing school. This would widen their scope of practice.
- Improve the overall care for all residents, as there would be more staff to care for them. Nurse aides, medication aides, and nurses.
- Improve the facilities ability to recruit nurses into the profession of long term care, as they would be using their professional assessment skills to assess, plan, and then implement the established plan of care. Nurses in long-term care currently spend approximately 1/2 of their time passing routine medications established and ordered by the physician and monitored by registered pharmacists.

- Would maximize the available nurse force to provide more professional care in regard to the nursing shortage and the increasing numbers of elders requiring long term care services.
- Could increase the financial status of Vocational Technical Schools and Junior Colleges who would then have another source of revenue through established classes.
- Increase job satisfaction for RN's, LPN's and CNA's.

Risks

- Nurses may inadvertently decrease their involvement with medication effects, side effects, drug interactions, etc. when they are no longer responsible for administering meds. Compartmentalize care.
- Risk for the possibility for increased medication errors due to lack of experience and minimal education. However this should potentially increase the amount of time the professional nurses could monitor residents in a nursing home, as they would have more time.
- Responsibility of the licensed nurse if a medication aide makes an error. Who would be held accountable? Potential confusion over the delegation and role of this position in regard to LPN's and RN's.
- Possibility of some nursing homes requiring the medication aide to also work as a Certified Nurse Aide. Would need to require that the medication aides primary job responsibility would be the administration of medications, not the management of medications.
- Currently CNA's do not have to have a high school diploma or a GED.
- Could lose nurses as medication aides would be paid a lower wage, mandated nursing hours/patient would be an option to prevent this.
- Concern voiced over isolating this potential practice to just nursing homes and home health. Would like to see hospitals included in the possible use of medication aides.

- This committee wanted to also express their concern about the current practice of allowing medication aides to function in Assisted Living facilities in Colorado. These people have a minimum number of hours of training (8-12) and are allowed to give medications to at risk elderly people without the supervision that is even required currently in skilled facilities. This committee believes that this program if accepted should be enforced in all elder care facilities equally.

B. Effect of the use of medication aides on the level of patient care

Patients in nursing homes overall care could improve by allowing nurses to use their professional judgment in a more timely manner as they would have the time to do assessments and direct patient care. Would allow the nurse to have more time to do head to toe assessments in regard to skin integrity, circulation, hydration, nutrition, and mental status.

Would increase the time they could spend discussing the needs of the resident with the families, physician and consultant pharmacists. Could decrease the practice of polypharmacy as the nurses would have more time to study ordered medications, side effects and interactions.

Could improve the timeliness that residents receive their medications as medication aides would be focused on only ONE job. Signs and symptoms related to side effects of medications could also be identified and managed in a more timely manner as the professional nurse would have more time to assess residents. Thus medication aides could enhance the level of patient care by allowing the professional the right to delegate appropriate task related activity. This would be a specialty area for those Certified Nurse Aides who had met the criteria and successfully passed the established requirements. This committee feels that it would be important for the candidate to have at least a high school diploma or GED.

In regard to home health care patients this committee felt there could be an increased possibility of experiencing medication side effects and errors due to decreased monitoring by a nurse. The C.N.A. currently acts independently without direct supervision.

The current scope of practice for a C.N.A. in home health care is medication assistance. This can occur in two ways. The first scenario is: a nurse may fill a mediplanner and the C.N.A. can remind the patient to take his/her medications. The second situation is: if a patient has the ability to supervise the aide, then the aide may prepare the medication under the supervision of the patient. It is up to the registered nurse who is case managing the patient to determine if the patient is competent enough to direct the C.N.A. The January 28, 1982 Colorado State Board decision supports these actions based on a ruling "that a nurse must decide if the patient has the ability to supervise the aide."

The creation of medication aides in the home health care setting would increase the scope of practice of the C.N.A. Increased risk to the patient would be created. The home care setting lacks controls found in the skilled nursing facilities. Skilled nursing facilities have constant oversight of not only medications but also all of the care that patients receive by professional nurses. They also have oversight of the patient's medication regimen by a pharmacist. Thus in regard to home health this committee found that the use of medications aides would not be beneficial.

C. The level of experience a Certified Nurse Aide must have in order to be considered for training as a medication aide

- Proof of a high school diploma or GED as this would assure they have met this higher level of learning which would be required to be able to read, comprehend, and understand written orders, use of medications, route to be delivered and common side effects.
- Proof of being at least 18 years of age.
- Be able to read and write in English to decrease the potential of misunderstanding orders. This person would need to be able to find medications in a medication book and understand what they are reading as all of our current systems are in English.
- A Minimum of 2000 hours experience as a Certified Nurse Aide in the same health care agency/facility in Colorado prior to being considered. This would show longevity and an understanding of the residents in any particular home. The medication aide would have a decreased chance of making medication errors in regard to giving medications to the wrong resident. This would also enable the Director of Nursing and professional nurses a reasonable amount of time to evaluate the performance of the candidate as a C.N.A.

- Must have a written recommendation by his/her Director of Nursing and 2 other nurses (R.N. or L.P.N.) prior to being accepted to take a medication administration course.
- If a medication aide terminates their employment at a facility where they are currently working as a medication aide this person should be required to work for at least 3 months as a certified nurse aide prior to getting to work as a medication aide. Thus the medication aide could become familiar with the residents and their needs prior to administering medications. This committee felt that no facility should be allowed to hire this type of position through a pool/registry. Thus by having a requirement of 3 months as a certified nurse aide in a new facility this would prohibit this practice.

