Washington State Nursing Care Quality Assurance Commission

1103 Report

Comparison of Performance Outcomes

December 2012

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Executive Summary

In 2008, the Washington State legislature passed and Governor Christine Gregoire signed House Bill 1103 to assess the impact of increased authority for the Nursing Care Quality Assurance Commission (Nursing Commission) on measures of its performance. The statute, RCW 18.79.390, required the Nursing Commission to conduct a pilot project and evaluate the effect of granting additional authority over budget development, spending and staffing. The statute required the Nursing Commission to report on the results of the pilot project using negotiated performance measures on licensing, disciplinary and financial outcomes. The report from the Secretary of Health details those comparisons with Washington boards and commissions. This report focuses on:

- the Nursing Commission's performance at the beginning of the pilot project;
- achievements made and innovations implemented during the pilot project; and,
- a review of summaries of national research and data regarding regulatory effectiveness and patient safety.

This report demonstrates that increased authority allowed the Nursing Commission to secure additional financial resources and needed staffing. Increased licensing fees supported adequate staffing for licensing, investigation and the chemical dependency monitoring program to:

- avoid denying access to potential participants of the Washington Health Professionals Services program;
- increase the number of completed investigations by 71%;
- decrease the backlog of investigative cases by 34%;
- decrease the amount of time used in investigations by 37%; and,
- increase efficiencies in licensing; licensing decisions now occur on the same day as receipt of final documents.

The Nursing Commission evaluated its performance with the boards of nursing in Arizona and North Carolina using a national database collected by the National Council of State Boards of Nursing. Both the Arizona and North Carolina boards have more independent authority than the authority granted to the Nursing Commission in the pilot project. The evaluation found:

- **Licensing**: Arizona and North Carolina collect more FBI background information on potential licensees than the Nursing Commission. Both Arizona and North Carolina regulate nursing assistants in addition to nurses.
- **Discipline**: Arizona dedicates more full time equivalent employees to investigations and disciplinary activity than the Nursing Commission. Both Arizona and North Carolina resolve cases using less time.
- **Financial resources**: Both Arizona and North Carolina use less funding to complete disciplinary functions than the Nursing Commission.

The Nursing Commission improved its performance with the additional authority over budget development, spending and staffing. The data comparison with the state boards of nursing in Arizona and North Carolina demonstrated even greater performance could be achieved if the Nursing Commission's authority was similar to the Arizona and North Carolina boards of nursing.

Introduction and Background

The Nursing Care Quality Assurance Commission (Nursing Commission) regulates the licensure, discipline and practice of nursing in Washington State. The purpose of the Nursing Commission (RCW 18.79.010) is to:

> ". . . .regulate the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. Rules, policies, and procedures developed by the commission must promote the delivery of quality health care to the residents of the state of Washington."

The Nursing Commission regulates over 100,000 licensed practical nurses (LPN), registered nurses (RN), and advanced registered nurse practitioners (ARNP).

In 2008, the Washington State Legislature passed and Governor Christine Gregoire signed House Bill 1103. This bill amended the Nursing Practice Act by adding RCW 18.79.390 (full text in Appendix A). The law granted the Nursing Commission additional authority over budget development, spending, and staffing. The legislation required the Nursing Commission to participate in a pilot project. The law required the Nursing Commission to compare licensing, disciplinary, and financial outcomes using performance measures with other boards and commissions prior to and during the pilot project. The report from the Secretary of Health compares the Nursing Commission's performance measures with other Washington boards and commissions, and performance prior to the pilot project.

This report summarizes the Nursing Commission's performance on licensing, nursing education, discipline and financial measures. The Nursing Commission included nursing education due to its fundamental relationship with licensing. Each section includes:

- The Nursing Commission's performance at the beginning of the pilot project;
- achievements made and innovations implemented during the pilot project; and,
- comparison with national research and data regarding regulatory effectiveness and patient safety.

The Nursing Commission's performance continually improved throughout the pilot project in licensing, disciplinary and financial outcomes. The Nursing Commission is grateful to Governor Gregoire and the legislature for the opportunity to participate in the pilot project and the additional authority granted for budget and personnel. This additional authority provided the Nursing Commission with the ability to develop decision packages. The decision packages documented the need to increase staffing and the licensing fee to support the necessary resources. These resources assisted the Nursing Commission in improving their performance and meeting the targets of the negotiated performance measures. Licensing fees support all Nursing Commission expenses. No general fund dollars are used.

According to the pilot project law, the executive director position changed. The executive director was to serve at the pleasure of the Nursing Commission as an exempt employee through June 30, 2013. This moved the reporting relationship for the executive director from the Department of Health to the Nursing Commission. Employees continued to report to the Secretary of the Department of Health.

While the Nursing Commission improved its performance during the pilot project, the data comparison with a national database showed that even improved performance could be reached in areas such as education approval, disciplinary and financial outcomes. The Nursing Commission compared their performance with the state boards of nursing in Arizona and North Carolina. The titles board of nursing and Nursing Commission both refer to state regulatory bodies. Both Arizona and North Carolina have more authority than granted to the Nursing Commission during the pilot project. Both Arizona and North Carolina demonstrated more effective licensing measures and greater efficiency in investigative and financial measures. The data comparison with the state boards of nursing in Arizona and North Carolina demonstrated even greater performance could be achieved if the Nursing Commission's authority was similar.

The Nursing Commission used the Commitment to Ongoing Regulatory Excellence (CORE) data and research collected by the National Council of State Boards of Nursing (NCSBN) for the comparison with Arizona and North Carolina. According to the NCSBN:

> The purpose of this project [CORE] is the establishment of a performance measurement system that incorporates data collection from internal and external sources, and the use of benchmarking strategies and identification of best practices. A key element of this system is the monitoring of performance on outcome-oriented indicators. Such performance monitoring will simultaneously provide accountability to the state's citizens and assist nursing boards to better manage and improve its services to its customers and citizens throughout the states. Performance information also provides a basis for strategic planning and a starting point for benchmarking and identification of best practices. (NCSBN, 2012, NCSBN.org/984.htm, Commitment to Ongoing Regulatory Excellence, para. 2-3.)

Boards of nursing voluntarily submit data to CORE using surveys developed by the NCSBN. The CORE surveys collect data on licensing, disciplinary, financial and personnel measures. The CORE measures are not an exact match with the performance measures adopted in Washington but share striking similarities. The full CORE survey collects data from four sources: employers, nurses, nursing education programs and the board of nursing. The Nursing Commission compared 57 measures from the CORE board of nursing survey directly related to the performance measures required in RCW 18.79.390.

The Nursing Commission asked the question: **Does increased authority of the state board of nursing influence performance outcomes?** There are three recognized governance structures for state boards of nursing related to their authority: **umbrella, semi-autonomous and independent**. This report uses the following descriptions of umbrella, semi-autonomous and independent governance structures. These are not legal definitions, nor could they be found in

dictionary sources. Regulatory personnel commonly use the definitions to describe differences in governance structures.

The **umbrella** structure has the most centralized decision-making organized under a state agency. QFinance defines an umbrella organization as "organization embracing several member organizations, a large organization that includes a number of member organizations and works to protect their shared interests." [1] With state boards of nursing, an umbrella structure refers to a state board working within a state agency. The state agency has authority and responsibilities functions and the state board has defined authority and responsibilities. Laws often describe the authority and the functions.

A **semi-autonomous** state board of nursing often has more independence, authority and responsibility than a board in an umbrella organization. There is wide variation in semi-autonomous boards. Most semi-autonomous boards have a percentage of their licensure revenues deposited into the state general fund to pay for state overhead; e.g., risk management and human resources. Usually, there is oversight or association with the governor's office and reporting relationships with the executive branch. The governor appoints board members for specific terms of office.

A fully **independent** state board of nursing has no direct relationship to a branch of government. The independent board collects fees to support expenses, does not contribute a percentage of licensure fees to the state general fund, and has full budgetary authority and responsibility for its revenue and expenditure of its funds.

The Nursing Commission is an umbrella structure, sharing regulatory responsibilities with the Washington State Department of Health. An Operating Agreement (Appendix B) defines the relationship between the Department of Health and the Nursing Commission. The Nursing Commission originally proposed to compare its CORE performance data with three boards of nursing. Two of the three state boards of nursing were to have governance structures different from the Nursing Commission and one board of nursing with an umbrella structure. The Nursing Commission also proposed using states with nursing populations similar to the nursing population in Washington State. The Nursing Commission approached three boards of nursing with umbrella structures to participate in the study. Two of the three state boards of nursing (Indiana and Virginia) did not submit CORE data by the date of publication of this report. The third state, Wisconsin, declined participation.

Previous collections of CORE data identified both the Arizona state board of nursing and North Carolina board of nursing as high performing boards of licensing, disciplinary and financial performance. The Arizona state board of nursing is a semi-autonomous board, each member appointed by its governor. The Arizona state board of nursing is accountable for its budget, personnel and outcomes and conducts an annual sunset review. The North Carolina board of nursing is a fully independent board, with all board members elected by nurses. The North Carolina board is not a state agency. The Nursing Commission then chose to compare its CORE

[1] QFinance Dictionary, definition of umbrella organization, http://www.qfinance.com/dictionary/umbrella-organization.

performance measures with the Arizona state board of nursing and the North Carolina board of nursing.

The Nursing Commission requested and was granted an exemption from the Department of Social and Health Services Institutional Review Board to conduct the research. The CORE data are not related to human subjects. The data are also publicly discloseable upon request to the participating states. The Nursing Commission officially requested the Arizona state board of nursing and the North Carolina board of nursing to share its CORE data through memoranda of understanding (Appendix C).

Licensing activities: Comparison of efficiency, effectiveness, timelines, personnel and financial resources

Prior to the Pilot Project

Licensing decisions clearly affect public safety. Delays in reviewing applications could lead to unnecessary delays in licensing qualified nurses to deliver patient care. Delays could lead to unnecessary time taken to deny a license. Prior to the pilot project, the Nursing Commission's performance in licensing applicants did not meet the expectations of nursing employers, nurses, or the staff. Another factor affecting licensure was a predicted shortage of nurses to care for our state's population. Presented with this looming shortage, colleges and universities added new nursing programs and admitted more students. The additions increased the number of graduates. The increase in graduates resulted in more applications for licensure, thereby increasing the Nursing Commission's workload in areas such as background checks, transcripts, examinations, communication with applicants, data entry, application denials, revenue, bad checks and legal proceedings related to denial of licensure.

Achievements made and innovations implemented during the Pilot Project

The Nursing Commission developed a decision package seeking the resources necessary to improve the licensing process and to respond to the projected growth in the number of nurses in Washington State. The decision package identified increasing licensing fees as a way to secure needed resources. The Nursing Commission subsequently received support from professional nursing associations, unions, employers, and educators to increase fees to improve overall licensing services. In late 2008, the Nursing Commission presented decision packages (Appendix D) to Governor Gregoire for consideration. Governor Gregoire included the packages in her proposed budget for 2009 that the Legislature approved as well. Figure 1 demonstrates the annual increase in licenses issued prior to the pilot project (2006-2007) and during the pilot project (2008-2011).

Licensing process. To measure efficiency, Washington licensing authorities measure the length of time from the date the final document is received to the date of a licensing decision. In Washington, the target for this measure is 14 days from the receipt of the final document to licensure. The CORE measure also used this date of receipt of the final document to the licensing decision to measure licensing efficiency. Licensing is not always a streamlined process. Some applications may be incomplete due to missing information. For nursing applications, there may be missing transcripts or the results of the National Council Licensure Examination, the NCLEX®.

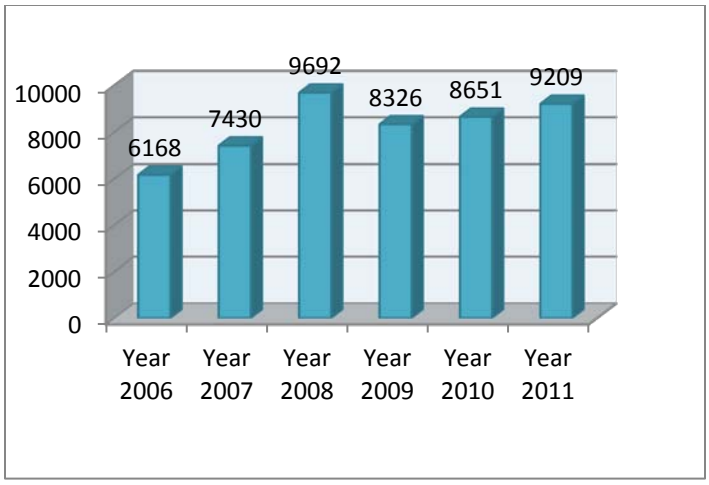

Figure 1: Nursing licenses issued per year, 2006-2011
Source: Nursing Care Quality Assurance Commission, Department of Health, Olympia, Washington

Two licensure application processes exist: initial examination and endorsement. New graduates of nursing education programs submit an *initial examination* application. The correct licensure fee must accompany the application. Staff enters application data, reviews the application to assure all licensing requirements are met, and evaluates required documents. All new graduates must complete an education program approved by a state board of nursing, request official transcripts from the nursing education program, and successfully pass the NCLEX® examination. A nurse licensed in another state may request licensure in Washington. This is a request for *endorsement* of the license and the nurse submits an endorsement application.

Background checks. After receiving an application, staff in the Nursing Commission Unit reviews three databases for background information on every application:

1. A Washington State Patrol background check is required for applicants with a Washington address. An FBI background check is required for applicants possessing an out of state address.
2. The Healthcare Integrity and Portability database, or HIPDB, is a federal database. Federal regulation requires all health care regulatory bodies to report disciplinary actions to the HIPDB.
3. The NurSYS® database is an unduplicated database of all nurses licensed in the United States and territories. Individual nurses can be licensed in multiple states, but the individual has only one record in NurSYS®.

A positive background check could include felony and misdemeanor convictions or action on a license in another state. A positive background check on any of the databases requires further evaluation in the decision to grant or deny the license.

In 2008, the legislature required completion of criminal background checks on all health care applications. To be eligible for licensure, all out of state applicants must submit an FBI fingerprint background check. The Nursing Commission adopted rules allowing temporary practice permits to address delays in receiving background information from the FBI. A temporary permit

(60 days) may be issued if the nurse meets all requirements and has satisfactory HIPDB and NurSYS® background checks.

Comparison with national research and data regarding regulatory effectiveness and patient safety.

Table 1 captures the differences in data collected on licensing applications in Arizona, North Carolina and Washington. Both Arizona and North Carolina collect FBI background checks on all initial examination and endorsement applications.

Table 1: Differences in nursing licensing Activities in Arizona, North Carolina and Washington (licensed practical and registered nursing licenses only)

Licensing Activities	Initial Examination		Endorsement		Renewal	
NurSYS®* data bank check	**AZ**	Yes	**AZ**	Yes	**AZ**	Yes
	NC	Yes	**NC**	Yes	**NC**	Yes
	WA	Yes	**WA**	Yes	**WA**	Yes
Healthcare Integrity and Protection Data Bank (HIPDB) check	**AZ**	Yes	**AZ**	Yes	**AZ**	No
	NC	Yes	**NC**	Yes	**NC**	No
	WA	Yes	**WA**	Yes	**WA**	No
State Patrol Background Check	**AZ**	No	**AZ**	No	**AZ**	No
	NC	No	**NC**	No	**NC**	No
	WA	Applications with Wa state addresses	**WA**	No	**WA**	No
FBI Criminal Background Check	**AZ**	All applications	**AZ**	Yes	**AZ**	No
	NC	All applications	**NC**	Yes	**NC**	No
	WA	Out of state addresses only	**WA**	Yes	**WA**	No
On-line licensing	**AZ**	Must download and submit with fingerprint card	**AZ**	Must download and submit with fingerprint card	**AZ**	Yes
	NC	Yes	**NC**	Yes	**NC**	Yes
	WA	No	**WA**	No	**WA**	Yes

Source: Arizona, North Carolina and Washington State Boards of Nursing

*NurSYS® is the only database in the United States containing unduplicated licensure information. Individual nurses can be licensed in multiple states, but the individual has only one record in NurSYS®.

**Washington produces a paper license with the initial examination application and licensure. Renewals are paperless. Arizona produces a paper license. North Carolina does not produce any paper licenses.

The numbers in all tables and figures in this report represent activity for only licensed practical and registered nurses. On further discussions related to criminal background checks, the executive directors from Arizona and North Carolina described their regulation of nursing assistants and the associated criminal background evaluations and outcomes. In Washington, the Secretary of Health regulates the licensure of nursing assistants. In Arizona and North Carolina, the boards of nursing regulate the licensure, practice and discipline of nursing assistants. In Washington, the

Nursing Commission approves the curriculum and the training programs used by certified nursing assistant training programs and define where nursing assistants can work.

The Nursing Commission chose eleven CORE licensing measures for comparison. The full board of nursing surveys from Arizona, North Carolina and Washington are included in Appendix E. The surveys captured licensing activity for fiscal year 2012 for each state.

Table 2: Nursing licensing performance measures, Fiscal year 2012

CORE element	Arizona	North Carolina	Washington
Initial examination applications,	3,583	6,151	4,234
Endorsement applications	2,827	4,949	4,969
Total applications	6,410	11,100	9,203
Licensure by initial exam, days	0.9	6	1
Licensure by endorsement, days	1.8	5	1
Average days for licensure decisions	1.35	5.5	1.0
FTEs, licensure manager	.60	.20	1.00
FTEs, licensure staff	6.00	8.35	9.40
Total FTEs	6.60	8.55	10.40
Licensure, total salaries	401,294	726,914	432,640
Expenses, verification	*	0	0
Expenses, endorsement	1,116	*	152,205
Expenses, examination	1,030	*	3,000
Expenses, renewal	1,631	*	8,118
Total salaries and expenses	405,071	726,914	595,963

*No data supplied in these fields on the National Council of State Boards of Nursing survey
* Source: Arizona, North Carolina and Washington State Boards of Nursing

Total Full Time Equivalents (FTE) per applications:

AZ: 6.60/ 6,410 = .0010
NC: 8.55/11,100 = .0007
WA: 10.40/ 9,203 = .0011

Total Salaries and Expenses per FTE:

AZ: 405,071/ 6.60 = $61,374
NC: 726,914/ 8.55 = $85,019
WA: 595,963/10.40 = $57,304

License Expenses per license decisions:

AZ: 405,071/6410 = $ 63.29
NC: 726,914/11100 = $ 65.49
WA: 595,963/9203 = $ 64.76

Negligible differences exist in the total Full Time Equivalents per applications among the three state boards of nursing. **Both Arizona and North Carolina complete more criminal**

background activities than Washington. Arizona and North Carolina both complete FBI criminal background checks on all applicants for initial examination and endorsement. North Carolina is seeking legislation in 2013 to conduct FBI criminal background checks on renewal of licenses.