D. The extent and content of classroom training and education required to be a medication aide

- The program should consist of a minimum of 140 hours of the following:

  100 hours of classroom instruction and training
  20 hours of return skills demonstration in a laboratory
  20 hours of clinical experience including clinical observation and skills demonstration under the direct supervision of a licensed nurse in a facility
- Pass the clinical and skills section with a minimum of 80% competency
- Make this a standardized program consisting of a minimum of 140 hours through an approved program for all facilities including Assisted Living and Board and Care homes.
- Content of the 100 hours of classroom instruction and training should have at least the following areas covered, with the candidate completing each section with an 80% competency level.

  Successfully perform the four basic mathematical functions, addition, subtraction, multiplication and division
  Fundamentals of pharmacology
  Medication orders
  Fundamentals of the following systems and medications affecting each system

    Gastrointestinal
    Musculoskeletal
    Skin and Sensory
    Urinary

Cardiovascular
Respiratory
Endocrine
Male and Female reproductive
Nervous

- Psychotherapeutic medications
- Inflammation, infection, immunity, and malignant disease
- Pain management
- Principles of administering medications/infection control/handwashing
- Documentation of medication administration
- Patients rights and ability to refuse medications
- Behavioral interventions with medication administration
- Positioning of resident in preparation for medication/treatment administration, including the following:

  Supine position
  Lateral/Sims position
  Fowlers position
  Prone position

- Measurement of vital signs, including pulse, respiratory rate, and blood pressure
- Administration of medications via G-tube or J-tube (crushable vs. non-crushable)
- Administration of medications via inhaled medications.

E. The extent and limit to the scope of practice of a certified nurse aide who has completed training as a medication aide

Reporting observations to the licensed/registered nurse and documentation of those observations in the medical record, including potential side effects to medications exhibited by a patient. This committee felt a medication aide should be allowed to do the following tasks in addition to the tasks they currently are allowed to do as a Certified Nurse Aide.

- Clean technique in handling medications
- Administration of medication via inhalation (metered dose).
- Measure and document vital signs prior to the administration of medication that could affect or change the vital signs. Report any abnormalities to the licensed nurse for assessment prior to medication administration.

- Administer routinely prescribed medication which the medication aide has been trained to administer only after personally preparing (setting up) the medication to be administered. Prescribed oral, ophthalmic, otic, nasal, vaginal, and rectal medications.
- Document in the resident's medication records any medications they personally administered.
- Crush and administer medications if such preparation is appropriate per manufacturers instructions and physicians order.
- Count and document with a licensed nurse controlled substances.
- Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facilities licensed nurse on duty. Appropriate documentation in the resident's medication record should follow along with a follow up of result obtained.

Limitations: The following tasks should not be included in the medication aides scope of practice.

- Should not administer medication by the injection route, including the following:
  *Intramuscular route
  *Intravenous route
  *Subcutaneous route
  *Intradermal route
- Should not administer medication used for intermittent positive pressure breathing (IPPD) treatments or any form of medication inhalation treatments, other than metered dose inhalers.
- Should not instill, irrigate or flush foley or supra pubic catheters, ears, naso gastric tubes, J-tubes or G-tubes, and intravenous catheters.
- Should not assume responsibility for receiving in writing or receiving a verbal or telephone order.
- Should not administer a treatment that involves advanced skin conditions, including stage II, III, and IV decubitus ulcers.
- Should not administer Coumadin or chemotherapeutic agents.

- Should not administer scheduled drugs, including oral, transdermal and rectal routes. Should not be allowed to remove transdermal patches of a scheduled drug.
- Should not be allowed to administer PRN medications unless a licensed nurse has assessed the patient.
- Should not administer medications to a ventilator patient.
- Should not administer medications to any patient 15 years of age or younger.

F. The requirements for the supervision for the medication aide

Supervisory personnel (licensed practical nurses/registered nurses) should be on duty at a minimum in accordance with current State and/or Federal regulations governing the health care setting/facility. The following regulation is currently in affect for SNF's (Skilled Nursing Facilities) in the State of Colorado.

Federal regulations in regard to nursing personnel are found under tags F-353-355.

State regulations for nursing personnel are found in Chapter V, Part 7:7.1-7.6.

In addition to current State and Federal regulations regarding nurse staffing, this committee felt there should be at a minimum one additional supervising licensed nurse on premises for every two medication aides working.

Current state regulations require 2.0 minimal nursing hours/patient. This currently includes C.N.A.'s and non-management nurses. The requirement of an additional nurse for every two working medication aides along with the mandated nurses by the federal and state regulations would ensure that nursing homes could not simply replace all of their current nurses with medication aides. This medication nurse would be responsible for supervising the medication aides and performing the duties that the medication aides would be prohibited from administering.

The purpose of this requirement would be to protect and preserve the quality care of our patients.

Respectfully submitted,
Joyce Humiston-Berger R.N.-Committee Chair
August 26, 2002

Appendix D – Nurse Aide Practice Act

12-38.1-101. Legislative declaration.
It is declared to be the policy of the state of Colorado that, in order to safeguard life, health, property, and the public welfare of the people of the state of Colorado, and in order to protect the people of the state of Colorado against unauthorized, unqualified, and improper application of services by nurse aides in a medical facility, it is necessary that a proper regulatory authority be established. The general assembly further declares it to be the policy of this state to regulate the practice of nurse aides in medical facilities through a state agency with the power to enforce the provisions of this article. Any person who practices as a nurse aide in a medical facility without qualifying for proper certification and without submitting to the regulations provided in this article endangers the public health thereby. The general assembly hereby finds and declares that this article will meet the requirements of the federal "Omnibus Budget Reconciliation Act of 1987".

12-38.1-102. Definitions - repeal.
As used in this article, unless the context otherwise requires:

(1) "Approved education program" means:

(a) A course of training conducted by an educational or health care institution which implements the basic nurse aide curriculum prescribed and approved by the board; or

(b) (I) A course of training conducted by an educational or health care institution that is approved by the board for the purposes of the direct care provider career path pilot program established in part 2 of this article.

(II) This paragraph (b) is repealed, effective July 1, 2008.

(2) "Board" means the state board of nursing in the division of registrations in the department of regulatory agencies, created in section 12-38-104.

(3) "Certified nurse aide" means a person who meets the qualifications specified in this article and who is currently certified by the board. Only a person who holds a certificate to practice as a nurse aide in this state pursuant to the provisions of this article shall have the right to use the title "Certified Nurse Aide" and its abbreviation, "C.N.A.".

(3.5) "Home health agency" means a provider of home health services, as defined in section 26-4-103 (6), C.R.S., that is certified by the department of public health and environment.

(4) "Medical facility" means a nursing facility licensed by the department of health or home health agencies certified to receive medicare or medicaid funds, pursuant to the federal "Social Security Act", as amended, distinct part nursing facilities, or home health agencies or entities engaged in nurse aide practices as such practices are defined in subsection (5) of this section. "Medical facility" does not include hospitals and other facilities licensed or certified pursuant to section 25-1-107 (1) (l), C.R.S.

(4.5) "Nursing facility" shall have the same meaning as set forth in section 26-4-103 (11), C.R.S.

(5) "Practice of a nurse aide" or "nursing aide practice" means the performance of services requiring the education, training, and skills specified in this article for certification as a nurse aide. Such services are performed under the supervision of a dentist, physician, podiatrist, professional nurse, licensed practical nurse, or other licensed or certified health care professional acting within the scope of his license or certificate.

12-38.1-103. Certification - state board of nursing.
(1) In addition to all other powers and duties conferred and imposed upon the board by law, the board shall have the authority to certify nurse aides to practice in the state of Colorado, and the board shall implement the provisions of this article.

(2) The department of public health and environment, which is otherwise responsible for the regulation of certain medical facilities, shall, as necessary, assist the board in implementing the provisions of this article.

(3) The board shall promulgate rules and regulations to carry out the purposes of this article and to ensure compliance with federal law and regulation relating to nurse aides.

(4) The board shall maintain a registry of all certified nurse aides as well as a record of all final disciplinary action taken against persons under the provisions of this article. Such registry shall conform to all requirements of federal law and regulation.

(5) (a) The board shall not issue a certificate to a former holder of a certificate whose certificate was revoked unless the applicant meets the requirements of this article, has successfully repeated an approved education program as required by the board, and has repeated and passed a competency evaluation.

(b) No nurse aide certificate holder who has had a certificate revoked may apply for recertification before a one-year waiting period after such revocation.

(6) Funding for the nurse aide certification program, as operated by the department of regulatory agencies, shall be provided by the federal medicaid and medicare programs. Medicaid funding shall be secured by the department of health care policy and financing and medicare funding shall be secured by the department of public health and environment. All such funding shall be forwarded to the department of regulatory agencies for its use in operating the nurse aide certification program. The departments of health care policy and financing and public health and environment shall take all reasonable and necessary steps to secure such funding from the federal Medicaid and Medicare programs.

12-38.1-104. Application for certification - fee.

(1) Every applicant for certification as a nurse aide, whether qualifying by competency evaluation or by endorsement, shall submit the application on forms provided by the board.

(2) (a) The application submitted pursuant to subsection (1) of this section shall be accompanied by an application fee established pursuant to section 24-34-105, C.R.S.

(b) The board may reduce the application fee if federal funds are available. Such fee shall not be subject to the provisions of section 24-34-104.4, C.R.S.

(3) (a) Every applicant seeking certification pursuant to this section shall submit a criminal history background check conducted within the ninety-day period prior to submittal of the application from a company approved by the board.

(b) Companies approved by the board to conduct criminal history background checks must be able to include information on convictions.

12-38.1-105. Application for certification by competency evaluation.

(1) Every applicant for certification by competency evaluation shall pay the required application fee and shall submit written evidence that said applicant:

(a) Has not committed any act or omission that would be grounds for discipline or denial of certification under this article;

(b) Has successfully completed an approved education program; and

(c) Has had a criminal history background check conducted within the ninety-day period prior to submittal.

12-38.1-106. Application for certification by endorsement.