Important differences exist among the three state boards of nursing in expenses for licensing activities. Although the volume of license process actions is very different among the states, the expense per action is very similar. While there are more staff FTEs in Washington, the salary expenses per staff are lower than in Arizona and North Carolina.

Evaluation of efficiency and effectiveness

1. Both the Arizona and North Carolina boards of nursing conduct more FBI criminal background checks per licensee than Washington.
2. The Arizona and North Carolina boards of nursing perform the licensing activities for nursing assistants at a level higher than registration (certification).
3. Total licensing expenses per FTE are higher for the Arizona and North Carolina boards of nursing than in Washington.
4. The Nursing Commission consistently makes licensing decisions on the day of receiving the last document for initial examination applications and endorsement of a license.
5. The data did not demonstrate appreciable differences in the length of time to make a licensing decision in Arizona and Washington.

Nursing education activities: Comparison of efficiency, effectiveness, timeliness, personnel and financial resources

Prior to the Pilot Project

Nursing licensure decisions depend on the regulation of nursing education activities by boards of nursing. All new applicants in all states and United States territories must graduate from a nursing program approved by the state board of nursing. All new graduates must successfully pass the NCLEX® examination to be licensed in any state or United States territory. State boards of nursing regulate nursing education programs to assure they meet regulatory standards. The span of regulatory authority for the state boards of nursing varies from state to state, as do the regulatory requirements.

The increases in the 'baby boomer' population led to predictions of increased need for health care resources and nurses. This predicted shortage of nurses prompted changes in nursing education programs. In Washington, the Council of Nursing Educators of Washington State is evaluating standard prerequisite requirements for all registered nursing programs. Nursing education programs located outside of Washington State request approval of their nursing education programs to allow their students to complete clinical requirements in Washington. There are increasing on-line registered nurse to baccalaureate nursing education programs and pre-licensure programs seeking a presence in Washington State. Advanced Registered Nurse Practitioner programs located outside of Washington State are seeking Nursing Commission advice on approval requirements to allow their students to gain clinical experience in Washington. These trends increase the regulatory activity of the board of nursing.

The Nursing Commission revised nursing education regulations in 2005. The revised regulations define requirements for program administration, curriculum, and necessary resources.

Achievements made and innovations implemented during the Pilot Project

The Nursing Commission conducts site surveys of nursing education programs to evaluate compliance with regulatory requirements for curriculum, faculty, equipment and facility resources, and financial resources to sustain nursing education programs. Based on the survey results, the Nursing Commission may continue the full approval, place the program on conditional approval, or withdraw approval. In Washington, there are 39 approved schools of nursing. Each school may include several programs: nursing assistants, licensed practical nursing, registered nursing and advanced registered nurse practitioner.

From July 1, 2008, through July 1, 2012, the Nursing Commission placed eleven different nursing programs on conditional approval. Six of the eleven programs improved their approval status from conditional approval to full approval, three programs remained on conditional approval status for multiple years, one program repeated conditional approval status, and one new program obtained conditional approval status in 2012.

The Nursing Commission uses reports from the United States Department of Education's approved nursing accrediting bodies to evaluate nursing education programs. Reviewing and using the reports decreased the amount of time needed in approval of nursing education programs. The Nursing Commission retains the authority to conduct site surveys of accredited nursing education programs if the program's national accreditation status changes or if the Nursing Commission identifies substantial concerns about the program. These concerns included complaints against the program and decreasing NCLEX® pass rates. The Nursing Commission provides annual training to all new nursing education program administrators on regulatory requirements.

The Nursing Commission must produce an annual report summarizing trends in nursing education in Washington. The annual report includes annual NCLEX® pass rates for each program, trends in curriculum, and numbers of graduates per program. Schools of nursing provided the Nursing Commission with data on a paper survey. The annual report survey is now an electronic survey sent to program administrators. The program administrator completes the online survey and returns this to the Nursing Commission. The Nursing Commission compiles the results and electronically releases the report to each program. The Nursing Commission publishes the full report on their website.

The annual report includes information on the percentage of new graduates passing the NCLEX® examination per nursing education program. The Nursing Commission refers to this data as the program pass rate. Regulations require all nursing programs to have 80% of their graduates pass the NCLEX® examination. The most recent annual report compared Washington state nursing programs with the national average for pass rates

- LPNs: Washington average pass rate of 91.95% compared to the national average of 87.90%.
- RNs: Washington average pass rate of 90.32% compared to the national average of 84.84%

The Nursing Commission also conducts site surveys of nursing assistant training programs. There are over 200 Nursing Assistant Training Programs in Washington State. Nursing Assistant training programs exist in nursing homes, community colleges, high school training programs and private training sites. The Department of Social and Health Services (DSHS) regulates nursing homes in Washington State for compliance with federal standards. The Nursing Commission, DSHS, the Office of the Superintendent of Public Instruction, the Workforce Training and Education Board, and the State Board for Community and Technical Colleges each have some regulatory responsibilities for nursing assistant programs depending on the setting for the program.

Comparison with national research and data regarding regulatory effectiveness and patient safety.

The Nursing Commission compared thirteen CORE performance measures on nursing education programs with the Arizona and North Carolina boards of nursing. Table 3 includes the measures and outcomes.

Table 3: Nursing education performance measures, Fiscal year 2012

CORE element	Arizona	North Carolina	Washington
Education programs with initial approval in 2012	1	10	2
Education programs with existing full approval	32	110	38
Education programs placed on conditional approval in 2012	2	3	5
Total existing nursing education programs	35	123	45
Programs received initial approval	1	1	1
Programs received full approval	2	15	0
Programs, approval withdrawn	*	2	0
Programs denied initial approval	0	0	1
Total activity in FY 2012	3	18	2
FTE Education Consultant	.5	3.2	1.0
FTE Education admin staff	1.0	1.0	1.0
Total FTEs	1.5	4.2	2.0
Total salaries, Education approval	$192,404	$413,848	$161,986
Travel, education approval	417	18,226	1,549
Expenses, distribution of materials	*	19,009	2,536
Other costs of education approval	62	8,230	28,624
Total salaries and expenses	$192,883	$459,313	$194,695

*No data supplied in this field on the National Council of State Boards of Nursing survey
Source: Arizona, North Carolina and Washington State Boards of Nursing

Activity per educational program

AZ: 3/ 35 = 8.6 % programs with activity
NC: 18/123 = 14.6 % programs with activity
WA: 2/ 45 = 4.4 % programs with activity

FTEs per educational program

AZ: 1.5/ 35 = .04
NC: 4.2/123 = .03
WA: 2.0/ 45 = .04

Expenses per educational program

AZ: $192,883/ 35 = $5,510.94
NC: $459,313/123 = $3,734.25
WA: $194,695/ 45 = $4,326.55

The North Carolina board of nursing conducts the largest number of program approvals of the three boards of nursing and has the largest number of programs in the state with 123 programs.
Differences in the FTEs per education program did not vary greatly among the three boards of nursing. Notable differences in expenses per nursing education program exist among the three boards of nursing.

Evaluation of efficiency and effectiveness

The North Carolina board of nursing conducted more activities per nursing education program with fewer FTEs and associated expenses per program.

Disciplinary activities: Comparison of efficiency, effectiveness, timeliness, personnel and financial resources

Prior to the Pilot Project

A primary responsibility of the Nursing Commission is public protection. The Nursing Commission achieves protection through the disciplinary process. While the majority of nurses in Washington practice safely, a number of nurses do not. Disciplinary action removes unfit nurses and brings unskilled nurses to a higher level of safe practice through monitoring, education and supervision. By intervening when issues are initially identified, the Nursing Commission prevents future practice issues. Delays in discipline result in unsafe or unskilled nurses continuing to practice.

The disciplinary process identifies public concern through the complaint process. The Nursing Commission evaluates complaints every week. The Nursing Commission determines if the complaint requires investigation, if the complaint can be closed without any further work, or if the complaint can be resolved without discipline. The investigation collects evidence to support cases disposition decisions. All decisions made by the Nursing Commission must be legally defensible and supported by sufficient evidence. The process involves investigators, attorneys, and discipline staff. The process may include a hearing or settlement.

In 2005-2007, the Health Professions Quality Assurance division of the Department of Health worked on complaints representing about five percent of the 319,292 credentialed health care providers in the state, over 97,000 of these being nurses. Investigating the highest priority cases caused a backlog of lower priority investigations. An increase in the number of nursing graduates and applicants produced an increase in investigations due to positive criminal background checks and personal data questions. In July 2008, 1499 new applications resulted in 40 applications with positive personal data question or criminal background results.

Achievements made and innovations implemented during the Pilot Project

In the first year of the pilot project, an analysis of the resources for the Nursing Commission revealed the need for additional investigative staff as well as licensing staff (discussed above). Delays in discipline resulted in unsafe or unskilled nurses continuing to practice. The increase in licensing fees supported hiring new investigators, nursing consultants, an Advanced Registered Nurse Practitioner Consultant, and disciplinary staff. The decision packages also identified the need for increased staff in the Washington Health Professional Services (WHPS) program. The WHPS program monitors nurses and other health professionals with impairment issues related substance use and abuse. The WHPS program uses a strict contract including required body fluid testing, workplace monitoring and supervision, evaluation for safe practice, and required support groups.

The Nursing Commission received support from professional nursing associations, unions, employers, and educators to provide satisfactory licensing services and the increase in fees. The Nursing Commission presented decision packages (Appendix D) to Governor Gregoire for

consideration. Governor Gregoire accepted the packages and included them in the budget for 2009. The state legislature adopted the packages in the budget.

At the beginning of the pilot project, four investigators moved from Health Professions Quality Assurance to the Nursing Commission Unit. One of the investigators became the supervisor. Investigators and support staff were hired oriented and completed required training. There are currently ten investigators, one chief investigator, and six disciplinary staff to support the work from the receipt of the complaint through the completion of the investigation and case disposition phase.

Figure 2 shows the decrease in investigations from July 1, 2008 to July 1, 2012. Table 4 captures the investigations at the beginning of the pilot project, July 1, 2008, the beginning of fiscal year 2012, and the end of the month of publication of the report, November 30, 2012.

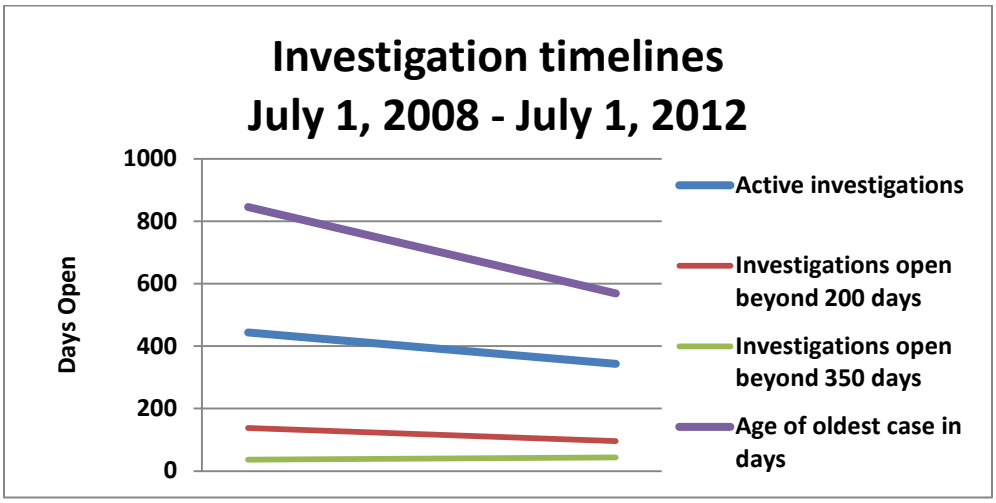

Figure 2: Investigation timelines, 2008-2012

Source: Nursing Care Quality Assurance Commission, Department of Health, Olympia, Washington

Table 4: Nursing investigation performance measures at the beginning of the pilot project, during pilot project and current date

	July 1, 2008	July 1, 2012	November 30, 2012
Active investigations	444	343	230
Investigations open beyond 200 days	138	96	53
Investigations open beyond 350 days	36	44	13
Age of oldest case in days	845	569	615
Investigator FTEs	4	10	10

Source: Nursing Care Quality Assurance Commission, Department of Health, Olympia, Washington

Figure 3 shows the increase in the number of investigations completed per fiscal year by the Nursing Commission. Table 5 captures the number of investigations completed in each fiscal year, July 1 to June 30, and the percent increase from year to year.

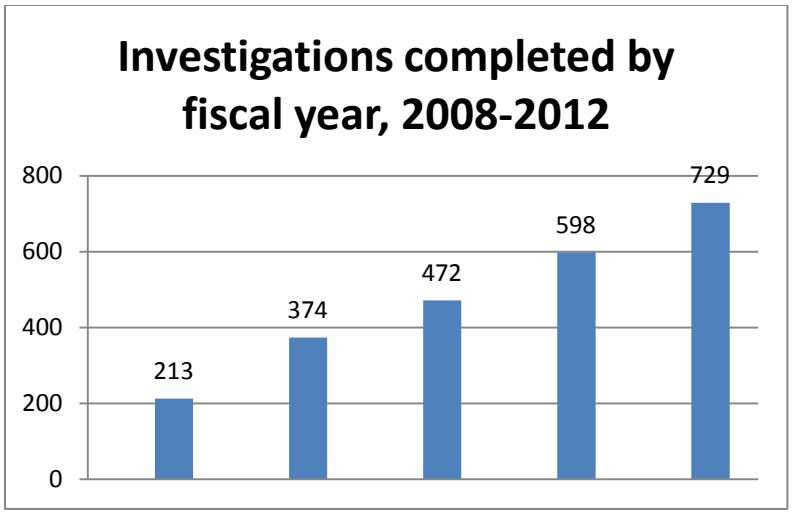

Figure 3: Investigations completed, 2008-2012
Source: Nursing Care Quality Assurance Commission, Department of Health, Olympia, Washington

Table 5: Nursing investigations closed per fiscal year

Fiscal Year	2008		2009		2010		2011		2012	
	Total complete	Percent Change	Total complete	Percent Increase	Total complete	Percent Increase	Total complete	Percent Increase	Total complete	Percent Increase
Investigations completed	213	0	374	76%	472	26%	598	27%	729	22%

Source: Nursing Care Quality Assurance Commission, Department of Health, Olympia Washington

The investigative report completed by each investigator was revised to increase the efficiency of its use throughout the disciplinary process. When an investigation is completed, the investigator summarizes the evidence collected in a report. The narrative in the report was reduced to bullet points. Nursing commission members and attorneys must review the evidence and use the investigative report. Changing the format decreased the amount of time needed to review the evidence presented in the investigation.

During the pilot project, the Nursing Commission ***decreased*** the backlog of investigations by 48% and ***increased*** the number of investigations completed by 71%. Figure 4 shows the dramatic decrease in the number of existing investigations and investigation closed within 170 days. Table 4 also captures the 37% decrease in time used in investigations

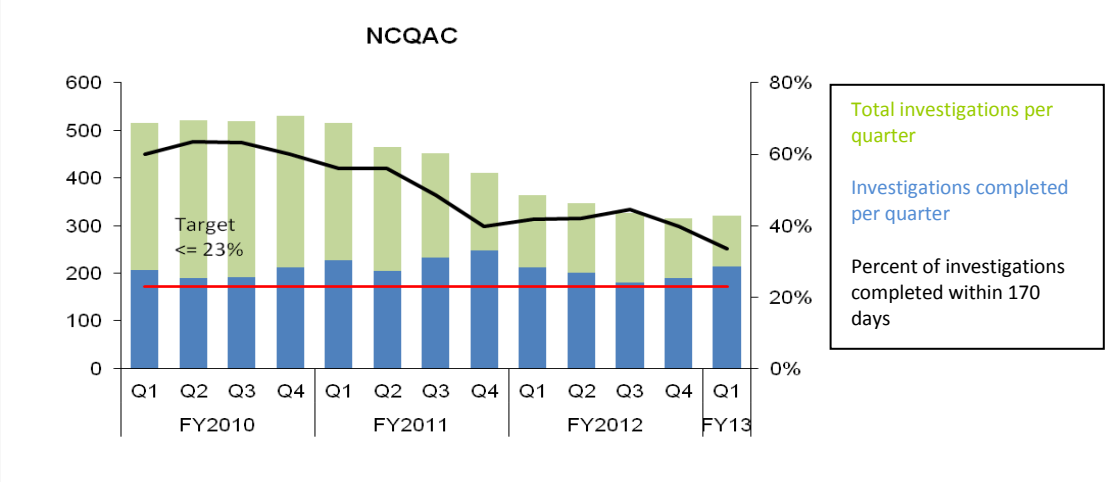

Figure 4: Number of investigations per quarter completed within 170 days
Source: Performance Measure 2.4, Nursing Care Quality Assurance Commission, Department of Health, Olympia Washington

Nursing consultants analyze completed nursing practice investigations and provide the Nursing Commission, nurses and nursing employers with trends in discipline. The nursing consultants complete the analysis using a standardized tool developed by the NCSBN. The tool determines if there were gaps in nursing practice. The consultants submit the results to a national database. The data collection identifies areas of practice concerns throughout the United States that may be addressed by nursing education or regulation. The nursing consultants provide this information to the Nursing Commission, employers and nurses. Knowledge of the trends could decrease nursing discipline and increase patient safety.