(1) Every applicant for certification by endorsement shall pay the required application fee, shall submit the information required by the board in the manner and form specified by the board, and shall submit written evidence that said applicant:

(a) Is certified to practice as a nurse aide by another state or territory of the United States with requirements that are essentially similar to the requirements for certification set out in this article and that such certification is in good standing;

(b) Has not committed any act or omission that would be grounds for discipline or denial of certification under this article;

(c) Has successfully completed an education program approved by the board or a nurse aide training program that meets the standards for such programs specified in this article and those standards set by the board;

(d) Has no record of abuse, negligence, or misappropriation of resident's property or any disciplinary action taken or pending in any other state or territory against such certification; and

(e) Has had a criminal history background check conducted within the ninety-day period prior to submittal.

12-38.1-107. Certification by competency evaluation.

(1) All applicants except those certified by endorsement shall be required to pass a clinical competency evaluation. Such evaluation shall be in a written or oral form and shall include the following areas:

(a) Basic nursing skills;

(b) Personal care skills;

(c) Recognition of mental health and social services needs;

(d) Basic restorative services;

(e) Resident or patient rights.

(2) Competency evaluations shall be held at such times and places as the board determines but shall be held at least four times per year.

12-38.1-108. Approved nurse aide training programs.

(1) Except for any medical facility or program that has been explicitly disapproved by the department of public health and environment, the board may approve any nurse aide training program offered by or held in a medical facility or offered and held outside a medical facility. Such approval by the board shall be sufficient to authorize and permit the operation of such training program.

(2) The curriculum content for nurse aide training must include material which will provide a basic level of both knowledge and demonstrable skills for each individual completing the program and be presented in such a manner which will take into consideration individuals with limited literacy skills. The curriculum content must include needs of populations which may be served by an individual medical facility.

(3) The following topics shall be included in the curriculum:

(a) Communication and interpersonal skills;

(b) Infection control;

(c) Safety and emergency procedures;

(d) Promoting residents' and patients' independence;

(e) Respecting residents' and patients' rights.

(4) The training program shall be designed to enable participants to develop and demonstrate competency in the following areas:

(a) Basic nursing skills;

(b) Personal care skills;

(c) Recognition of mental health and social services needs;

(d) Basic restorative services;

(e) Resident or patient rights.

(5) The board or its designee shall inspect and survey each nurse aide training program it approves during the first year following such approval and every two years thereafter. Such inspection or survey may be made in conjunction with surveys of medical facilities conducted by the department of public health and environment.

(6) Except as provided in this article, the board shall not require a nurse aide training program that substantially exceeds the requirements established in the federal "Omnibus Budget Reconciliation Act of 1987", as amended.

12-38.1-109. Renewal of certification.

Each certificate to practice as a nurse aide shall be renewed biennially upon payment of a specified renewal fee established pursuant to section 24-34-105, C.R.S. The board may reduce such fee if federal funds are available. Such fee shall not be subject to the provisions of section 24-34-104.4, C.R.S. At the time of such renewal, the nurse aide shall submit proof to the board, as required by federal law or regulation, of either having performed nurse aide services, or the equivalent, as defined in rules and regulations, for pay during the preceding twenty-four-month period or having completed a new training program approved under the provisions of this article during the preceding twenty-four months.

12-38.1-110. Advisory committee.
(1) To assist in the performance of its duties under this article, the board may designate an advisory committee. Such committee shall be composed of five members. One member shall be a certified nurse aide, one member shall be a member of the state board of nursing, one member shall represent professional associations composed of home health agencies, one member shall be from a group representing the concerns of senior citizens, and one member shall represent professional associations composed of nursing homes. A department of public health and environment employee shall serve as an ex officio member. Committee members shall be compensated for their services in accordance with the provisions of section 24-34-102 (13), C.R.S.

(2) (Deleted by amendment, L. 93, p. 1747, § 5, effective July 1, 1993.)

12-38.1-110.3. Medication administration advisory committee - created - department of regulatory agencies report.
(1) The executive director of the department of regulatory agencies shall appoint an advisory committee to assist with a study of the administration of medication by certified nurse aides in nursing facilities and through home health care agencies.

(2) The advisory committee shall consist of eleven members as follows:

(a) The director of the division of registrations in the department of regulatory agencies or the director's designee who is a member of or a staff person for the state board of nursing;

(b) One geriatric physician licensed pursuant to article 36 of this title;

(c) One pharmacist experienced in the delivery of pharmaceutical products in a health care-based setting who is licensed pursuant to article 22 of this title;

(d) One advocate who represents the residents or patients in nursing facilities;

(e) One home health care nurse;

(f) One director of a home health agency;

(g) One professional nurse who is a director of a nursing home located in an urban area;

(h) One professional nurse who is a director of a nursing home located in a rural area;

(i) One registered nurse who has experience teaching medication administration;

(j) One registered nurse who has experience teaching the certified nurse aide program; and

(k) One clinical researcher who has studied care delivery in long-term settings and in home health care.

(3) The members appointed to the advisory committee pursuant to subsection (2) of this section shall not receive compensation for their services.

(4) For the purposes of the review provided in sections 12-38.1-120 and 24-34-104, C.R.S., the advisory committee shall provide input to the department of regulatory agencies regarding the issue of allowing certified nurse aides to administer medications in nursing facilities and through home health agencies. After such review, the report by the department of regulatory agencies required pursuant to section 24-34-104 (8), C.R.S., shall include, but not be limited to, the following:

(a) The benefits and risks associated with certified nurse aides serving as medication aides;

(b) The effect of the use of medication aides on the level of patient care;

(c) The level of experience a certified nurse aide must have in order to be considered for training as a medication aide;

(d) The extent and content of classroom training and education required to be a medication aide;

(e) The extent and limit to the scope of practice of a certified nurse aide who has completed training as a medication aide; and

(f) The requirements for supervision for medication aides.

12-38.1-111. Grounds for discipline.
(1) The board may suspend, revoke, or deny any certification to practice as a nurse aide or issue a letter of admonition to a certified nurse aide upon proof that such person:

(a) Has procured or attempted to procure a certificate by fraud, deceit, misrepresentation, misleading omission, or material misstatement of fact;

(b) Has been convicted of a felony or has had a court accept a plea of guilty or nolo contendere to a felony. A certified copy of such conviction or plea from a court of competent jurisdiction shall be prima facie evidence of such conviction or plea. In considering discipline based on the grounds specified in this paragraph (b), the board shall be governed by the provisions of section 24-5-101, C.R.S.

(c) Has willfully or negligently acted in a manner inconsistent with the health or safety of a person under his care;

(d) Has had a certification to practice as a nurse aide or to practice any other health care occupation suspended or revoked in any jurisdiction. A certified copy of the order of suspension or revocation shall be prima facie evidence of such suspension or revocation.

(e) Has violated any provision of this article or has aided or knowingly permitted any person to violate any provision of this article;

(f) Has negligently or willfully practiced as a nurse aide in a manner which fails to meet generally accepted standards for such practice;

(g) Has negligently or willfully violated any order, rule, or regulation of the board pertaining to practice or certification as a nurse aide;

(h) Has abused, neglected, or otherwise harmed a person under his care;

(i) Has habitually abused or excessively used any habit-forming drug as defined in section 12-22-102 (13), or any controlled substance as defined in section 12-22-303 (7);

(j) Has misused any drug or controlled substance as defined in section 12-22-303 (7);

(k) Has a physical or mental disability which renders him unable to practice as a certified nurse aide with reasonable skill and safety to the patients and which may endanger the health or safety of persons under his care;

(l) Has violated the confidentiality of information or knowledge as prescribed by law concerning any patient;

(m) Has misappropriated patient or facility property;

(n) Has engaged in any conduct that would constitute a crime as defined in title 18, C.R.S., if such conduct relates to the person's ability to practice as a nurse aide. In considering discipline based upon the grounds specified in this paragraph (n), the board shall be governed by the provisions of section 24-5-101, C.R.S.

(2) Except as otherwise provided in subsection (1) of this section, the board need not find that the actions which form the basis for the disciplinary action were willful. However, the board, in its discretion, may consider whether such action was willful in determining the sanctions it imposes on the nurse aide.

(3) Whenever a complaint or investigation discloses an instance of misconduct which, in the opinion of the board does not warrant formal action by the board but which should not be dismissed as being without merit, a letter of admonition may be sent by certified mail to the nurse aide against whom a complaint was made and a copy thereof to the person making the complaint. When the letter of admonition is sent by certified mail by the board to a nurse aide complained against, such nurse aide shall be advised that such person has the right to request in writing within twenty days after proven receipt of the letter, that formal disciplinary proceedings be initiated to adjudicate the propriety of the complaint on which the letter of admonition is based. If such request is timely made, the letter of admonition shall be deemed vacated and the matter shall be heard as a formal disciplinary proceeding.

12-38.1-112. Withholding or denial of certification.

(1) If the board determines that an applicant for an initial certificate to practice as a nurse aide does not possess the qualifications specified in section 12-38.1-105 or 12-38.1-106, that section 12-38.1-111 (1) (n) is applicable, or that there is reasonable cause to believe that the applicant has committed any of the acts set forth in section 12-38.1-111 as grounds for discipline, it may deny the applicant a certificate. When the board denies a certificate, it shall comply with the following procedures:

(a) The provisions of section 24-4-104, C.R.S., shall apply, and the board shall provide the applicant with a written statement that sets forth the basis for the board's determination.

(b) If the applicant requests a hearing pursuant to section 24-4-104 (9), C.R.S., the following shall apply:

(I) An applicant whose certification has been denied on the basis of a lack of qualifications has the burden of proof to show that he possesses the qualifications required under this article.

(II) For an applicant whose certification has been denied on the basis of reasonable cause to believe that grounds for discipline exist, the board has the burden of proof to show the commission of acts constituting grounds for discipline under this article.

(c) If a hearing is conducted, the board shall affirm, modify, or reverse its prior determination and action in accordance with the findings resulting from such hearing.

(d) If an applicant who has requested a hearing pursuant to section 24-4-104 (9), C.R.S., fails to appear at such hearing, absent a determination by the board that there was good cause for such failure to appear, the board may affirm its prior action of withholding certification without conducting a hearing on the matter.

(e) If the board withholds certification without a hearing in accordance with the provisions of this section, it shall be immune from suit concerning such withholding unless it has acted unreasonably or has failed to act in good faith.

12-38.1-113. Mental and physical competency of nurse aides.

(1) If any certified nurse aide is determined to be mentally ill by a court of competent jurisdiction, the board shall automatically suspend his certification, and such suspension shall continue until the certified nurse aide is determined by such court to be restored to competency; duly discharged as restored to competency; or otherwise determined to be competent in any other manner provided by law.