An Advanced Registered Nurse Practitioner (ARNP) consultant was hired. Increasing numbers of ARNP disciplinary cases and requests for information justified the request. Appendix F provided information on the requests and categories for information.

The Nursing Commission analyzed the Stipulations to Informal Discipline served in 2009. Agreed orders for these stipulations routinely required supervision of the nurse and education. The time from complaint to resolution of the agreed order frequently took over 18 months. The stipulations also used work and time in the following areas:

- Disciplinary staff and Nursing Commission members for intake and assessment of the complaint
- Nursing Commission members to decide if the allegations required an investigation
- Investigation of the allegation(s)
- Legal review of the allegation and investigation
- A Nursing Commission member to review the evidence
- Nursing Commission members determining conditions of the stipulation

Because of the results of this analysis, the Nursing Commission adopted the Early Remediation program. During the intake and assessment phase of the disciplinary process, the Nursing

Commission may offer the Early Remediation Program to a nurse if there is minimal patient harm or injury, and the nurse agrees to a plan to improve practice. If the nurse successfully completes the plan, there is no investigation or legal action. This program improved the efficiency and decreased costs associated with disciplinary actions. Both the Arizona and North Carolina boards of nursing use more non-disciplinary actions than the Nursing Commission. This strategy aligns with the movement towards analyzing errors and near misses as opportunities to improve practice.

Comparison with national research and data regarding regulatory effectiveness and patient safety.

The Nursing Commission compared twenty CORE disciplinary measures with the state boards of nursing in Arizona and North Carolina. Table 6 describes the data elements.

Table 6: Disciplinary performance measures, Fiscal year 2012

CORE element	Arizona	North Carolina	Washington
New complaints received FY 2012	1839	1570	1714
Complaints closed without action	819	641	1103
Cases assigned to investigations	1020	652	611
Investigative cases resolved with disciplinary action	417	139	231
Investigative cases resolved with non-disciplinary action	382	222	18
Length of time (in days) from opening investigation to resolution	285.7	298.4	822.7
Formal hearings conducted	18	5	9
Cases appealed in FY 2012	1	0	2
Cases appealed in FY 2011	1	3	1
Total appeals in 2011 and 2012	2	3	3
FTEs investigative staff, nurse	7.5	4.2	5.0
FTEs investigative staff, non nurses	10.0	2.0	6.0
FTEs investigative staff, admin support	8.0	3.0	1.0
FTEs investigative staff attorney	1.8	*	0.0
FTEs, investigative process, contract	0.0	.30	0.0
Total FTEs for investigative functions	27.3	9.5	12.0
Discipline total salaries	$1,819,073	$ 995,061	$353,664
Attorney salaries	246,617	65,125	1,187,553
Investigator salaries	1,230	12,511	1,002,925
Hearing costs	54,548	29,852	251,448
Compliance costs	*	12,650	55,511
Alternative program expenses	*	70,050	500,807
Total salaries and costs associated with discipline	$2,121,468	$1,185,249	$3,351,908

*No data supplied in this field on the National Council of State Boards of Nursing survey

* Source: Arizona, North Carolina and Washington State Boards of Nursing

The data reported on the surveys for length of time from opening investigation to resolution of a case was not consistent among the three state boards of nursing. Washington and North Carolina reported a range of dates while Arizona gave a distinct number. Further discussions with the executive directors provided consistent data for comparison.
There is a distinct difference in the number of days from opening an investigation to resolution. This figure is based on the number of cases that went to hearing in 2012 and the days from opening the investigation to resolution. Because of the dramatic difference, further information was requested from the executive directors in Arizona and North Carolina. The data was confirmed.

Cases assigned to investigations per FTE and expenses:

AZ: 1,020/27.3 = 37.4 at $2,121,468
NC: 652/ 9.5 = 68.6 at $1,185,249
WA: 611/12.0 = 50.9 at $3,351,908

Arizona opens more cases and dedicates more FTEs to investigations. Arizona's costs associated with discipline are less than Washington's costs associated with discipline. North Carolina opens a similar number of investigations with Washington with fewer FTEs dedicated to investigations and lower costs associated with discipline than Washington. Arizona and North Carolina both use significantly fewer days to resolve cases that go to hearings.

Evaluation of efficiency and effectiveness

1. The Arizona and North Carolina boards of nursing both use programs similar to the Early Remediation program, and have many more years of experience using these programs. Arizona resolved 382 cases with non-disciplinary actions and North Carolina resolved 222 cases with non-disciplinary actions. Washington resolved 18 cases using a non-disciplinary program.
2. Both the Arizona and North Carolina boards have lower expenses associated with disciplinary processes than Washington does.
3. Both Arizona and North Carolina use less time to adjudicate their cases than Washington does.

Financial resources: Comparison of Operating Expenses

Prior to the Pilot Project

Prior to the pilot project, allotments for spending and licensure fees were not adequate to address the resource needs of the Nursing Commission. The decision packages previously discussed identified the needed resources, including an increase in licensing fees. According to RCW 43.70.250, all health professions must use licensing fees to support all expenses associated with their work. There are no general state funds used to support any functions performed by the Nursing Commission.

Achievements made and innovations implemented during the Pilot Project

The additional authority and budgeting responsibility identified in RCW 18.79.390 directed the Nursing Commission to develop its budget for the 2009-2011 biennium to be included with the Department of Health's budget. Governor Gregoire accepted the decision packages and included them in the budget for 2009. The state legislature adopted the decision packages in the budget.

During the pilot project, the Nursing Commission experienced spending reductions as directed by the Governor and legislature. During the 2009 fiscal year, the Nursing Commission adopted the following strategies to decrease spending:

1. Temporary reduction in service days. During the 2009-2011 biennium, all state agencies were directed to decrease staff salaries. The Department of Health closed one day per month. Licensing and investigative staff was allowed to continue functioning. In the 2011-2013 budget, all employees received one day per month reduction in salary and a corresponding day's service.
2. Elimination of out of state travel unless funded for by a third party.
3. Fifty percent reduction in Nursing Commission face-to-face board meetings per year (with other meetings held by videoconference). While many board members prefer meeting in person, annual evaluations of the board performance demonstrated that just as many board members preferred the videoconference meetings to travel. This decreased board pay and expenses associated with travel.
4. Reduced paper documents associated with licensing, disciplinary and nursing education responsibilities.
    a. The Nursing Commission purchased laptop computers for each member to use for meetings and disciplinary documents.
    b. The packets for business meetings are posted on the Nursing Commission webpage prior to each meeting. Nursing Commission members and the public access all public documents supporting the business meetings on the Nursing Commission web site.
    c. The Nursing Commission began using webinar and Secured File Transfer Protocols (SFTP) to decrease mailing disciplinary cases and increase the security of the information.
    d. Produce one paper license for nurses on initial licensure. Nurses no longer receive a paper copy of their license with each renewal. The Provider Credential

Lookup provides primary source verification and up to date licensing information for all nurses and employers.

The Nursing Commission's authority for budget development, spending and staffing is an ongoing process. The implementation of the financial resources granted in the decision packages assisted the Nursing Commission in meeting the targets of the negotiated performance measures.

The Nursing Commission chose thirteen CORE measures to compare to the financial outcomes of Arizona and North Carolina state boards of nursing. Table 7 compares the financial measures used for comparison.

Table 7: Comparison of nursing financial performance measures, fiscal year 2012

CORE element	Arizona	North Carolina	Washington
Total expenditures	3,801,358	6,930,007	7,603,297
Discipline total salaries	1,819,073	995,061	353,664
Expenses, miscellaneous	41,103	738,260	49,735
Other costs	*	183,968	503,217
Postage	55,408	100547	508
Office supplies	11,500	53,345	7,100
Rent	227,843	244,199	111,992
Equipment maintenance	11,138	45,237	0
Data management	57,757	434,302	221,458
Total salaries, executive director and support staff	534,195	1,401,549	354,862
Board expenses	40,664	18,797	142,155
Other administrative costs	102,327	532,558	67,663
Other costs - indirect costs	*	53,243	1,582,796
Total other costs	102,327	585,801	1,650,459

*No data supplied in this field on the National Council of State Boards of Nursing survey
* Source: Arizona, North Carolina and Washington State Boards of Nursing

Discipline salaries as a percentage of total expenditures:

AZ: 1,819,073/3,801,358 = 48%
NC: 995,061/6,930,007 = 14%
WA: 353,664/7,603,297 = 5%

Licensing salaries as a percentage of total expenditures:

AZ: 401,292/3,801,358 = 10.56%
NC: 726,914/6,930,007 = 10.49%
WA: 432,640/7,603,297 = 5.69%

Education program salaries as a percentage of total expenditures:

AZ: 192,404/3,801,358 = 5.06%
NC: 413,848/6,930,007 = 5.97%
WA: 161,986/7,603,297 = 2.13%

Administrative/indirect costs as a percentage of total expenditures:

AZ: 102,327/3,801,358 = 2.7%
NC: 585,801/6,930,007 = 8.4%
WA: 1,650,459/7,603,297 = 22.0%

Evaluation of budgetary activities

Noticeable differences in spending exist in the total expenditures, licensing salaries, education program salaries, disciplinary salaries, and administrative/indirect costs among the three state boards of nursing. Washington spends 5.69% of their total expenditures for licensing activities as compared to Arizona at 10.56% and North Carolina at 10.49%. There are more FTEs in licensing staff in Washington. The salary expenses are 7% lower than Arizona and 48% lower than North Carolina.

The FTEs per nursing education programs are not appreciably different among the three boards of nursing, while the expenses per nursing education program differ. Washington spends 2.13% of their total expenditures for education program salaries, while Arizona spends 5.06% and North Carolina spends 5.97%. Comparisons among the three boards of nursing show Arizona's nursing education program salary expenses are 27% higher than Washington's expenses. North Carolina's nursing education program salary expenses are 16% lower than Washington's expenses.

Arizona spends more of their total expenditures and a higher percentage of their expenditures (48%) on disciplinary salaries than North Carolina (14%) and Washington (5%). There are more FTEs in disciplinary staff in Arizona than in Washington and North Carolina. Washington's disciplinary salary expenses are 47% lower than Arizona and 28% lower than North Carolina.

Washington uses more of its total expenditures on administrative and indirect costs than Arizona and North Carolina. Washington spends 22.0% of their total expenditures for administrative and indirect costs, where Arizona spends 2.7% and North Carolina spends 8.4%.

Distinct and important differences in spending exist in the total expenditures, total disciplinary salaries and administrative/indirect costs. **Arizona spends more of its total expenditures and a higher percentage of its expenditures on disciplinary salaries than North Carolina and Washington. Washington uses more of its total expenditures on administrative and indirect costs.**

Summary

The Nursing Commission appreciates the opportunity to participate in the 1103 pilot project. The additional authority granted to the Nursing Commission allowed them to increase their licensing, discipline and financial performance. The performance measures adopted by the Secretary of Health and health regulatory boards and commissions addressed the licensing, discipline, and financial measures. The Nursing Commission demonstrated that the additional authority improved their performance.

The comparison to two other state boards of nursing, Arizona and North Carolina, demonstrated that even greater performance can be achieved in disciplinary performance and financial outcomes. Both Arizona and North Carolina boards of nursing currently have greater authority than the authority granted to the Nursing Commission in the 1103 pilot project.

1. Both the Arizona and North Carolina boards of nursing conduct more FBI criminal background checks per licensee than Washington.
2. The Arizona and North Carolina boards of nursing perform the licensing activities for nursing assistants at a level higher than registration (certification).
3. Total licensing expenses per FTE are higher for the Arizona and North Carolina boards of nursing than in Washington.
4. The Nursing Commission consistently makes licensing decisions on the day of receiving the last document for initial examination applications and endorsement of a license.
5. The data did not demonstrate appreciable differences in the length of time to make licensing decisions in Arizona and Washington.
6. The North Carolina board of nursing conducted more activities per nursing education program with fewer FTEs and associated expenses per program.
7. The Arizona and North Carolina boards of nursing both use programs similar to the Early Remediation program, and have many more years of experience using these programs. Arizona resolved 382 cases with non-disciplinary actions and North Carolina resolved 222 cases with non-disciplinary actions. Washington resolved 18 cases using a non-disciplinary program.
8. Both the Arizona and North Carolina boards have lower expenses associated with disciplinary processes than Washington does.
9. Both Arizona and North Carolina use less time to adjudicate their cases than Washington does.
10. Distinct and important differences in spending exist in the total expenditures, total disciplinary salaries and administrative/indirect costs. Arizona spends more of its total expenditures and a higher percentage of its expenditures on disciplinary salaries than North Carolina and Washington. Washington uses more of its total expenditures on administrative and indirect costs.

Appendix A

RCW 18.79.390
Pilot project — Commission — Authority over budget.

(1) The commission shall conduct a pilot project to evaluate the effect of granting the commission additional authority over budget development, spending, and staffing. The pilot project shall begin on July 1, 2008, and conclude on June 30, 2013.

(2) The pilot project shall include the following provisions:

(a) That the secretary shall employ an executive director that is:

(i) Hired by and serves at the pleasure of the commission;

(ii) Exempt from the provisions of the civil service law, chapter 41.06 RCW and whose salary is established by the commission in accordance with RCW 43.03.028; and

(iii) Responsible for performing all administrative duties of the commission, including preparing an annual budget, and any other duties as delegated to the executive director by the commission;

(b) Consistent with the budgeting and accounting act:

(i) With regard to budget for the remainder of the 2007-2009 biennium, the commission has authority to spend the remaining funds allocated with respect to advanced registered nurses, registered nurses, and licensed practical nurses regulated under this chapter; and

(ii) Beginning with the 2009-2011 biennium, the commission is responsible for proposing its own biennial budget which the secretary must submit to the office of financial management;

(c) That, prior to adopting credentialing fees under RCW 43.70.250, the secretary shall collaborate with the commission to determine the appropriate fees necessary to support the activities of the commission;

(d) That, prior to the secretary exercising the secretary's authority to adopt uniform rules and guidelines, or any other actions that might impact the licensing or disciplinary authority of the commission, the secretary shall first meet with the commission to determine how those rules or guidelines, or changes to rules or guidelines, might impact the commission's ability to effectively carry out its statutory duties. If the commission, in consultation with the secretary, determines that the proposed rules or guidelines, or changes to existing rules or guidelines, will negatively impact the commission's ability to effectively carry out its statutory duties, then the individual commission shall collaborate with the secretary to develop alternative solutions to mitigate the impacts. If an alternative solution cannot be reached, the parties may resolve the dispute through a mediator as set forth in (f) of this subsection;

(e) That the commission shall negotiate with the secretary to develop performance-based expectations, including identification of key performance measures. The performance expectations should focus on consistent, timely regulation of health care professionals; and

(f) That in the event there is a disagreement between the commission and the secretary, that is unable to be resolved through negotiation, a representative of both parties shall agree on the designation of a third party to mediate the dispute.

(3) By December 15, 2013, the secretary, the commission, and the other commissions conducting similar pilot projects under RCW 18.71.430, 18.25.210, and 18.32.765, shall report to the governor and the legislature on the results of the pilot project. The report shall:

(a) Compare the effectiveness of licensing and disciplinary activities of each commission during the pilot project with the licensing and disciplinary activities of the commission prior to the pilot project and the disciplinary activities of other disciplining authorities during the same time period as the pilot project;

(b) Compare the efficiency of each commission with respect to the timeliness and personnel resources during the pilot project to the efficiency of the commission prior to the pilot project and the efficiency of other disciplining authorities during the same period as the pilot project;

(c) Compare the budgetary activity of each commission during the pilot project to the budgetary activity of the commission prior to the pilot project and to the budgetary activity of other disciplining authorities during the same period as the pilot project;

(d) Evaluate each commission's regulatory activities, including timelines, consistency of decision making, and performance levels in comparison to other disciplining authorities; and

(e) Review summaries of national research and data regarding regulatory effectiveness and patient safety.

(4) The secretary shall employ staff that are hired and managed by the executive director provided that nothing contained in

this section may be construed to alter any existing collective bargaining unit or the provisions of any existing collective bargaining agreement.

[2011 c 60 § 8; 2008 c 134 § 30.]

Notes:

Effective date -- 2011 c 60: See RCW 42.17A.919.

Finding -- Intent -- Severability -- 2008 c 134: See notes following RCW 18.130.020.

Appendix B

An Operating Agreement Between the Department of Health And the Nursing Care Quality Assurance Commission

Chapter 41, Laws of 1909, created the Nurses Examining Board. In 1949, the legislature established the Board of Professional Nurse Registration (ch.18.88 RCW) and the Board of Practical Nurse Examiners (ch.18.78 RCW). These became the Board of Nursing and the Board of Practical Nursing in 1973 and 1983, respectively. In 1994, the legislature combined the state Board of Nursing and the State Board of Practical Nursing to form the Nursing Care Quality Assurance Commission (NCQAC), under chapter 18.79 RCW, the Nurse Practice Act. The purpose of the NCQAC is to regulate the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. Rules, policies, and procedures developed by the commission must promote the delivery of quality health care to the residents of the state of Washington.

Chapter 9, Laws of 1989, 1st Ex. Sess., chapter 43.70 RCW, created the Department of Health (DOH). The primary responsibilities of the DOH include

- preservation of public health,
- monitoring health care costs,
- maintenance of minimal standards for quality in health care delivery, and,
- general oversight and planning for all the state's activities as they relate to the health of the public.

RCW 43.70.240 requires the Secretary enter into a written operating agreement on administrative procedures with the health profession Boards/Commissions. The statute requires this agreement address at a minimum administrative activity supporting NCQAC policies, goals and objectives, and budget.

RCW 43.70.250 requires the cost of each profession be fully borne by members of the profession. The Secretary shall collaborate with the NCQAC to establish the licensing fees. The licensing fees cover the costs of administering the NCQAC program.