(2) (a) If the board has reasonable cause to believe that the physical or mental condition of a certified nurse aide has resulted in such nurse aide being unable to practice with reasonable skill or that the practice of such nurse aide is a threat to the safety of such nurse aide's patients, the board may require such nurse aide to submit to a mental or physical examination by a physician designated by the board.

(b) If such nurse aide fails to submit to such examination, absent a determination by the board that there is good cause for such failure, the board may summarily suspend such nurse aide's certification until such time as the nurse aide submits to the required examination.

(3) Every person who applies to the board for certification as a nurse aide shall be deemed by virtue of such application to have given his consent to undergo a physical or mental examination at any time if the board so requests. Any request by the board to a nurse aide to submit to such an examination shall be in writing and shall contain the basis upon which the board determined that reasonable cause to believe the condition specified in paragraph (a) of subsection (2) of this section exists.

(4) A certified nurse aide who has been requested to submit to a physical or mental examination may provide the board with information concerning such nurse aide's physical or mental condition from a physician of the nurse aide's own choice. The board may consider such information in conjunction with, but not in lieu of, testimony and information provided by the physician designated by the board to examine the nurse aide.

(5) The results of any mental or physical examination requested by the board pursuant to this section shall not be used as evidence in any proceeding except a proceeding conducted pursuant to this article. The results of such examination shall not be deemed to be public records and shall not be made available to the public.

12-38.1-114. Disciplinary proceedings - hearing officers.

(1) The board, through the department of regulatory agencies, may employ hearing officers to conduct hearings as provided by this article or to conduct hearings on any matter within the board's jurisdiction, upon such conditions and terms as the board determines to be appropriate.

(2) A proceeding for discipline of a certified nurse aide may be commenced when the board has reasonable grounds to believe that a nurse aide certified by the board has committed acts which may violate the provisions of this article.

(3) The license of a person certified by the board as a nurse aide may be revoked or suspended or such person may otherwise be disciplined upon written findings by the board that the licensee has committed acts which violate the provisions of this article.

(4) Any certified nurse aide disciplined under subsection (3) of this section shall be notified by the board, by a certified letter to the most recent address provided to the board by the certified nurse aide, no later than thirty days following the date of the board's action, of the action taken, the specific charges giving rise to the action, and the certified nurse aide's right to request a hearing on the action taken.

(5) (a) Within thirty days after notification is sent by the board, the certified nurse aide may file a written request with the board for a hearing on the action taken. Upon receipt of the request the board shall grant a hearing to the certified nurse aide. If the certified nurse aide fails to file a written request for a hearing within thirty days, the action of the board shall be final on that date.

(b) (Deleted by amendment, L. 93, p. 1747, § 7, effective July 1, 1993.)

(6) The attendance of witnesses and the production of books, patient records, papers, and other pertinent documents at the hearing may be summoned by subpoenas issued by the board, which shall be served in the manner provided by the Colorado rules of civil procedure for service of subpoenas.

(7) Disciplinary proceedings shall be conducted in the manner prescribed by article 4 of title 24, C.R.S., and the hearing and opportunity for review shall be conducted pursuant to said article by the board or a hearing officer at the board's discretion.

(8) Failure of the certified aide to appear at the hearing without good cause shall be deemed a withdrawal of his or her request for a hearing, and the board's action shall be final on that date. Failure, without good cause, of the board to appear at the hearing shall be deemed cause to dismiss the proceeding.

(9) (a) No previously issued certificate to engage in practice as a nurse aide shall be revoked or suspended except under the procedure set forth in this section, except in emergency situations as provided by section 24-4-104, C.R.S.

(b) The denial of an application to renew an existing certificate shall be treated in all respects as a revocation.

(10) In order to aid the board in any hearing or investigation instituted pursuant to this section, the board, through any member or executive officer thereof, shall have the power to issue subpoenas commanding production of copies of any documents containing information relevant to the practice of the nurse aide, including, but not limited to, hospital and physician records. The person providing such copies shall prepare them from the original record and shall delete from the copy provided pursuant to the subpoena the name of the patient, but the patient shall be identified by a numbered code to be retained by the custodian of the records from which the copies were made. Upon certification of the custodian that the copies are true and complete except for the patient's name, they shall be deemed authentic, subject to the right to inspect the originals for the limited purpose of ascertaining the accuracy of the copies. No privilege of confidentiality shall exist with respect to such copies, and no liability shall lie against the board or the custodian or the custodian's authorized employee for furnishing or using such copies in accordance with this subsection (10).

(11) Any person participating in good faith in the making of a complaint or report or participating in any investigative or administrative proceeding pursuant to this article shall be immune from any civil liability that otherwise might result by reason of such action.

(12) An employer of a nurse aide shall report to the board any disciplinary action taken against the nurse aide or any resignation in lieu of a disciplinary action for conduct which constitutes a violation of this article.

(13) Except when a decision to proceed with a disciplinary action has been agreed upon by a majority of the board or its designee, any investigations, examinations, hearings, meetings, or any other proceedings of the board related to discipline that are conducted pursuant to the provisions of this section shall be exempt from the provisions of any law requiring that the proceedings of the board be conducted publicly.

12-38.1-115. Surrender of certificate.

(1) Prior to the initiation of an investigation or hearing, any certified nurse aide may surrender his certificate to practice as a nurse aide to the board.

(2) Following the initiation of an investigation or hearing and upon a finding that to conduct such an investigation or hearing would not be in the public interest, the board may allow a certified nurse aide to surrender his certificate to practice.

(3) The board shall not issue a certificate to a former holder of a certificate whose certificate has been surrendered unless a one-year waiting period has passed since the date of the surrender, the applicant has met the requirements of this article, has successfully repeated an approved education program, and has repeated and passed a competency evaluation.

(4) The surrender of a certificate in accordance with this section removes all rights and privileges to practice as a nurse aide, including the right to apply for renewal of a certificate.

12-38.1-116. Judicial review.

The court of appeals shall have initial jurisdiction to review all final actions and orders of the board that are subject to judicial review. Such proceedings shall be conducted in accordance with section 24-4-106 (11), C.R.S.

12-38.1-117. Exclusions.
(1) This article shall not be construed to affect or apply to:
(a) The gratuitous care of friends or family members;
(b) A person for hire who does not represent himself as or hold himself out to the public as a certified nurse aide. However, no person for hire who is not a nurse aide certified under this article shall perform the duties of or hold himself out as being able to perform the full duties of a nurse aide.
(c) Nursing assistance in the case of an emergency;
(d) A person who is directly employed by a medical facility while acting within the scope and course of such employment for the first four months of such person's employment at such medical facility if such person is pursuing certification as a nurse aide. A person may utilize this exclusion only once in any twelve-month period. This exclusion shall not apply to any person who has had his certification as a nurse aide suspended or revoked or his application for such certification denied.
(e) Any person licensed, certified, or registered by the state of Colorado who is acting within the scope of such license, certificate, or registration;
(f) Any person performing services pursuant to sections 12-38-132, 25-1-107 (1) (ee), and 27-10.5-103 (2) (k), C.R.S.

12-38.1-118. Unlawful acts.
(1) It is unlawful for any person:
(a) On or after January 1, 1990, to practice in a medical facility as a nurse aide except as provided pursuant to this article;
(b) To use any designation in connection with his name that tends to imply that he is a certified nurse aide unless he is so certified under this article;
(c) To practice as a nurse aide during any period when his certificate has been suspended or revoked;
(d) To sell or fraudulently obtain or furnish a certificate to practice as a nurse aide or to aid or abet therein.
(2) Any person who violates the provisions of subsection (1) of this section commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S., and any person committing a subsequent offense commits a class 6 felony and shall be punished as provided in section 18-1.3-401, C.R.S.

12-38.1-119. Injunctive proceedings.
The board may apply for injunctive relief through the attorney general in any court of competent jurisdiction to enjoin any person who does not possess a current valid certificate as a nurse aide issued under the provisions of this article from committing any act declared to be unlawful under or prohibited by this article. Such injunctive proceedings shall be in addition to and not in lieu of all penalties and other remedies provided for in this article.

12-38.1-120. Repeal of article.
This article is repealed, effective July 1, 2003. Prior to such repeal, the certification functions of the state board of nursing shall be reviewed as provided for in section 24-34-104, C.R.S.

12-38.1-201. Short title.
This part 2 shall be known and may be cited as the "Direct Care Provider Career Path Pilot Program".

12-38.1-202. Legislative declaration.
(1) The general assembly hereby finds that:
(a) The population of Colorado, as well as the nation, is aging at an unprecedented rate;
(b) The United States bureau of census estimates the proportion of citizens over sixty-five years of age will double from ten percent in 1995 to approximately twenty percent in 2025;
(c) Meanwhile, nursing and entry-level health care staffing shortages for long-term care providers, hospitals, and other health care providers are already reaching a critical point in Colorado;
(d) Colorado has an unemployment rate of less than five and seven-tenths percent and a competitive labor market in a generally strong economy;
(e) As a result of these and other factors, the recruitment and retention of trained and capable direct care workers among health care providers is at a crisis state in Colorado;
(f) The governor appointed a blue ribbon panel to study the workforce issues related to long-term care,

which panel submitted an extensive and thorough report, dated June 25, 2001, identifying these issues and making recommendations to address the state's long-term care staffing shortage; and

(g) Among the recommendations of the governor's blue ribbon panel on workforce issues in health care was the development of a demonstration proposal for a tiered certified nursing assistant position.

(2) The general assembly therefore determines and declares that, in order to appropriately meet the long-term and other direct care needs of a growing population of vulnerable Coloradans now and in the future, to assist health care providers in attracting individuals to careers in direct care, and to increase employment satisfaction and retention among individuals working in the direct care field, it is appropriate and advisable to:

(a) Develop and adopt a tiered paraprofessional direct care provider career path tailored to encourage individuals entering the labor market into this important and satisfying career and to better reward such individuals as their skill levels increase;

(b) Enhance education and training opportunities in the direct care field and to increase accessibility to such education and training in both urban and rural settings, as well as improve outreach to individuals with language and other barriers to such education and training; and

(c) Establish a collaborative environment among institutions of higher education, vocational education institutions, educators, individuals seeking entry-level employment, Colorado works participants, county departments of social services, Colorado work force investment programs, job-training professionals, and potential health care employers to improve communication among such stakeholders, and ultimately to place more individuals in and stabilize the field of direct care through the successful development and implementation of a tiered long-term health care paraprofessional career path.

12-38.1-203. Pilot program - authorization.