This agreement between DOH and the NCQAC is intended to define functional and program areas of regulation of the practice of the nursing profession, licensure, examination and discipline. Appendix A contains copies of all statutory references in this document.

Section 2 Definitions

1. "Administrative services" means those services provided by the Department to the NCQAC in accordance with applicable General Administration, Office of Financial Management (OFM), Department of Information Services and Department of Personnel policies and regulations.
2. "Assistant Secretary" means the Assistant Secretary of Health Systems Quality Assurance Division accountable to the Secretary of Health.
3. "Business Plan "means a detailed outline for the biennium of the mission, goals, and objectives for a health profession Board/Commission. A business plan may be a strategic plan.
4. "Collaboration" means to work jointly with others or together.
5. "Department" or "DOH" means the Washington State Department of Health.
6. "Executive Director" means the Chief Administrative Officer hired by the NCQAC and employed by the Secretary of Health. The Executive Director serves at the pleasure of and is accountable to the NCQAC.
7. "Indirect costs" means the administrative costs related to activities varying with activity level or size, but usually cannot be practically or economically charged directly to those activities.
8. "NCQAC" is the regulatory authority for licensed practical nurses (LPNs), registered nurses (RNs), advanced registered nurse practitioners (ARNPs), and nursing technicians (NTs).
9. "Pilot Project" according to RCW 18.79.390 (Chapter 134, Laws of 2008), the NCQAC shall participate in a five year pilot project. The project will measure efficiency and effectiveness of the NCQAC.
10. "Program Manager" means the manager hired by the Executive Director assisting with and accountable for specific actions, assignments and responsibilities.
11. "Secretary" means the Secretary of the Department of Health or the Secretary's designee.

Section 3 Budget Development

1. NCQAC develops the budget consistent with the requirements contained in the instructions of the Office of Financial Management and DOH policies and procedures. Appendix B includes DOH policies and procedures specific to this item.

2. By November 15 of every year, the DOH communicates with NCQAC regarding anticipated indirect rate changes for service units and indirect charges. DOH shall provide detailed costs and budget information according to the agreed procedure. Meetings between DOH and the NCQAC to address input, questions, pros and cons of the business options of the final decision must occur prior to November 15 of each year. DOH communicates the rate changes for the Attorney General Office and facility by August 15, 2010 and August 15, 2012 in preparation for the biennial budgets.

3. In this process, NCQAC establishes goals and objectives for the regulation of nurses supported by the budget, and assigns priorities to the goals and objectives consistent with projected revenue, state and federal laws, administrative rules, policies, and Governor executive orders.

4. RCW 18.79.390 states the NCQAC shall participate in a pilot project, beginning July 1, 2008. The biennial budget for 2007-2009 must be honored, and the NCQAC will then develop their budget for the

2009-2011 budgets and beyond. The Secretary of Health must submit the 2009-2011 budget to the Office of Financial Management.

5. The NCQAC negotiates with the Secretary to develop performance based expectations for consistent timely regulation of nurses. The DOH will provide assistance in the development of the NCQAC's performance-based expectations and measurements as required by RCW 18.79.390. Both parties agree to begin a project to develop expectations and measurement techniques and processes immediately after July 1, 2008. The DOH and NCQAC shall agree upon a work plan to complete the project no later than March 31, 2009. The NCQAC may individualize and add measures.

6. The NCQAC reviews the business plan and performance measures with the Executive Director at least annually.

7. The Secretary collaborates with the NCQAC prior to adopting fees for nurses to be promulgated pursuant to RCW 43.70.250 and RCW 18.79.390.

Section 4 Financial Management

1. Financial management depends on several factors, primarily revenue forecasts and the reconciliation of allotments, expenditures, and revenue collected. DOH has the ultimate responsibility for financial matters under the State Budgeting, Accounting and Reporting System, 43.88 RCW. The Executive Director is accountable to the NCQAC and the Secretary for the proper management of the budget.

2. Unspent funds in the nursing subaccount within the Health Professions Account (O2G) remain in the subaccount per state law and carry forward from one biennium to the next. These funds are dedicated for the work of the NCQAC to carry out their goals, objectives, and program functions.

3. The NCQAC agrees to pay the DOH indirect costs consistent with the nature, efficiency and quality of services the DOH provides to the NCQAC. The ongoing charges for services through the indirect costs mechanism will be annually submitted by DOH to NCQAC by May 1. The NCQAC evaluates budgetary impact. Meetings between DOH and the NCQAC to address input, questions, pros and cons of the business options of the final decision must occur between May 1 and June 30 of each year. The DOH shall provide reliable and valid reports with detailed costs and budget information. The Secretary will inform the NCQAC's Executive Director in advance of any changes to the indirect rate.

4. The DOH will disclose any unanticipated charges, cost or rate increases to the NCQAC's account at least sixty (60) days before the expenditure action takes effect unless emergency circumstances make such notice impracticable. The DOH and the NCQAC will review the unanticipated charges, costs or rate increases. The NCQAC must respond within a reasonable time period on business impacts.

5. The DOH and the NCQAC will follow the directions given by the Governor on expenditures. The DOH agrees to continue to provide the fiscal and revenue services consistent with OFM regulations, including but not limited to the following:

- Pay vendors, contractors and other types of payment documents
- Review and pay travel vouchers for staff and NCQAC members

- Process payroll and benefits
- Prepare biennium budget submissions for NCQAC approval
- Coordinate fiscal note submissions on Legislative impact issues
- Process revenues and prepare monthly revenue reports
- Department representatives will meet with the NCQAC or its designee to review and discuss revenues and expenditures.

6. The Secretary grants signature authority to the Executive Director to approve travel and related documentation for NCQAC members and staff. The Executive Director will obtain the NCQAC or its designee approval before granting out-of-state travel requests. All travel by NCQAC members and staff will comply with the requirements and guidelines of the DOH, the OFM and Department of General Administration. The NCQAC understands all travel outside of the contiguous 48 states must be approved by the governor's office.

7. As authorized under RCW 43.70.320:

> (3) The secretary shall biennially prepare a budget request based on the anticipated costs of administering the health professions licensing activities of the department which shall include the estimated income from health professions fees.
>
> (4) The secretary shall, at the request of a board or commission as applicable, spend unappropriated funds in the health professions account that are allocated to the requesting board or commission to meet unanticipated costs of that board or commission when revenues exceed more than fifteen percent over the department's estimated six-year spending projections for the requesting board or commission. Unanticipated costs shall be limited to spending as authorized in subsection (3) of this section for anticipated costs.

The process to request the funds is according to HSQA business practice in Appendix C.

8. The NCQAC agrees to provide sufficient information and justification for any request and only when revenues exceed fifteen percent of the estimated six-year spending projections. The Secretary's designee will coordinate efforts to access any available funds with the OFM and the NCQAC. These reviews and subsequent requests will be performed in July/August of biennial budget periods (July/August 2010 and July/August 2012).

9. Both parties agree to collaborate to determine the appropriate fees necessary to support the activities of the NCQAC prior to adopting a revised fee schedule. All fee increases must meet current legislative requirements.

Section 5 Personnel

1. The Secretary employs an Executive Director, hired by and serving at the pleasure of the NCQAC to carry out 18.79 RCW.

2. The Executive Director is responsible for the overall management of the business of the NCQAC. The Executive Director is a State of Washington, Department of Health employee.

3. When a competitive hiring process is used, the NCQAC interviews and hires the Executive Director. This process will be used in addition to requirements outlined in 18.79 RCW.

4. The Executive Director manages, initiates, plans, budgets, organizes, directs, coordinates, implements, and monitors all aspects of the licensing, examination and disciplinary activities relating to NCQAC. The Executive Director is responsible for all aspects of management including personnel administration, budget development and management, review, and administration of all administrative activities.

6. All administrative, investigative, enforcement, examination, education and other personnel hired and managed by the Executive Director and assigned to NCQAC are State of Washington, DOH employees. The NCQAC provides input to the Executive Director in a mutually agreed upon manner regarding the performance and training needs of personnel working with them in their regulatory roles. This opportunity should be given at the time of the annual performance evaluation; however, input may be given at any time.

7. The DOH and the NCQAC agree to resolve all staffing issues that may be created as a result of the Pilot including the hiring process for the Executive Director. Solely the Executive Director or other direct supervisors within the NCQAC's unit will supervise NCQAC staff. The Executive Director will assign duties of staff as needed to carry out the work of the NCQAC. Nothing in this agreement shall be construed to authorize any party to modify the existing collective bargaining agreements governing the relationship of the NCQAC staff to the DOH. The NCQAC will comply with all standard DOH policies and procedures regarding human resources management.

8. Both parties agree that the NCQAC and/or its Executive Director or the Executive Director's designees will be solely responsible for completing performance evaluations of the NCQAC staff in a timely manner. The Executive Director will solicit input from the NCQAC leadership prior to any performance evaluation regarding the performance of management staff, staff attorneys, investigators and other employees as desired. The NCQAC will have sole responsibility to perform performance evaluations of the Executive Director.

9. According to 18.79.390(4), "The secretary shall employ staff that are hired and managed by the executive director provided that nothing contained in this section may be construed to alter any existing collective bargaining unit or the provisions of any existing collective bargaining agreement." The Executive Director will receive weekly reports from the service units under the management of the Secretary of Health. If performance falls below target measures, deliberate steps will be taken to identify causes, develop and implement an action plan.

10. The DOH continues to provide support services to the NCQAC including, but not limited to:

- Human Relations
- Labor Relations
- Information Services
- Records Management
- Electronic Communications
- Call Center
- Materials Management
- Purchasing
- Mail Delivery
- Legal Services Office
- Budget Preparation
- Criminal Background Checks
- Contracts
- Office of Professional Services
- Rule Making Technical Support
- Public Disclosure Records Center

Additional supporting services may be added to this provision by mutual agreement. A schedule of the administrative services currently provided shall be attached hereto and incorporated herein. Meetings between DOH and the NCQAC to address input, questions, pros and cons of the business options of the final decision must occur prior to November 15 every year. DOH provides detailed costs and budget information when requested to facilitate NCQAC review, input and questions.

11. Both parties agree to continue the services of the DOH presiding officers for formal disciplinary hearings and reinstatement procedures. It is presumed that this matter will remain essentially unchanged from the process in place prior to the effective date of this agreement.

12. As of July 1, 2010, DOH staff and processes related to the following will be under the supervision of the Executive Director:

Applications, Renewals, Licensing
Investigations
Disciplinary staff, Case management and Compliance

13. Service levels of all services reporting directly and indirectly to the Executive Director will be evaluated annually and open to negotiations.

14. All complaints regarding nurses will be forwarded to the NCQAC for the initial intake and assessment. Consistent with RCW 18.130.062, all complaints received with allegations of sexual misconduct will be assessed by the NCQAC to determine if the case involves a clinical or standard of care issue. If not, the complaint will be forwarded to the Secretary or designee for action. Cooperation and mutual assistance between the DOH and NCQAC staff with respect to the handling of sexually-related complaints is specifically encouraged by both parties. The NCQAC will have an opportunity to review and provide comment on any administrative rules the DOH develops regarding the process for complaints alleging sexual misconduct.

15. The DOH agrees to continue its support for public disclosure requests within the HSQA Public Disclosure Records Center. The DOH agrees to provide monthly reports as to the NCQAC's charges and revenues regarding nurse disclosure. The DOH agrees to notify the Executive Director of any significant public disclosure request that may have a financial impact or indicates an unusual interest by the media. Legal issues regarding responses to public disclosure requests will be coordinated with DOH and NCQAC staff and Assistant Attorneys General working with the DOH and the NCQAC.

16. The NCQAC will use the expertise of the DOH Communications Office in its media relations. Any information released to the press regarding NCQAC business will be reviewed and approved by the Executive Director, the Chair or designee and include direct contact information for NCQAC staff to facilitate response to substantive follow-up requests.

17. Within available resources, the DOH agrees to provide the technical support required to create and maintain a Website for the NCQAC. Website development and content will comply with the DOH policies and procedures.

18. The NCQAC will work collaboratively with the Secretary's designee regarding access to the resources and authority to have access to reports from the Washington State Patrol, national background checks, and other reports on out-of-state applicants for nursing licensure. The NCQAC acknowledges that access and possession must comply with the requirements in state and federal law, and policies and procedures established by the Washington State Patrol and the Federal Bureau of Investigations.

Section 6 Integrated Licensing and Regulatory System (ILRS)

1. The parties agree the Integrated Licensing Regulatory System (ILRS) is an enterprise system intended to support the regulation of the health care delivery system. The NCQAC shall have full access to any available functionality in the ILRS system that is needed to support the reasonable functions of the NCQAC. Since the effective use of any information technology (IT) system is dependent on the training of users, the NCQAC agrees to keep its staff fully trained as needed in the use of the ILRS system and will assure new staff are trained as quickly as possible. The DOH agrees to continue to review and update the effectiveness of the newly implemented Integrated Licensing and Regulatory System (ILRS) to meet reasonable business needs of the NCQAC. The DOH agrees to work collaboratively and in consultation with the Executive Director or designee when making any changes to the existing and or future system design, process or functionality that might affect the work of the NCQAC.

2. The DOH will make every effort to support NCQAC requests for the development of reports to support the work of the NCQAC. The DOH will make reasonable efforts with NCQAC to work collaboratively on efforts to align system requirements with the business requirements of all health professions, boards, and commissions. The DOH shall not implement permanent changes to the ILRS system that impact the NCQAC's work or budgets in any way without advance consultation through the NCQAC's designee. Emergency system occurrences may require that system changes be made immediately in order to restore system functionality or prevent data degradation. In these instances the DOH will make changes and afterwards notify the NCQAC.

3. The NCQAC acknowledges and recognizes that the ILRS system is an enterprise approach to support all health professions. While honoring this enterprise approach, the DOH will work cooperatively with NCQAC staff to review the form and content of automated licensing templates, documents, and reports and modify them as may be necessary to meet the NCQAC's business needs and the intent and purpose of chapter 18.79.RCW and chapter 18.130 RCW.

Section 7 Facilities, Equipment and Furnishings

1. The DOH agrees to furnish the needed facilities, equipment, and material for the NCQAC's staff to use in a manner equal to those afforded to similar employees of the DOH. The DOH shall make all reasonable efforts to co-locate staff supporting the NCQAC by the effective date of this agreement.

2. Nothing in this agreement limits the NCQAC's ability to authorize additional equipment and supplies needed to support the NCQAC's work as long as the purchase process complies with applicable General Administration, OFM, and Department of Information Services requirements. The Executive Director in collaboration with the NCQAC or its designee will determine the purchasing of any new technical and

electronic equipment, printers, copiers, fax machines and other equipment or items deemed necessary. Any equipment or software connected to or run on the DOH's networks, desktops, or laptops must meet the current DOH Information Technology standards and follow all applicable DOH policies.

3. The Executive Director has the signature authority for up to $10,000 for any additional or special purchases of supplies required by the NCQAC.

4. The DOH will continue to provide reasonable access to conference or meeting rooms and motor pool vehicles. NCQAC staff will schedule meetings through the DOH's current system.

5. The DOH agrees to continue to provide to the NCQAC staff basic office supplies purchased through direct and indirect costs. The DOH reserves the right to change its office supply structure to a "direct charge" model. The NCQAC will be consulted before this change occurs.

Section 8 Performance Based Expectations

1. The NCQAC reviews performance measures used by the DOH. The NCQAC may individualize and add measures. The NCQAC negotiates with the Secretary performance measures, data collection and analysis by December 31, 2008.

2. The Executive Director is responsible for all NCQAC administrative activities, policies, processes, and procedures. The Executive Director is required to ensure that the NCQAC functions efficiently, with consistent application and in compliance with state and federal laws, administrative rules, policies, and Governor executive orders.

3. The NCQAC establishes performance measures, goals, objectives, and priorities within available resources. The Executive Director implements the goals, objectives and priorities within available resources. DOH personnel may request revision of goals to achieve efficiency, effectiveness, and avoid duplication. The NCQAC may request revision of DOH performance and implementation methods for the same purposes.

4. The Executive Director provides the NCQAC with reports at least twice a year summarizing progress toward meeting the performance measures negotiated with the Secretary.

5. The Executive Director distributes a financial report at least twice a year to the NCQAC.

6. DOH, together with the NCQAC, under RCW 18.130.310 and RCW 40.07.030, and subject to RCW 40.07.040, submits an biennial report to the legislature on its proceedings. The report includes the number of complaints made, investigated, adjudicated and the manner of the disposition. NCQAC reviews the report prior to submission to the legislature and may contain recommendations for improving the disciplinary process, including proposed legislation. DOH will develop and submit the report. NCQAC may submit an annual report about disciplinary activities, rule-making and policy activities, receipts and expenditures.

7. The Secretary provides to the NCQAC reports and/or audits to the legislature or other agencies of government where the NCQAC is the material focus of such reports and/or audits. If appropriate, the Secretary provides to NCQAC reports and/or audits as far as possible in advance. The NCQAC may

make written comments on the report. The Secretary incorporates NCQAC comments into the text of the report or includes them in an appendix to the report.

8. The NCQAC provides the Secretary reports and/or audits to the legislature or other agencies of government, where DOH or the NCQAC is a material focus of such reports and/or audits. NCQAC provides reports and/or audits to the Secretary as far as possible in advance of submitting reports. The Secretary may make written comments on the report. The NCQAC incorporates DOH comments into the text of the report or includes them in an appendix to the report.

9. As required by RCW 18.79.390(2)(d) and (f), the Secretary meets with NCQAC prior to adopting uniform rules, guidelines or actions that may impact the licensing or disciplinary authority of the NCQAC. If the NCQAC determines a negative impact, NCQAC collaborates with the Secretary to develop alternatives. If the alternatives are not agreeable, a mediator may be used.

10. The NCQAC or Secretary, as mandated in law, has the authority to develop and adopt rules to carry out their respective statutory responsibilities. The Secretary is also required to review and coordinate all rules, interpretative statement and policy statements proposed by the NCQAC. The timeline and criteria for Secretary review are detailed in RCW 18.130.065.

11. The NCQAC may delegate responsibilities to DOH staff provided those responsibilities are consistent with state law.

12. The Executive Director, in consultation with the NCQAC, develops travel practices for NCQAC members, consistent with state travel regulations and DOH policies and procedures.

13. The NCQAC and the Executive Director establish an orientation and training program for all NCQAC members.

14. As directed by RCW 18.130.390, the NCQAC and the DOH will continue to collaborate with other boards and commissions to develop a uniform sanctioning schedule. The NCQAC is specifically authorized by RCW 18.130.390(3) to deviate from the uniform sanctioning schedule when selecting sanctions when, in the exercise of its discretion, the NCQAC determines that a case presents unique circumstances that the schedule adopted does not address. When the NCQAC exercises this authority, it will issue a written explanation in its order explaining the basis for its decision not to follow the schedule. The Executive Director shall ensure that the methodology, statistics, and reports related to sanctions and all other performance measures developed by the DOH and the NCQAC are complete and accurate. The DOH pledges its cooperation in this regard. The NCQAC Sanctioning Standards may be used in conjunction with the Secretary's rules. Appendix D contains the Nursing Sanctioning Standards.

Section 9 Legislation

1. Communication with the governor and the legislature will be in partnership with the DOH Office of Policy, Legislation, and Constituent Relations. NCQAC communications with legislature will be consistent with the authority in RCW 42.52.804. The NCQAC and its members will comply with the reporting requirements of the Public Disclosure Commission.

2. The NCQAC may propose to DOH issues that require a legislative solution. DOH, in establishing its legislative agenda, will consult the NCQAC. The DOH and NCQAC agree to discuss and attempt to come to an agreement on public positions expressed on any legislative matters. The DOH agrees to provide a copy of all legislative bills that may affect the practice of nursing, and/or the credentialing or disciplinary process for nurses to the Executive Director.

3. The Executive Director or designee will complete all bill analysis and fiscal notes within the required time frames. The Executive Director will have the same opportunity to participate in Health Systems Quality Assurance bill review meetings and have the same access regarding legislation as Executive Directors of the other health boards and commissions.

4. The NCQAC agrees to comply with the Executive Ethics Act and the Public Disclosure Act including, but not limited to, the requirements of the Public Disclosure Commission.

5. The Executive Director keeps the NCQAC informed regarding DOH and legislative activity/actions. The Executive Director provides information, to include explanations about agency decision-making, and guidance to the NCQAC before and during each legislative session.

6. Strategic decisions regarding testifying are based on the political context of the issue and the emphasis required stating the agency position on a bill. The Executive Director and chair of the NCQAC determine who provides testimony on nursing issues. DOH, recognizing time constraints, assures that the most knowledgeable and effective person on a legislative issue is assigned to provide testimony to the Legislature. Any such testimony will be provided in partnership with the DOH Office of Policy, Legislation, and Constituent relations.

7. While NCQAC members may educate the legislature and the public regarding issues, there are strict statutory limitations on lobbying the legislature that must be followed.

8. NCQAC members, as individuals, are free to exercise their right to petition the government without restraint. Any NCQAC member should consult with the assigned Assistant Attorney General or Executive Director prior to partaking in any activity that could be perceived a lobbying by the NCQAC member.

9. NCQAC shall submit a biennial report using a uniform format to the legislature. The report must include:

- Number of complaints made, investigated and adjudicated and the disposition;
- DOH background check activities identifying license holders not qualified to practice;
- Distribution of the number of cases assigned to each attorney and investigator (identity will be anonymous)
- Recommendations for improvement including legislation.

Section 10 Rulemaking

1. Rulemaking is defined in the Administrative Procedures Act, 34.05 RCW. According to RCW 18.130.065, the Secretary shall review and coordinate all proposed rules, interpretive statements, policy

3. The DOH agrees to continue the current contracts for services necessary to assist in the work of the NCQAC. The Executive Director will be granted signature authority to approve Contract Processing Action Requests for contracts up to $10,000. The Executive Director will also approve and maintain all expert witness contracts for the NCQAC cases or use the current contract in place as determined by the NCQAC. The Executive Director will review contracts prior to any renewal, amendment, or termination in order to recommend any necessary action to the NCQAC. Contract format and process will be consistent with OFM regulations and DOH policies and procedures. The NCQAC or its delegate will approve any new contract or changes to existing contracts when the contract's statement of work impacts the substantive responsibilities of the NCQAC, including but not limited to, credentialing and disciplining functions, and the fiscal impact to the NCQAC exceeds $15,000.

Section 12 Review

It is the intent of the NCQAC and the Secretary that this Operating Agreement be reviewed annually. The Agreement may be revised when necessary upon the request and mutual agreement of the Secretary and the NCQAC.

Section 13 Meetings

1. Representative(s) of NCQAC and the Secretary will be offered the opportunity to have semi-annual meetings to discuss matters of mutual concern specific to the pilot project. Agenda items will be submitted from and to the NCQAC and Secretary two weeks in advance of the meeting. These meetings are separate from those between the NCQAC Executive Director and the HSQA Assistant Secretary. These meetings are separate from the annual meetings of the boards and commissions and the leadership meeting.

2. Both parties agree to work collaboratively and cooperatively on any decision that may impact the other party. In order to achieve this goal, both parties agree to share any planned action, issue, concern, or recommendation prior to making a final decision. The parties agree to keep each other informed on matters of general interest. The Secretary or Assistant Secretary is the primary contact for the Executive Director. The Executive Director is the primary contact for the Assistant Secretary or Secretary.

Section 14 Disagreements

In the event there is an impasse between the NCQAC and the Secretary, that is unable to be resolved through negotiation, a representative of both parties shall agree on the designation of a third party to mediate the dispute.

Mary C. Selecky, Secretary
Department of Health

Susan Wong 10/7/2010

Susan Wong, RN, MBA, MPA
Chair, Washington State Nursing Care
Quality Assurance Commission

statements and declaratory orders. RCW 43.70.040 also defines the Secretary's role in adopting rules. RCW 18.79.110 defines the NCQAC rulemaking authority. Based on these laws and the provisions of RCW 18.79.390, there is shared responsibility between the NCQAC and the Secretary for rulemaking. A process for adopting rules is to be negotiated that demonstrates:

A. Valid external stakeholder involvement in rules workshops to include
    a. Practitioner representation
    b. Geographic distribution
    c. Stakeholders besides nurses
B. DOH review process of internal stakeholders involvement to include
    a. Other professions
    b. Facilities
    c. Public health

2. The NCQAC intends to use the DOH electronic rule management system for technical assistance and administrative support.

3. The parties agree to keep each other informed and to consult with each other concerning proposed rule changes that affect the other party.

4. The DOH agrees to assist NCQAC staff to comply with technical requirements for rulemaking, and assist with preparation of required. Documentation such as significant analysis, small business impact statements and other administrative services the NCQAC requests in order to support proposed rules, repeals, and amendments in a streamlined and timely manner.
Upon completion, NCQAC forwards the rule documents directly to the Secretary for review and filing with the Code Reviser's Office.

5. NCQAC develops reasonable implementation plans and timelines.

6. The Executive Director and the Assistant Secretary will approve and forward rules to the Office of the Secretary for final approval for filing.. The Office of the Secretary completes the approval within six weeks from the date of delivery to the Secretary.

Section 11 Contracts

1. Where not otherwise prohibited by law, DOH in consultation with the NCQAC may enter into contracts for services on behalf of the NCQAC. The Secretary's designee will negotiate the contracts and assist the NCQAC in implementing the contracts within the parameters of the law.

2. As authorized in RCW 18.130.095, the Secretary shall enter into interagency agreements for exchange of records with other agencies. Communications with outside parties not subject to RCW 18.130.095 will be made directly between NCQAC and the third party. The Secretary will keep the NCQAC's Executive Director informed of agreements impacting the exchange of information on nurses.

Appendix A Statutory References

18.79.110 Nursing Practice Act – Purpose statement

18.79.390 Pilot project

18.130.062 Uniform Disciplinary Act - Authority of secretary -- Disciplinary process -- Sexual misconduct

18.130.065 Rules, policies, and orders -- Secretary's role

18.130.095 Uniform procedural rules

18.130.310 Biennial report -- Contents – Format

18.130.390 Sanctioning schedule – Development

40.07.030 Reports -- Where filed -- Review of state publications -- Duties of agency head with respect to publications -- Guidelines for publications -- Director's duties

40.07.040 Duties of the governor

42.52.804 Exemption -- Health profession board or commission -- Professional opinions

43.70.040 Secretary's powers -- Rule-making authority -- Report to the legislature

43.70.240 Written operating agreements

43.70.250 License fees for professions, occupations, and businesses

43.70.320 Health professions account -- Fees credited -- Requirements for biennial budget request -- Unappropriated funds

43.88 State budgeting, accounting, and reporting system

Appendix B – DOH Procedures

11.001 Memberships in Associations and Organizations

11.002 Accounts Receivable

11.004 Applying for and soliciting Outside Funding

11.006 Indirect Rate Proposal (since this is a proposal, all modifications require review and approval by NCQAC)

11.007 Non-Sufficient Funds Charge

11.009 Employee Recognition Awards (changes anticipated; will need to review as modified)

11.012 Vendor Payments

11.014 Timekeeping for Federal Requirements

11.015 Internal audit Policy

11.016 Reimbursement for Use of privately Owned Motor Vehicles

11.017 Professional Licenses and Certifications

11.018 Payroll Overpayments

12.003 Capital Projects Program

12.012 Commute Trip Reduction (CTR) Program

12.013 Distribution of Rent Costs

14.002 Consumable Inventory (includes Gift Incentive procedure)

14.003 Asset Management

14.004 Use of State Vehicles or Private Vehicles for State Business

14.005 Procurement of Supplies, Equipment, Materials, Services

14.007 Light refreshments

14.008 Meals with Meetings/Events

17.002 Records Inventory and Disposition

18.001 Contracting Policy

18.003 DOH Granting Authority

Appendix C – HSQA Business Practice

Appendix D Nursing Sanction Standards

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
POLICY

Title:	Use of Sanction Standards in Disciplinary Action	**Number:** A27.06
Reference:	RCW 18.130.180; RCW 18.130.160	
Effective Date:	March 13, 2009	
Supersedes:	Use of Sanction Guidelines in Disciplinary Action September 12, 2003; January 9, 2004; July 1, 2005 Use of Sanction Standards in Disciplinary Action September 8, 2006; November 16, 2007	
Approved:		
	Chair **Nursing Care Quality Assurance Commission**	

Purpose: To provide consistency and uniformity in disciplinary sanctions for similar violations.

Policy:

The Nursing Commission, upon a finding that a license holder or applicant has committed unprofessional conduct or is unable to practice with reasonable skill and safety due to a physical or mental condition, may issue an order taking action against a license holder or applicant.

The Commission has determined that it is the best interest of license holders, applicants and the public to adopt "Sanction Standards" for common violations.

Procedure

A Reviewing Commission Member (RCM), Case Review Panels and Hearing Panels will utilize Commission-approved Sanction Standards to determine sanctions.

The RCM or Panel will document the rationale for deviation from the Sanction Standards in the Disciplinary Worksheet.

Washington State Nursing Care Quality Assurance Commission

Sanction Standards for Charging Licensees With Violations Involving Documentation Errors

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Time for Completion
I. Documentation Errors - 1 - 2 Times Only Within Short Time Period, *i.e.*, Over 1-2 Shifts	Risk of Recurrence See appendix for list of aggravating and mitigating factors.	(A) No or Minimal Patient Harm or Low Risk of Harm	Close case NOC SOA	N/A N/A 0-3 yrs	N/A N/A Cost Recovery	N/A	N/A
II. Pre-Charting Procedures or Medications	Risk of Recurrence See appendix for more aggravating and mitigating factors.	(A) No or Minimal Patient Harm or Low Risk of Harm	SOA/STID	0-3 yrs Until successful completion of coursework	Cost Recovery $250-500	1. 6 Contact hour course in Documentation 2. Obtain passing score 3. Submit course evaluation for approval	1. 90 days 2. 90 days 3.120 days
III. Falsification of Records **Deliberate changing or falsification of documentation to cover up error** One or more of the following: • Documenting care not provided • Charting incorrect patient condition • Changing charting to cover up practitioner error or omission	Risk of Recurrence Likely Cause(s) of Error: • Lack of fiduciary concern • Error in performance of procedure or intervention • Poor judgment See appendix for more aggravating and mitigating factors.	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	↑ Fine/Cost Recovery $750 to $1000 per violation ↓	1. 24 Contact hour Documentation course 2. Obtain passing score 3. Submit course evaluation for approval 4. 12 Contact hour Nursing Ethics course 5. Obtain passing score 6. Submit evaluation for approval 7. Notification to current & future employers 8. Employer reports-quarterly 9. Direct RN supervision 10. No employment with an agency, home health, hospice, community care settings 11. Request modification	1. 120 days 2. 120 days 3. 150 days 4. 90 days 5. 90 days 6. 120 days 7. Duration 8. Duration 9. Unless modified 10. Unless modified 11. 12-24

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Time for Completion
							months
IV - VI Relate to Documentation of Patient Assessment & Observations							
IV. Developing Pattern Of Documentation Errors and/or Omissions *Related To Patient Assessment & Observations* 2 to 4 of the following type(s): ◦ Missing assessment ◦ Inappropriate or inaccurate assessment ◦ Lack of attentiveness to changing condition ◦ Failure to recognize signs & symptoms	Risk of Recurrence Likely Cause(s) of Error: • Inappropriate clinical judgment • Lack of time management skill & organizational ability *Consider individual practice responsibility and system influence and nurse's demonstration of experiential learning* See appendix for more aggravating and mitigating factors.	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Cost Recovery $250-500	1. 24 Contact hour course in Patient Assessment including appropriate language on documentation 2. Obtain passing score 3. Submit course evaluation for approval	1. 120 days 2. 120 days 3. 150 days

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Time for Completion
V. Established Pattern Of Documentation Errors and/or Omissions of Essential Patient Information ***Related To Patient Assessment & Observations*** Errors/Omissions of the following type(s): • Missing assessment • Inappropriate or inaccurate assessment • Lack of attentiveness to changing condition • Failure to recognize signs & symptoms • Failure to document patient deterioration, pain, agitation or other signs of complications or reaction to illness or therapies	Likely Cause(s) of Error: • Practitioner lacked adequate knowledge or competence • Lack of time management skill & organizational ability • Inappropriate clinical judgment • Disregard for patient safety & well being *Consider individual practice responsibility and system influence and nurse's demonstration of experiential learning* See appendix for more aggravating and mitigating factors.	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Fine/Cost Recovery $250 to $500 per violation	1. 24 Contact hour course in Patient Assessment including documentation 2. Obtain passing score 3. Submit course evaluation for approval 4. Worksite monitor to provide 40 hours of oversight of assessment & documentation 5. Notice to current & future employers 6. Employer reports quarterly 7. Request modification	1. 120 days 2. 120 days 3. 150 days 4. 160 days 5. Duration 6. Duration 7. 12 -18 months

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Time for Completion
VI. Significant Error(s) In Documentation of Essential Patient Information *Related To Patient Assessment & Observations with* One or more of the following type(s): • Missing or inaccurate assessment • Lack of attentiveness • Failure to recognize signs & symptoms • Failure to document patient deterioration, pain, agitation or other signs of complications or reaction to illness or therapies	Risk of Recurrence Likely Cause(s) of Error: • Practitioner lacked adequate knowledge or competence • Inappropriate clinical judgment • Disregard for patient safety & well being • Lack of attentiveness or surveillance *Consider individual practice responsibility and system influence and nurse's demonstration of experiential learning* See appendix for more aggravating and mitigating factors.	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Patient Harm or Death	$OA/SOC $OA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Fine $500 to $1000 per violation	1. 24 Contact hour course in Patient Assessment including documentation 2. Obtain passing score 3. Submit course evaluation for approval 4. Notice to current & future employers 5. Employer reports quarterly 6. Indirect supervision 7. Worksite monitor to provide 40 hours of oversight of assessment & documentation 8. No employment with agency, home health, hospice community based care settings 9. Request modification	1. 120 days 2. 120 days 3. 150 days 4. Duration 5. Duration 6. Duration 7. 160 days 8. Unless modified 9. 18 to 24 months

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Time for Completion
VII & VIII Relate to Documentation of Medication Administration, Procedures and Treatments							
VII. Developing Pattern Of Errors and/or Omissions In Documentation ***Related To Medication Administration, Procedures & Treatments*** 2-4 of the following types: • Missed medications &/or treatments • Misrepresentation of patient's condition • Failure to document care that has been provided	Risk of Recurrence Likely cause(s) of Error: • Failure to follow agency policy • Lack of adequate knowledge or competence • Disregard for patient safety & well being *Consider individual practice responsibility and system influence and nurse's demonstration of experiential learning* *See appendix for more aggravating and mitigating factors.*	**(A)** No or Minimal Patient Harm or Low Risk of Harm **(B)** Patient Harm or Risk of Severe Patient Harm **(C)** Severe Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Cost Recovery $250 to 500	1. 24 hr. Documentation class 2. Obtain passing score 3. Submit course evaluation for approval	1.120 days 2. 120 days 3. 150 days

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Time for Completion
VIII. Established Pattern of Errors and/or Omissions in Documentation *Related To Medication Administration, Procedures & Treatment* 5 or more of the following type(s): ◦ Missed medications &/or treatments ◦ Misrepresentation of patient's condition ◦ Failure to document care that has been provided	Risk of Recurrence Likely cause(s) of Error: ◦ Failure to follow agency policy ◦ Lack of adequate knowledge or competence ◦ Disregard for patient safety & well being ◦ Poor judgment *Consider individual practice responsibility and system influence and nurse's demonstration of experiential learning* *See appendix for more aggravating and mitigating factors.*	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Patient Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Fine/Cost Recovery $250 to $750 per violation	1. 24 hr. Documentation class 2. Obtain passing score 3. Submit course evaluation for approval 4. Notice to current & future employers 5.Employer reports quarterly 6. Indirect supervision 7. Worksite monitor to provide 40 hours of oversight of documentation 8. Request modification	1.120 days 2. 120 days 3. 150 days 4. Duration 5. Duration 6. Duration 7. 180 days 8. 12-24 months

Reference:
Benner, Patricia, PhD, RN, FAAN, Vickie Sheets, JD, RN, et al, Individual, Practice, and System Causes of Errors in Nursing - A Taxonomy, JONA Vol. 32, No., 10, October 2002.