(1) There is hereby created the direct care provider career path pilot program, referred to in this part 2 as the "pilot program", the purpose of which shall be to bring together, in a collaborative environment, institutions of higher education and other appropriate educators, individuals seeking entry-level employment including but not limited to Colorado works participants, county departments of social services, Colorado work force investment programs, job-training professionals, and potential employers in the sub-acute and long-term health care provider industry toward the achievement of the common goal of improved recruitment and retention of workers in the direct health care profession. The pilot program shall continue for a period of three years and shall be implemented in southwest Colorado.

(2) It shall be the responsibility of the state board for community colleges and occupational education established pursuant to section 23-60-104, C.R.S., under the pilot program to coordinate communication and collaboration among interested stakeholders in the pilot program, including but not limited to the community colleges in southwest Colorado, the vocational education institutions in southwest Colorado, local work force investment boards in southwest Colorado, established pursuant to part 2 of article 71 of title 8, C.R.S., county departments of social services' Colorado works programs, individuals seeking entry-level employment, Colorado works participants, and potential employers in the health care industry to achieve the common goal of improved recruitment and retention of paraprofessionals working in the long-term care field.

(3) The board shall establish and seek input from a direct care advisory committee, which shall include interested stakeholder representatives from southwest Colorado, concerning the development and implementation of the direct care provider career path pilot program.

(4) (a) The department of health care policy and financing and the department of public health and environment shall seek the necessary waivers, if any, to allow the board to implement the pilot program.

(b) The implementation of this part 2 is conditioned upon the approval of necessary waivers by the federal government. This part 2 shall be implemented on January 1 of the year following the receipt of all required federal waivers.

12-38.1-204. Rule-making - training - education.

(1) Conditioned upon the necessary federal waivers being approved, the board shall promulgate rules to implement the direct care provider career path pilot program, consistent with waivers received from the federal government, which rules shall provide for a three-tiered certification for individuals performing the tasks of a nurse aide paraprofessional, which shall be defined by the tasks to be performed by the individual and the training or education of the individual. Prior to promulgating rules implementing the pilot program, the board shall first consult with the parties identified in section 12-38.1-203 (2) and (3). The three tiers of paraprofessional certification shall be for:

(a) A certified personal care provider, who possesses some of the training and performs a limited number of the tasks of a nurse aide certified pursuant to part 1 of this article, as determined by the board;

(b) A certified nurse aide - level I, who is fully trained and in compliance with the provisions of part 1 of this article and all applicable regulations; and

(c) A certified nurse aide with a specialty or advanced training - level II, who is fully trained and in compliance with the provisions of part 1 of this article and all applicable regulations and, in addition, meets mentor or preceptor standards or any other specialty or advanced training requirements specified by the board.

(2) The board shall conduct the direct care provider career path pilot program in southwest Colorado. The board is authorized to determine, by rule, the geographic parameters of the pilot program within southwest Colorado.

(3) The rules promulgated by the board to implement the pilot program shall specify the pilot program's requirements and restrictions, which shall include but shall not be limited to:

(a) Defining the tasks to be performed by each paraprofessional certification level;

(b) Defining the training and educational requirements for each paraprofessional certification level;

(c) Providing for appropriate oversight of and accountability from individuals performing nursing assistant tasks under the pilot program;

(d) Requiring a criminal history background check to be conducted and submitted with the individual's application for certification;

(e) Restricting recertification, consistent with the provisions of part 1 of this article, of an individual whose certification has been revoked or surrendered;

(f) Providing for a tiered application fee structure for pilot program applicants that is consistent with the paraprofessional certification tiers;

(g) Providing for a disciplinary structure for pilot program participants that is consistent with the disciplinary provisions of part 1 of this article; and

(h) Any other requirement or restriction, consistent with the provisions of part 1 of this article, that is necessary to implement the pilot program.

(4) The board shall approve education programs in southwest Colorado for the education and training of individuals participating in the pilot program. The board shall coordinate these education and training efforts with the state board for community colleges and occupational education established pursuant to section 23-60-104, C.R.S., and the local work force investment boards established pursuant to part 2 of article 71 of title 8, C.R.S.

12-38.1-205. Applicability.

Nothing in this part 2 shall be construed to change or affect the regulation or certification of nurse aides as provided in part 1 of this article.

12-38.1-206. Report.

(1) The board and the direct care advisory committee, established pursuant to section 12-38.1-203 (3), shall report to the members of the health, environment, children and families committee of the senate and to the members of the health, environment, welfare, and institutions committee of the house of representatives of the general assembly, as well as to the governor, within two months of the completion of the pilot program, concerning the effectiveness of the pilot program in recruiting new entry-level workers into the long-term care profession and in retaining current and new long-term care workers through enhanced employment satisfaction. The report shall include, but need not be limited to:

(a) The number of persons participating in the pilot program;

(b) The number of entry-level workers entering the direct care profession during the course of the pilot program and whether such persons are or were Colorado works participants or work force investment program participants, or whether they learned about the pilot program through an institution of higher education;

(c) Changes that were instituted in the education and training of nurse aide paraprofessionals; and

(d) Any other additional information that the board and the direct care advisory committee deem appropriate and informative.

12-38.1-207. Funding.

Funding for certification under this pilot program shall be provided by federal medicaid and medicare programs in the same manner as established in section 12-38.1-103 (6).

12-38.1-208. Repeal of part.

This part 2 is repealed, effective July 1, 2008, unless otherwise repealed pursuant to section 12-38.1-120.