Individual practice responsibility may include factors such as knowledge, competence, judgment, thoroughness.

System contributions & issues may include level of orientation and education provided; policies, procedures and systems in place including prescribing, order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use

Washington State Nursing Care Quality Assurance Commission

Sanction Standards for Charging Licensees For Violations Involving Failure to Assess and/or Intervene on the Patient's Behalf

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Timeline for Completion
I. Failure To Assess and/or Intervene On The Patient's Behalf *Error(s) of the following type:* • ***Failure to promptly assess*** • ***Failure to adequately assess*** • ***Failure to recognize &/or detect signs & symptoms*** • ***Faulty intervention*** • ***Failure to call for assistance*** • ***Failure to notify physician or other provider*** • ***Failure to properly initiate CPR***	Risk of Recurrence Likely Cause(s) of Error/Omission: • Lack of attentiveness • Inadequate clinical judgment • Faulty logic due to use of rote action • Lack of appropriate priorities • Poor or faulty monitoring • Lack of agency/ fiduciary concern *Consider individual practice responsibility and system influence and nurse's demonstration of experiential learning* See appendix for more aggravating and mitigating factors.	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Fine $750 to $1000 per violation	***1. 24 Contact hour course on Patient Assessment, obtain passing score, submit evaluative data*** 2. 6 Contact hour course on Nursing Ethics, obtain passing score, submit evaluative data 3. Notice to current & future Employers 4. Commission permission for Employment 5. No employment in temporary agency, home health, hospice or community-based agency 6. Employer reports addressing clinical judgment & decision-making ability - quarterly 7. Personal reports - quarterly 8. Indirect RN supervision, No charge or supervisory responsibilities 9. Request Modification	1. 120 days 2. 90 days 3. Duration 4. Unless modified 5. Duration 6. Duration 7. If working as nurse 8. Unless modified 9. 12 - 24 months

II. Failure to Recognize Risk Factors And Implement Prevention Techniques To Avoid Predictable, Preventable Condition(s) Existence Of A Preventable Condition Including Decubiti, Stasis Pneumonia, Incidence Of Falls *Errors or Omissions of the following type:* • Failure to anticipate and/or recognize risk factors • Failure to implement prevention techniques to reduce patient risk • Faulty intervention • Breach of infection precautions • Failure to recognize equipment failure	Risk of Recurrence Likely Cause(s) of Error/Omission: • Lack of attentiveness • Inadequate clinical judgment • Lack of appropriate priorities • Poor or faulty monitoring • Lack of evaluation of patient response to therapy • Failure to evaluate effectiveness of intervention *Consider individual practice responsibility and system influence and nurse's demonstration of experiential learning* See appendix for more aggravating and mitigating factors.	No or Minimal Patient Harm or Low Risk of Harm Patient Harm or Risk of Severe Patient Harm Severe Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Fine $500 to $1000 per violation	***1. 24 Contact hour course on Patient Assessment, obtain passing score, submit evaluative data*** 2. 6 Contact hour course on Patient Safety, obtain passing score, submit evaluative data 3. Notice to current & future Employers 4. No employment in temporary agency, home health, hospice or community-based agency 5. Employer reports addressing clinical judgment & decision-making ability - quarterly 6. Personal reports - quarterly 7. Indirect RN supervision, No charge or supervisory responsibilities 8. Request Modification	1. 120 days 2. 90 days 3. Duration 4. Duration 5. Duration 6. If working as nurse 7. Unless modified 8. 12 months

Reference:
Benner, Patricia, PhD, RN, FAAN, Vickie Sheets, JD, RN, et al, Individual, Practice, and System Causes of Errors in Nursing - A Taxonomy, JONA Vol. 32, No., 10, October 2002.

Individual practice responsibility may include factors such as knowledge, competence, judgment, thoroughness.

System contributions & issues may include level of orientation and education provided; policies, procedures and systems in place including prescribing, order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration, education; monitoring; and use.

Sanction Standards for Charging Licensees For Violations Involving Medication Errors

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Timeline for Completion
I. Practice of Pre-Pouring and/or Pre-Charting Medications	Risk of Recurrence **Likely Cause of Practitioner Error** • Lack of knowledge of nursing standards • Failure to follow agency policy See appendix for more aggravating and mitigating factors.	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Patient Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Cost Recovery $250 - 500	1. 6 Contact hour course in Time Management 2. Obtain passing score 3. Submit course evaluation for approval	1. 90 days 2. 90 days 3. 120 days
II. Developing Pattern of Medication Errors 2 to 5 Errors of the Following Type(s): • Missed dose(s) • Wrong time • Wrong dose • Wrong frequency • Wrong IV rate - wrong dose	Risk of Recurrence Likely Cause of Practitioner Error: - Failure to follow 6 "rights" for safe medication administration - Lack of time management skill & organizational ability *Consider individual practice responsibility and system influence and nurse's demonstration of experiential learning.* See appendix for more aggravating and mitigating factors.	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Cost Recovery $100 - 250 per violation	1. 60 Contact hour course in Safe Medication Administration, including a minimum of 20 hours of theory and 40 hours of RN supervised medication administration. 2. Obtain passing score 3. Submit course evaluation for approval 4. 6 Contact hour course in time management at RCM discretion	1. 90 days 2. 90 days 3. 120 days 4. RCM discretion

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Timeline for Completion
III. Established Pattern Of Medication Errors 6 or More Errors of the Following Type(s): • Missed dose(s) • Wrong time • Wrong dose • Wrong frequency • Wrong IV rate delivering wrong dose	Risk of Recurrence Likely Cause of Practitioner Error: • Failure to follow 6 "rights" for safe medication administration • Lack of time management skill & organizational ability *Consider individual practice responsibility and system influence and nurse's demonstration of experiential learning* See appendix for more aggravating and mitigating factors.	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Fine $250 to $500 per violation	1. 60 Contact hour course in Safe Medication Administration, including a minimum of 20 hours of theory and 40 hours of RN supervised medication administration. 2. Obtain passing score 3. Submit course evaluation for approval 4. Current & future employer notification & reports 5. Worksite monitor to provide additional 40-120 hours supervision of medication administration (If licensee is an LPN, an LPN may provide supervision) 6. 6 Contact hour course in time management at RCM discretion 7. Request Modification	1. 90 days 2. 90 days 3. 120 days 4. Quarterly unless modified 5. 6-9 months 6. RCM discretion 7. 12 months

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Timeline for Completion
IV. Pattern of Medication Errors 2 or More Errors of the Following Type(s): • Wrong IV rate delivering wrong dose of medication • Wrong concentration or dosage of medication delivered IV • Wrong route • Wrong medication • Wrong dose • Wrong medication due to misidentifying the patient	Risk of Recurrence Likely Cause of Practitioner Error: • Failure to follow 6 "rights" for safe medication administration • Lack of adequate knowledge or competence for administering medication • Disregard for patient safety & well being *Consider individual practice responsibility and system influence* *Consider nurse's demonstration of experiential learning* *See appendix for more aggravating and mitigating factors.*	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Fine $ 500 to $1000 per violation	1. 60 Contact hour course in Safe Medication Administration, including a minimum of 20 hours of theory and 40 hours of RN supervised medication administration. 2. Obtain a passing score 3. Submit course evaluation 4. Current and future employer notification & employer reports quarterly 5. Commission approval for employment 6. No charge, floating, agency, home health, hospice, etc. 7. Worksite monitor to provide additional 40 -120 hours supervision of medication administration (If licensee is an LPN, an LPN may provide supervision) 8. Indirect RN supervision 9. Request Modification	1. 90days 2. 90 days 3. 120 days 4. Quarterly unless modified 5. Unless modified 6. Unless modified 7. 6 to 9 months 8. Unless modified 9. 12 to 24 months

Individual practice responsibility may include factors such as knowledge, competence, judgment, thoroughness, attentiveness.

System influence and contributing factors may include orientation and education provided; policies, procedures and systems in place including prescribing, order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration, education; monitoring; and use.

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	Cost Recovery or Fine	Conditions	Timeline for Completion
V. Single Significant Medication Error Type of Error: • Wrong concentration or dosage of medication delivered IV • Wrong route • Wrong medication • Wrong dose • Wrong medication due to misidentifying patient	Likelihood of Recurrence Low → Serious Risk to Future Patients Low → Serious Likely Cause(s) of Practitioner Error: - Medication with similar name or packaging - Medication not commonly used - Patient allergic - Missed/Mistaken Physician Order - Practitioner lacked adequate knowledge or competence for administering medication - Medication required testing to ensure proper therapeutic levels - Inadequate or inaccurate patient assessment - Inappropriate clinical judgment Potential System Contributor(s): - High-alert medication with no system controls to monitor or prevent error *Consider individual practice responsibility and system influence and nurse's demonstration of experiential learning.* *See appendix for more aggravating and mitigating factors.*	(A) No or Minimal Patient Harm or Low Risk of Harm (B) Patient Harm or Risk of Severe Patient Harm (C) Severe Harm or Death	SOA/SOC SOA/SOC SOC	0-3 yrs 2-5 yrs 3 yr Minimum	Fine $500 to 1000	1. 60 Contact hour course in Safe Medication Administration, including a minimum of 20 hours of theory and 40 hours of RN supervised medication administration. 2. Obtain a passing score 3.Submit course evaluation 4. Worksite monitor to provide additional 20 -60 hours supervision of medication administration (If licensee is an LPN, an LPN may provide supervision) 5. Direct RN Supervision 6. Current and future employer notification, worksite monitor, employer reports quarterly 7. Commission approval for employment 8. Request Modification 9. No charge, floating, agency, home health, hospice, etc.	1. 90 days 2. 90 days 3. 120 days 4. 120-150 days 5. Until supervised med admin complete 6. Quarterly unless modified 7. Duration 8. 12-24 months 9. Duration

Reference: Benner, Patricia, PhD, RN, FAAN, Vickie Sheets, JD, RN, et al. Individual, Practice, and System Causes of Errors in Nursing - A Taxonomy, JONA Vol. 32, No., 10, October 2002. Approvals: Discipline Subcommittee - April 2, 2003

Washington State Nursing Care Quality Assurance Commission

Sanction Standards for Charging Respondents For Failure to Comply with the Conditions of an Order

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	New Fine	Conditions	Timeline for Completion
I. Failure To Comply With Any Terms(s) Or Condition(s) Of One STID or Order Related To Diversion Or Substance Abuse Not Eligible For WHPS	N/A	N/A	SOC	Indefinite suspension (2 yr min) w/ opportunity for modification	$750 - $1000 per violation	1. Complete prior to seeking modification: a. Substance Abuse evaluation by a Commission approved evaluator b. Submit evidence of 12 or more most recent consecutive months of being clean and sober, evidenced by: i. Biological fluid testing ii. AA or NA attendance 3. Appear before the Commission 4. New conditions determined by Hearing Panel 5. Fine Paid	1. a. Within 60 days of petition for modification b. i. 24 tests/12 months ii. 2/week/12 months 4. Prior to seeking modification
II. Failure To Comply With Any Substantive Term(s) Or Condition(s) Any One STID or Order	N/A	N/A	SOG	Indefinite Suspension Until Compliance	$250 - 500 per violation	1. Complete all conditions in original STID: ***2. BEFORE stay is granted: license stamped probation, education classes, papers, implement employment restrictions*** 3. New Classes: Legal Issues in Nursing, Nursing Ethics, 6 hours each; submit evaluative reports 4. Fine paid	1. Per STID timelines 2. Probation following completion 3.90 days 4. 90 days
III. Failure to Comply with a technical, non remedial requirement in a prior order or STID. (Cost Recovery or Fine)	N/A	N/A	Refer to Collections	N/A			

Description of Violation	Aggravating & Mitigating Factors	Harm (Tier)	Charge	Duration of Sanction	New Fine	Conditions	Timeline for Completion
IV. Failure to Comply with a substantive requirement in a prior order or STID with serious physical injury or death or with additional unprofessional conduct	N/A	N/A	SOC w/ possible Summary Suspension	Indefinite Suspension until Compliance or Revocation w/ a Minimum of 5 yrs			

APPENDIX

Washington State Nursing Care Quality Assurance Commission

Aggravating and mitigating factors. The following nonexclusive list identifies factors that may mitigate or aggravate the sanctions that should be imposed in an order or stipulation to informal disposition.

(1) Factors related to the misconduct:

(a) Gravity of the misconduct;

(b) Age, capacity and/or vulnerability of the patient, client or victim;

(c) Number or frequency of the acts of misconduct;

(d) Injury caused by the misconduct;

(e) Potential for injury to be caused by the misconduct;

(f) Degree of responsibility for the outcome;

(g) Abuse of trust;

(h) Intentional or inadvertent act(s);

(i) Motivation is criminal, immoral, dishonest or for personal gain;

(j) Length of time since the misconduct occurred.

(2) Factors related to the license holder:

(a) Experience in practice;

(b) Past disciplinary record;

(c) Previous character;

(d) Mental and/or physical health;

(e) Personal circumstances;

(f) Personal problems having a nexus with the misconduct.

(3) Factors related to the disciplinary process:

(a) Admission of key facts;

(b) Full and free disclosure to the disciplining authority;

(c) Voluntary restitution or other remedial action;

(d) Bad faith obstruction of the investigation or discipline process or proceedings;

(e) False evidence, statements or deceptive practices during the investigation or discipline process or proceedings;

(f) Remorse or awareness that the conduct was wrong;

(g) Impact on the patient, client, or victim.

(4) General factors:

(a) License holder's knowledge, intent, and degree of responsibility;

(b) Presence or pattern of other violations;

(c) Present moral fitness of the license holder;

(d) Potential for successful rehabilitation;

(e) Present competence to practice;

(f) Dishonest or selfish motives;

(g) Illegal conduct;

(h) Heinousness of the misconduct;

(i) Ill repute upon the profession;

(j) Isolated incident unlikely to reoccur.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HUMAN RESEARCH REVIEW SECTION
P.O. Box 45205 ● Olympia, Washington 98504-5205 ● 360.902.8075 ● wsirb@dshs.wa.gov

June 12, 2012

Paula R. Meyer, M.S.N., R.N.
Susan Wong, R.N., M.B.A., M.P.A.
Department of Health
P.O. Box 47864
Olympia, Washington 98504-7864

Re: DOH Exempt Request E-060512-H: "Governance Structure of State Boards of Nursing and Effect on Performance"

Dear Ms. Meyer and Ms. Wong:

I have reviewed your Exempt Determination Request for the activity identified above. I understand that you intend to compare the regulatory performance outcomes of four boards of nursing.

As described in the materials submitted, this activity is involves the collection of existing data that is publicly available. This research is considered exempt; therefore it does not require review by the Washington State Institutional Review Board. Please promptly inform us if data collected for this activity would later be used for research purposes, or if the activity is changed in a manner that might jeopardize this determination. Thank you for submitting your plans for review.

Sincerely,

Lilly Moneer
Compliance Coordinator

cc: Washington State Institutional Review Board

Governance Structure of State Boards of Nursing and Effect on Performance

Paula R. Meyer, MSN, RN
Susan Wong, RN, MBA, MPA

Institute of Regulatory Excellence
National Council of State Boards of Nursing

Memorandum of Understanding

As the executive director for the Arizona board of nursing, I agree to share the NCSBN Commitment to Ongoing Regulatory Excellence data for the sole purposes of this research study.

The research is a comparison of selective outcomes of four boards of nursing. The study proposes the null hypothesis: there is no significant difference in the performance outcomes of four boards of nursing based on their governance structure. There are no human subjects in the study. All data used is public domain.

Attached are the data collection tools to compare select measures from the CORE data. The researchers will share preliminary and final data comparisons with each state. A systematic approach will be used to collect and compare the data and test for significance. The projects will contribute to general knowledge on the performance of state boards of nursing. The results will be compiled and submitted for publishing in a peer reviewed journal, The Journal of Nursing Regulation.

The final report will be presented to the Washington State Nursing Care Quality Assurance Commission. The final report will be given to the Governor of Washington, Christine Gregoire. The final report will be given to legislative committees, especially the House of Representatives Health Care and Wellness Commission and Senate Health and Long Term Care Committee. The final report will be a public document once adopted by the Nursing Commission at their November business meeting.

At any time, you feel you do not care to share your state board of nursing date, or do not want the data to be published, you may contact the researchers at:

Ms. Paula R. Meyer, MSN, RN
Executive Director
Nursing Care Quality Assurance Commission
PO Box 47864
Olympia WA 98504-7864

Your signature below confirms your consent to share your state board of nursing's CORE data and willingness to contribute to the published results.

Signature	Jurisdiction	Date
J. Rideaux	Arizona	8/14/2012

Governance Structure of State Boards of Nursing and Effect on Performance

Paula R. Meyer, MSN, RN
Susan Wong, RN, MBA, MPA

Institute of Regulatory Excellence
National Council of State Boards of Nursing

Memorandum of Understanding

As the executive director for the North Carolina board of nursing, I agree to share the NCSBN Commitment to Ongoing Regulatory Excellence data for the sole purposes of this research study.

The research is a comparison of selective outcomes of four boards of nursing. The study proposes the null hypothesis: there is no significant difference in the performance outcomes of four boards of nursing based on their governance structure. There are no human subjects in the study. All data used is public domain.

Attached are the data collection tools to compare select measures from the CORE data. The researchers will share preliminary and final data comparisons with each state. A systematic approach will be used to collect and compare the data and test for significance. The projects will contribute to general knowledge on the performance of state boards of nursing. The results will be compiled and submitted for publishing in a peer reviewed journal, The Journal of Nursing Regulation.

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At any time, you feel you do not care to share your state board of nursing date, or do not want the data to be published, you may contact the researchers at:

Ms. Paula R. Meyer, MSN, RN
Executive Director
Nursing Care Quality Assurance Commission
PO Box 47864
Olympia WA 98504-7864

Your signature below confirms your consent to share your state board of nursing's CORE data and willingness to contribute to the published results.

John L. Runyan — Signature
North Carolina — Jurisdiction
8/16/12 — Date

Appendix D

STATE OF WASHINGTON

DEPARTMENT OF HEALTH
Nursing Care Quality Assurance Commission
P.O. Box 47864
Olympia, WA 98504-7864

Nursing Care Quality Assurance Commission
Discipline Staffing Decision Package 2009

While the majority of nurses in Washington practice safely, a number of nurses do not. Investigating the highest priority cases caused a backlog of lower priority investigations, including complaints of substance abuse. On July 1, 2009, 42% of our backlog of investigations involved substance abuse or drug diversion. This translates to over 200 nurses with allegations of substance abuse or drug diversion whose investigations are delayed. An increase in the number of nursing graduates and applicants produced an increase in investigations due to positive criminal background checks and personal data questions.

Disciplinary action removes unfit nurses and brings unskilled nurses to a higher level of safe practice through monitoring, education and supervision. By intervening when issues are initially identified, the Nursing Care Quality Assurance Commission (NCQAC) prevents future practice issues. Delays in discipline result in unsafe or unskilled nurses continuing to practice.

Due to budget constraints and limited increases in staffing, the NCQAC prioritized work to focus on complaints alleging the most serious unprofessional conduct. For the 2007-2009 biennium, the Nursing Commission served eight summary suspensions and 48 mandatory summary suspensions. The emphasis on the highest priority cases comes at the expense of a growing backlog of lower priority cases including nurses with allegations of substance abuse.

As more cases are investigated, the number of cases requiring legal review and further disciplinary action increase. The staffing formula identifies the number of staff necessary to meet the increasing disciplinary workload. The initial formula predicted a 7.75 percent caseload growth factor. Without additional resources, more cases will exceed disciplinary timelines and the backlog will continue to grow. Delays in resolving complaints directly impacts patient safety.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Nursing Care Quality Assurance Commission
P.O. Box 47864
Olympia, WA 98504-7864

Nursing Care Quality Assurance Commission
Licensing Decision Package 2009

In 2007, the number of nursing applications increased 12%. In 2008, the number of nursing applications increased another 20%. The nursing application process ensures quality nurses for public safety and increases health care access by getting qualified nurses licensed as quickly as possible.

Public protection is ensured in the review process through assessment of all credentials and criminal background checks on all nursing applicants applying for licensure to work in Washington. A pilot project using FBI background checks necessitated issuing Temporary Practice Permits to allow applicants meeting requirements to work while waiting for FBI results. While meeting workplace demands, this increased the workload for the licensing staff. Delays in issuing licenses to qualified nurses results in decreased access to health care for the citizens of Washington State. Nurses are the backbone of the health care delivery system. Having fewer nurses can result in increased medical errors and jeopardizing patient safety.

The Department of Health implemented a new computer system in February 2008. It successfully meets the agency's goal to separate the revenue, assessment and approval functions for licensing processes. The State Auditor required this separation, as did the Department of Health Performance Audit. The agency's internal auditor required the separate revenue function in the new computer system to meet this requirement. This separation of duties takes additional staffing to perform. In the mean time, the number of applicants has increased due to a nursing shortage and the schools' ability to increase the number of graduating students.

NCQAC anticipates the student applications to continue to increase in the next biennium based on current school enrolment figures. Additional staff is needed to process applications, coordinate discipline review, approval or denial steps and answer practice related questions. Timely licensure of qualified nurses and health care access for citizens depends on Nursing Commission Unit staffing.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Nursing Care Quality Assurance Commission
P.O. Box 47864
Olympia, WA 98504-7864

Health Systems Quality Assurance
Preventing Impaired Practice
Washington Health Professionals Services

Substance abuse and drug diversion by nurses is a significant threat to public health and safety. The traditional discipline process takes from six to 14 months to remove an impaired nurse from practice. It takes the Washington Health Professional Services program 24 to 48 hours from getting a referral to removing or restricting the licensee's practice. The program supports patient safety by providing effective, accountable monitoring rather than suspending or revoking a license, which allows licensed health professionals to safely return to practice. The Nursing Commission supports the Department of Health's request for necessary resources to keep pace with increased workload.

There are currently seven full-time employees working in the WHPS program with a caseload over 400 open cases and nearly 80 cases in development. Additional staff is required to keep up with the increase in caseload. This program is vital to the agency, since it allows nurses to safely return to practice while being monitored. This monitoring includes compliance with substance abuse treatment recommendations, individual therapy, drug screening, worksite monitoring, participation in professional peer support groups, and ongoing recovery programs.

With increasing evidence of the nursing shortage, monitoring is an important component of patient safety, because it helps to assure access to care throughout the state. Monitoring provides an assurance of patient safety for providers who otherwise might be barred from practice. Continued monitoring (typically over a five year period) assures safe practice.
While the program averages 47 new cases each month, only eight or ten participants graduate each month after completing all requirements. Another eight participants are referred to the nursing commission for failure to comply with the monitoring agreement. Of all the investigations with nursing, 42% are related to substance abuse or drug diversion.

Appendix E

2012

WASHINGTON

NCSBN
Leading in Nursing Regulation

Board of Nursing Survey

Part I: Licensure

How many applications for nursing licensure were received in FY2012?

1. Initial Exam: 4234
2. Endorsement: 4969
3. Renewal: N/A

4. What percentage of **initial** nursing licenses are processed online?

0 %

5. What percentage of nursing licensure **renewals** are processed online?

0 %

During FY2012, what was the average length of time in days it took to process applications for nurse licensure **from receipt of all required information to authorization of license**? Exclude disciplinary and/or unusual situations.

6. Nurse licensure by initial examination: 1 day
7. Nurse licensure by endorsement: 1 day
8. Nurse licensure by renewal: N/A

9. Do you perform audits of your nurse licensure process?

X Yes

☐ No

Over ▸

Part II: Education

10. Does your Board of Nursing approve nursing educational programs?

XYes

☐ No *(Go to Question 12)*

11. What is the total number of approved nursing education programs at the end of FY2012?

Total: 40

What is the status of all nursing education programs at the end of FY 2012?

12. Number of education programs with initial approval: 2

13. Number of education programs with full approval: 38

14. Number of education programs with conditional approval: 5

15. Other (*Specify*):

How many nursing education program decisions were made in FY2012?

16. Number of programs received initial approval in FY2012: 1

17. Number of programs received full approval in FY2012: 0

18. Number of programs received conditional approval in FY2012: 5

19. Number of programs had their approval withdrawn in FY2012: 0

20. Number of programs were denied initial approval in FY2012: 1

21. Other (*Specify*)

22. How many nursing education program applications were pending at the end of FY2012?

Total: 3

Over ▸

Part III: Discipline

22. How many new complaints were received in FY2012? 1,714

23. How many of these complaints were closed without action?: 1,103

24. How many cases were assigned to investigations? 611

How many investigative cases were resolved by the Board of Nursing in FY2012?

25. With disciplinary action: 231

26. With non-disciplinary action: 18

27. Closed without action: Not Available

28. Of the cases brought to resolution by the Board of Nursing in FY2012, what was the average number of calendar days between receipt of the cases/complaint to resolution of the case/complaint?

Total number of days: Non disciplinary action only

Of the cases brought to resolution by the Board of Nursing in FY2012, how many had been open for:

	Non disciplinary action only
29. 4 months or less:	
30. 5 – 6 months:	
31. 7 – 12 months:	
32. 13 – 18 months:	
33. 19 – 24 months:	
34. Over 24 months:	

35. How many formal hearings were conducted by the Board of Nursing or by the Administrative Law Judge in FY2012?

Formal Hearings: 9

36. What was the length of time in days from opening investigation to resolution of these cases?

Days: Between 207 – 1,569 days. Average = 801 days.

Over ▶

How many cases were appealed during:

37. FY2012: 2

38. FY2011: 1

During FY2011, how many appeals were:

39. Remanded: 0

40. Overturned: 0

41. Upheld: 0

During FY2012, how many appeals were:

42. Remanded: 0

43. Overturned: 1

44. Upheld: 0

Does staff have delegated authority by the Board of Nursing policy to:

	Yes	No
44. Triage/prioritize complaints	☐	☒X
45. Close complaints	☐	☒X
46. Resolve discipline cases	☐	☒X
47. Propose settlements	☐	☒X
48. Other (*specify*):		

Over ▶

Part IV: Administrative

Please enter the number of full-time equivalent (FTEs) staff. An FTE of 1.0 means that the person is equivalent to a full-time worker, while an FTE of 0.5 signals that the worker is only half-time:

Number of FTEs involved in **Nursing Practice** Issues who are…

49. Nurses: *3.5*
50. Other (*Specify*) 0:

Number of FTEs involved in the **licensure process** who are…

51. Managers: *1*
52. Licensing Staff: 9.4
53. Other (*Specify*):

Number of FTEs involved in the **education program approval and monitoring process** who are…

54. Education Consultant/Manager: *1*
55. Administrative Staff: *1*
56. Contract Personnel: *0*
57. Other (*Specify*): *Pro tem commission member paid for nursing assistant training program investigations.*

Number of FTEs involved in the **investigative process** that are Board of Nursing employees who are…

58. Nurses: *5*
59. Not Nurses: *6*
60. Administrative Support Staff: *1*
61. Attorney (who are not investigators): *0*
62. Other (*Specify*): *0*

63. Number of FTEs involved in **investigative process** that are **contracted personnel**, not employed by the Board of Nursing: 0

Over ▸

Part V: Budget

FY2012 Budget Worksheet

This worksheet is provided so that costs will be uniformly reported. Because we want to be able to calculate variables such as "cost per complaint handled" and compare the costs of the work of the board by staffing patterns, we are requesting you use this worksheet to calculate your costs.

Please indicate expenses for the following budget items. Adding the total expenses for all items should match your total FY2012 expenditures. **When a member of the Board staff contributes to more than one category, please allocate a proportion of their salary among the appropriate times.**

Note: Please do not include one-time capital expenditures or expenses related to the regulation of Certified Nursing Assistants (CNAs) or other Assistive Personnel in any of the following categories.

****If you are unable to answer a question or are not sure of the exact value, please leave the question blank, as approximations will alter the results and the integrity of the data.**

64. The Board's total fiscal year 2012 expenditures (excluding capital expenditures)	7,603,297
Discipline/Complaint Handling	
65. Total salaries (including fringe) of board staff in discipline/complaint handling: NCQAC Discipline = 240,077; Division complaint intake = 13,587	353,664
66. Attorney (non board staff) fees: Staff attorneys = 697,250; AAGs = 490,303	1,187,553
67. Investigator (non board staff) fees: NCQAC investigators = 884,198; HP Investigations centralized = 27,108; Division investigations case management = 91,619	1,002,925
68. Hearing costs (including board expenses related to hearings): Judges = 148,659; Adjudicative Clerk Office = 84,206; travel = 5,295 ; commission payroll = 6,671; airfare = 624; rental cars =1,321; mileage reimbursement = 4,672	251,448
69. Expenses related to monitoring compliance with probation: one staff person salary + benefits.	55,511
70. Expenses related to alternative programs	500,807
71. Misc. expenses: Tort claims = 1,615, expert witnesses and testimony = 32,724, court reporters = 2,585, copies of medical records = 2,085, postage for mailing cases = 7,100, supplies = 110other contracts = 3,516.[Back out HIPD, WSP and court reporters from (C) and (ER).	49,735

	Over ▸
Licensure (including renewal)	
72. Total salaries (including fringe) of board staff involved in licensure [Does not include renewal expenses and staff]	432,640
73. Verification expenses	0
74. Expenses related to endorsement (excluding board staff salaries): Centralized federal background check.	152,205
75. Expenses related to examination (excluding board staff salaries): NCLEX contract = 3,000	3,000
76. Expenses related to renewal (excluding board staff salaries): Communications = 520; building rent = 5,432; travel = 159; equipment = 187; computers = 232; office relocation = 1,588	8,118
77. Other costs related to licensure Centralized call center = 157,354; Centralized revenue processing = 177,357; HIPDB = 48,689; Washington State Patrol = 13,327; supplies = 92;; building rent for licensing staff = 40,469; building rent for renewal staff = 5,432; renewal staff salaries and benefits = 60,497	503,217
Education Program Approval	
78. Total salaries (including fringe) of board staff involved in education program approval	161,986
79. Travel expenses related to education program approval	1,549
80. Expenses related to distribution of information and materials	2,536
81. Other costs related to approval of nursing programs: NPAP approval panel commission payroll = 11,078 ; NAPAP nursing assistant panel = 2,187; investigations of nursing assistant training programs = 15,359;	28,624
Practice	
80. Total salaries (including fringe) of board staff involved in practice activities: NCI positions and ARNP Practice	409,283
81. Other costs related to practice: travel for Debbie, Linda, Margaret, and Martha [Includes Chuck, Sam and Nancee for that same time period]	9,962
Operational Costs	
82. Postage and mailing expenses	508
83. Office supplies: Minus licensing <92>; minus investigations <110>	7,100

84. Rent: Building rent = 208,760 + room rental = 274 + lease = 1008 Minus renewals <5,432>; minus licensing <40,469>; minus investigations <52,149>	111,992
85. Maintenance on equipment	0
86. Data management expenses: On-line project = 122,960; Enterprise clearing for software = 6,679; Campus I.S. support = 50,766; Communications (phones, fax, blackberry, cell phones = 30,154; data processing 10,899;	221,458

Over ▶

Administrative Costs

87. Total salaries of Executive Officer and support staff (including support departments) not covered by previous categories	354,862
88. Board expenses (including payments such as per diem or for compensation to board members) not covered by previous categories (Minus <6,672> for hearings and minus <14,700> for NAPAP investigations.	142,155
89. Other administrative and indirect costs not covered by previous categories: Printing = 1,704; travel for board meetings and speaking engagements = 48,190 ; equipment = 13,487; other training = 4,282	67,663

90. **For any expenses not covered by this questionnaire, please list them here:**

Expense item	Amount
Centralized Public Disclosure	97,149
Agency management indirects	810,059
Assistant Secretary indirects	675,588

NCSBN
Leading in Nursing Regulation

ARIZONA

Board of Nursing Survey

Part I: Licensure

1. How many applications for nursing licensure were received in FY2012?

Initial Exam:	642 (LP) 2941 (RN) Total- 3,583
Endorsement:	355 (LP) 2,472 (RN) Total – 2,827
Renewal:	1837 (LP) 13,962 (RN) Total – 15,799

2. What percentage of **initial** nursing licenses are processed online?

none %

3. What percentage of nursing licensure **renewals** are processed online?

91 % in 2012 %

4. During FY2012, what was the average length of time in days it took to process applications for nurse licensure **from receipt of all required information to authorization of license**? Exclude disciplinary and/or unusual situations.

Nurse licensure by initial examination:	0.9 days or less than 1
Nurse licensure by endorsement: (Temp applicants usually have all the "required things" for temp lic when they submit, but it is reviewd scanned, verified, imported , NURSYS check, and then issued.)	Temp lic – 4 days Perm lic – 1.8 days
Nurse licensure by renewal:	Web & paper – less than 1 day.

5. Do you perform audits of your nurse licensure process?

   a. Yes

Over ▸

Part II: Education

6. Does your Board of Nursing approve nursing educational programs?

   a. **Yes**

7. What is the total number of approved nursing education programs at the end of FY2012?

   Total: 43

8. What is the status of all nursing education programs at the end of FY 2012?

Number of education programs with initial approval:	1
Number of education programs with full approval:	32
Number of education programs with conditional approval:	1 with probationary status and 2 with notice of deficiencies
Other (*Specify*):	Provisional - 7

9. How many nursing education program decisions were made in FY2012? 38

Number of programs received initial approval in FY2012:	1
Number of programs received full approval in FY2012:	2
Number of programs received conditional approval in FY2012:	NA
Number of programs had their approval withdrawn in FY2012:	0
Number of programs were denied initial approval in FY2012:	0
Other (*Specify*)	Renewal of approval - 5

10. How many nursing education program applications were pending at the end of FY2012?

    Total: 1 lifting probationary status and renewal of provisional approval

Over ▸

Part III: Discipline

11. How many new complaints were received in FY2012? 1839 (includes CANDO)

12. How many of these complaints were closed without action? : 819 (do not open cases)

13. How many cases were assigned to investigations? 1020 (investigative cases)

14. How many investigative cases were resolved by the Board of Nursing in FY2012?

With disciplinary action: (Includes unsuccessful CANDO c/o)	417 (cp, doc, prob, susp, and revocations)
With non-disciplinary action: (Includes successful CANDO c/o)	382 (dismisss, loc, case dispo. Summary loc, adm. Penalties)
Closed without action:	819

15. Of the cases brought to resolution by the Board of Nursing in FY2012, what was the average number of calendar days between receipt of the cases/complaint to resolution of the case/complaint?

Total number of days: 217 days

16. Of the cases brought to resolution by the Board of Nursing in FY2012, how many had been open for:

4 months or less:	180
4 - 6 months:	114
7 – 12 months:	245
13 - 18 months:	154
19 – 24 months:	69
Over 24 months:	37

17. How many formal hearings were conducted by the Board of Nursing or by the Administrative Law Judge in FY2012?

Formal Hearings: 18

18. What was the length of time in days from opening investigation to resolution of these cases?

Days: 9.4 months

Over ▸

19. How many cases were appealed during:

FY2012: 1

FY2011: 1

20. During **FY2011**, how many appeals were:

Remanded: 1

Overturned: 0

Upheld: 0

21. During **FY2012**, how many appeals were:

Remanded: 0

Overturned: 0

Upheld: 1

22. Does staff have delegated authority by the Board of Nursing policy to:

	Yes	No
Triage/prioritize complaints	X	☐
Close complaints	X	☐
Resolve discipline cases	X	☐
Propose settlements	X	☐

Other (*specify*): _____

Over ▶

Part IV: Administrative

Please enter the number of full-time equivalent (FTEs) staff. An FTE of 1.0 means that the person is equivalent to a full-time worker, while an FTE of 0.5 signals that the worker is only half-time:

23. Number of FTEs involved in **Nursing Practice** Issues who are...

Nurses: *A Nurse Practice Consultant is assigned to take the SOP questions each day. Usually they respond to 4-6 emails or phone calls per day and estimate about 15 minutes average per call/email. This would amount to approximately 375 hours per year or 0.2 FTE per year.*

Other (*Specify*): _____

24. Number of FTEs involved in the **licensure process** who are...

Managers: *Asso Dir of Op/Licensing – 0.6 FTE*

Licensing Staff: *6 exam tech FTE's*

Other (*Specify*): _____

25. Number of FTEs involved in the **education program approval and monitoring process** who are...

Education Consultant/Manager: *Asso Dir of Ed. - .5 FTE*

Administrative Staff: *Adm Assistant II – 1 FTE*

Contract Personnel: *0*

Other (*Specify*): *Ed Program administrator - 0.8 FTE*

26. Number of FTEs involved in the **investigative process** that are Board of Nursing employees who are...

Nurses: *NPC - 7.5 FTE*

Not Nurses: *Sr. Investigators – 10 FTE*

Administrative Support Staff: *8 FTE's*

Attorney (who are not investigators): *1.8 FTE*

Other (*Specify*): _____

27. Number of FTEs involved in **investigative process** that are **contracted personnel**, not employed by the Board of Nursing: 0

Over ▶

Part V: Budget

FY2012 Budget Worksheet

This worksheet is provided so that costs will be uniformly reported. Because we want to be able to calculate variables such as "cost per complaint handled" and compare the costs of the work of the board by staffing patterns, we are requesting you use this worksheet to calculate your costs.

Please indicate expenses for the following budget items. Adding the total expenses for all items should match your total FY2012 expenditures. **When a member of the Board staff contributes to more than one category, please allocate a proportion of their salary among the appropriate times.**

Note: Please do not include one-time capital expenditures or expenses related to the regulation of Certified Nursing Assistants (CNAs) or other Assistive Personnel in any of the following categories.

****If you are unable to answer a question or are not sure of the exact value, please leave the question blank, as approximations will alter the results and the integrity of the data.**

The Board's total fiscal year 2012 expenditures (excluding capital expenditures)	$3,801,358

Discipline/Complaint Handling

Total salaries (including fringe) of board staff in discipline/complaint handling	$1,819,073
Attorney (non board staff) fees	$246,617
Investigator (non board staff) fees	$1,230
Hearing costs (including board expenses related to hearings)	$54,548
Expenses related to monitoring compliance with probation	------
Expenses related to alternative programs	------
Misc. expenses	$41,103

Over ▸

Licensure (including renewal)

Total salaries (including fringe) of board staff involved in licensure	$401,294
Verification expenses	------
Expenses related to endorsement (excluding board staff salaries)	$1,116
Expenses related to examination (excluding board staff salaries)	$1,030
Expenses related to renewal (excluding board staff salaries)	$1,631

Other costs related to licensure	-------

Education Program Approval

Total salaries (including fringe) of board staff involved in education program approval	$192,404
Travel expenses related to education program approval	$417
Expenses related to distribution of information and materials	---------
Other costs related to approval of nursing programs	$62

Practice

Total salaries (including fringe) of board staff involved in practice activities	----------
Other costs related to practice	----------

Operational Costs

Postage and mailing expenses - *$51,100 was on account as we enter FY2012	$55, 408*
Office supplies	$11,500
Rent	$227,842
Maintenance on equipment	$11,138
Data management expenses	$57,757

Administrative Costs

Total salaries of Executive Officer and support staff (including support departments) not covered by previous categories	$534,195
Board expenses (including payments such as per diem or for compensation to board members) not covered by previous categories	$40,664
Other administrative and indirect costs not covered by previous categories	$102,327

For any expenses not covered by this questionnaire, please list them here:

Expense item	Amount

NORTH CAROLINA

NCSBN
Leading in Nursing Regulation

Board of Nursing Survey

Part I: Licensure

1. How many applications for nursing licensure were received in FY2012?

Initial Exam: 6151

Endorsement: 4949

Renewal: 64,730

2. What percentage of **initial** nursing licenses are processed online?

100 %

3. What percentage of nursing licensure **renewals** are processed online?

100 %

4. *During FY2012, what was the average length of time in days it took to process applications for nurse licensure* **from receipt of all required information to authorization of license**? Exclude disciplinary and/or unusual situations.

Nurse licensure by initial examination: 6

Nurse licensure by endorsement: 5

Nurse licensure by renewal: 1

5. Do you perform audits of your nurse licensure process?

(a.) Yes

b. No

Over ▸

Part II: Education

6. Does your Board of Nursing approve nursing educational programs?

   (a) Yes

   b. No *(Go to Question 12)*

7. What is the total number of approved nursing education programs at the end of FY2012?

   Total: 123

8. What is the status of all nursing education programs at the end of FY 2012?

   Number of education programs with initial approval: 10 (5 BSN; 5 ADN)

   Number of education programs with full approval: 110

   Number of education programs with conditional approval: 3

   Other (*Specify*): 0

9. How many nursing education program decisions were made in FY2012?

   Number of programs received initial approval in FY2012: 1

   Number of programs received full approval in FY2012: full renewal by survey 10 initial → full 5 total: 15

   Number of programs received conditional approval in FY2012: 2

   Number of programs had their approval withdrawn in FY2012: 0

   Number of programs were denied initial approval in FY2012: 0

   Other (*Specify*) 0

10. How many nursing education program applications were pending at the end of FY2012?

    Total: 1

Over ▸

Part III: Discipline

11. How many new complaints were received in FY2012? 1570

12. How many of these complaints were closed without action?: 641

13. How many cases were assigned to investigations? 652

14. How many investigative cases were resolved by the Board of Nursing in FY2012?

With disciplinary action: 139

With non-disciplinary action: 222

Closed without action: 95

15. *Of the cases brought to resolution by the Board of Nursing in FY2012, what was the average number of calendar days between receipt of the cases/complaint to resolution of the case/complaint?*

Total number of days: 70

16. Of the cases brought to resolution by the Board of Nursing in FY2012, how many had been open for:

4 months or less: 376

4 - 6 months: 40

7 – 12 months: 34

13 - 18 months: 9

19 – 24 months: 1

Over 24 months: 0

17. How many formal hearings were conducted by the Board of Nursing or by the Administrative Law Judge in FY2012?

Formal Hearings: 5 13 cases heard

18. What was the length of time in days from opening investigation to resolution of these cases?

Days: 13 Cases heard

range in days 37 days – 398 days for resolution

Over ▸

19. How many cases were appealed during:

FY2012: 0

FY2011: 3

20. During **FY2011**, how many appeals were:

Remanded: _____

Overturned: 2

Upheld: 1

21. During **FY2012**, how many appeals were:

Remanded: N/A

Overturned:

Upheld:

22. Does staff have delegated authority by the Board of Nursing policy to:

	Yes	No
Triage/prioritize complaints	☑	☐
Close complaints	☑	☐
Resolve discipline cases	☑	☐
Propose settlements	☑	☐

Other (*specify*): enter into Consent orders

Over ▶

Part IV: Administrative

Please enter the number of full-time equivalent (FTEs) staff. An FTE of 1.0 means that the person is equivalent to a full-time worker, while an FTE of 0.5 signals that the worker is only half-time.

23. Number of FTEs involved in **Nursing Practice** Issues who are...

Nurses: 4.3

Other (*Specify*): 2.15 (Coordinators)

24. Number of FTEs involved in the **licensure process** who are...

Managers: .20

Licensing Staff: 8.35

Other (Specify): .20 (Finance)

25. Number of FTEs involved in the **education program approval and monitoring process** who are...

Education Consultant/Manager: 3.20

Administrative Staff: 1.0

Contract Personnel: _____

Other (*Specify*): _____

26. Number of FTEs involved in the **investigative process** that are Board of Nursing employees who are...

Nurses: 4.20

Not Nurses: 2.0

Administrative Support Staff: 3.0

Attorney (who are not investigators): _____

Other (*Specify*): _____

27. Number of FTEs involved in **investigative process** that are **contracted personnel**, not employed by the Board of Nursing: .30 (Attorney)

Over ▸

Part V: Budget

FY2012 Budget Worksheet

This worksheet is provided so that costs will be uniformly reported. Because we want to be able to calculate variables such as "cost per complaint handled" and compare the costs of the work of the board by staffing patterns, we are *requesting you use this worksheet to calculate your costs.*

Please indicate expenses for the following budget items. Adding the total expenses for all items should match your total FY2012 expenditures. **When a member of the Board staff contributes to more than one category, please allocate a proportion of their salary among the appropriate times.**

Note: Please do not include one-time capital expenditures or expenses related to the regulation of Certified Nursing Assistants (CNAs) or other Assistive Personnel in any of the following categories.

****If you are unable to answer a question or are not sure of the exact value, please leave the question blank, as approximations will alter the results and the integrity of the data.**

The Board's total fiscal year 2012 expenditures (excluding capital expenditures)	6,930,007
Discipline/Complaint Handling 1,923,509	
Total salaries (including fringe) of board staff in discipline/complaint handling	995,061
Attorney (non board staff) fees	165,135
Investigator (non board staff) fees	12,511
Hearing costs (including board expenses related to hearings)	29,852
Expenses related to monitoring compliance with probation	12,650
Expenses related to alternative programs	70,050
Misc. expenses	
Total Salaries of Board staff in monitoring/ alternative programs	738,240

Over ▶

Licensure (including renewal) 910,882	
Total salaries (including fringe) of board staff involved in licensure	726,914
Verification expenses	-0-
Expenses related to endorsement (excluding board staff salaries)	
Expenses related to examination (excluding board staff salaries)	
Expenses related to renewal (excluding board staff salaries)	
Other costs related to licensure	183,968
Education Program Approval 459,313	
Total salaries (including fringe) of board staff involved in education program approval	413,848
Travel expenses related to education program approval	18,226
Expenses related to distribution of information and materials	19,009
Other costs related to approval of nursing programs	8,230
Practice 752,526	
Total salaries (including fringe) of board staff involved in practice activities	716,691
Other costs related to practice	35,835
Operational Costs 877,630	
Postage and mailing expenses	100,547
Office supplies	53,345
~~Rent~~ Office Space	244,199
Maintenance on equipment	45,237
Data management expenses	434,302

Administrative Costs 2,006,147

Total salaries of Executive Officer and support staff (including support departments) not covered by previous categories	1,401,549
Board expenses (including payments such as per diem or for compensation to board members) not covered by previous categories	18,797
Other administrative and indirect costs not covered by previous categories	532,558

For any expenses not covered by this questionnaire, please list them here:

Expense item	Amount
BULLETIN	53,243

INDEX TO ITEM CODES

NCSBN
Leading in Nursing Regulation

Board of Nursing Survey

Part I: Licensure

1. How many applications for nursing licensure were received in FY2012?

Initial Exam: L1A

Endorsement: L1B

Renewal: L1C

2. What percentage of **initial** nursing licenses are processed online?

L2 %

3. What percentage of nursing licensure **renewals** are processed online?

L3 %

4. During FY2012, what was the average length of time in days it took to process applications for nurse licensure **from receipt of all required information to authorization of license**? Exclude disciplinary and/or unusual situations.

Nurse licensure by initial examination: L4A

Nurse licensure by endorsement: L4B

Nurse licensure by renewal: L4C

5. Do you perform audits of your nurse licensure process?

a. Yes
b. No L5

Over ▶

Part II: Education

6. Does your Board of Nursing approve nursing educational programs?
   a. Yes L6
   b. No *(Go to Question 12)*

7. What is the total number of approved nursing education programs at the end of FY2012?
   Total: L7

8. What is the status of all nursing education programs at the end of FY 2012?
   Number of education programs with initial approval: L8A
   Number of education programs with full approval: L8B
   Number of education programs with conditional approval: L8C
   Other (*Specify*): L8_OTHER
   L8_NUMBER

9. How many nursing education program decisions were made in FY2012?
   Number of programs received initial approval in FY2012: L9A
   Number of programs received full approval in FY2012: L9B
   Number of programs received conditional approval in FY2012: L9C
   Number of programs had their approval withdrawn in FY2012: L9D
   Number of programs were denied initial approval in FY2012: L9E
   Other (*Specify*) L9_OTHER
   L9_NUMBER

10. How many nursing education program applications were pending at the end of FY2012?
    Total: L10

Over ►

Part III: Discipline

11. How many new complaints were received in FY2012? D11

12. How many of these complaints were closed without action?: D12

13. How many cases were assigned to investigations? D13

14. How many investigative cases were resolved by the Board of Nursing in FY2012?

With disciplinary action: D14A

With non-disciplinary action: D14B

Closed without action: D14C

15. Of the cases brought to resolution by the Board of Nursing in FY2012, what was the average number of calendar days between receipt of the cases/complaint to resolution of the case/complaint?

Total number of days: D15

16. Of the cases brought to resolution by the Board of Nursing in FY2012, how many had been open for:

4 months or less: D16A

4 - 6 months: D16B

7 – 12 months: D16C

13 - 18 months: D16D

19 – 24 months: D16E

Over 24 months: D16F

17. How many formal hearings were conducted by the Board of Nursing or by the Administrative Law Judge in FY2012?

Formal Hearings: D17

18. What was the length of time in days from opening investigation to resolution of these cases?

Days: D18

Over ▶

19. How many cases were appealed during:

FY2012: D19A

FY2011: D19B

20. During FY2011, how many appeals were:

Remanded: D20A

Overturned: D20B

Upheld: D20C

21. During FY2012, how many appeals were:

Remanded: D21A

Overturned: D21B

Upheld: D21C

22. Does staff have delegated authority by the Board of Nursing policy to:

	Yes	No
Triage/prioritize complaints	☐	☐ D22A
Close complaints	☐	☐ D22B
Resolve discipline cases	☐	☐ D22C
Propose settlements	☐	☐ D22D
Other (*specify*):	D22_OTHER	

Over ▶

Part IV: Administrative

Please enter the number of full-time equivalent (FTEs) staff. An FTE of 1.0 means that the person is equivalent to a full-time worker, while an FTE of 0.5 signals that the worker is only half-time:

23. Number of FTEs involved in **Nursing Practice** issues who are...

Nurses: A23A

Other (*Specify*): A23_OTHER A23_NUMBER

24. Number of FTEs involved in the **licensure process** who are...

Managers: A24A

Licensing Staff: A24B

Other (*Specify*): A24_OTHER A24_NUMBER

25. Number of FTEs involved in the **education program approval and monitoring process** who are...

Education Consultant/Manager: A25A

Administrative Staff: A25B

Contract Personnel: A25C

Other (*Specify*): A25_OTHER A25_NUMBER

26. Number of FTEs involved in the **investigative process** that are Board of Nursing employees who are...

Nurses: A26A

Not Nurses: A26B

Administrative Support Staff: A26C

Attorney (who are not investigators): A26D

Other (*Specify*): A26_OTHER A26_NUMBER

27. Number of FTEs involved in **investigative process** that are **contracted personnel**, not employed by the Board of Nursing: A27

Over ▶

Part V: Budget

FY2012 Budget Worksheet

This worksheet is provided so that costs will be uniformly reported. Because we want to be able to calculate variables such as "cost per complaint handled" and compare the costs of the work of the board by staffing patterns, we are requesting you use this worksheet to calculate your costs.

Please indicate expenses for the following budget items. Adding the total expenses for all items should match your total FY2012 expenditures. **When a member of the Board staff contributes to more than one category, please allocate a proportion of their salary among the appropriate times.**

Note: Please do not include one-time capital expenditures or expenses related to the regulation of Certified Nursing Assistants (CNAs) or other Assistive Personnel in any of the following categories.

****If you are unable to answer a question or are not sure of the exact value, please leave the question blank, as approximations will alter the results and the integrity of the data.**

The Board's total fiscal year 2012 expenditures (excluding capital expenditures)	B1

Discipline/Complaint Handling

Total salaries (including fringe) of board staff in discipline/complaint handling	B2A
Attorney (non board staff) fees	B2B
Investigator (non board staff) fees	B2C
Hearing costs (including board expenses related to hearings)	B2D
Expenses related to monitoring compliance with probation	B2E
Expenses related to alternative programs	B2F
Misc. expenses	B2G

Over ▸

Licensure (including renewal)	
Total salaries (including fringe) of board staff involved in licensure	B3A
Verification expenses	B3B
Expenses related to endorsement (excluding board staff salaries)	B3C
Expenses related to examination (excluding board staff salaries)	B3D
Expenses related to renewal (excluding board staff salaries)	B3E
Other costs related to licensure	B3F
Education Program Approval	
Total salaries (including fringe) of board staff involved in education program approval	B4A
Travel expenses related to education program approval	B4B
Expenses related to distribution of information and materials	B4C
Other costs related to approval of nursing programs	B4D
Practice	
Total salaries (including fringe) of board staff involved in practice activities	B5A
Other costs related to practice	B5B
Operational Costs	
Postage and mailing expenses	B6A
Office supplies	B6B
Rent	B6C
Maintenance on equipment	B6D
Data management expenses	B6E

Administrative Costs

Total salaries of Executive Officer and support staff (including support departments) not covered by previous categories	B7A
Board expenses (including payments such as per diem or for compensation to board members) not covered by previous categories	B7B
Other administrative and indirect costs not covered by previous categories	B7C

For any expenses not covered by this questionnaire, please list them here:

Expense Item	Amount
B8A_OTHER	B8A_NUMBER
B8B_OTHER	B8B_NUMBER
B8C_OTHER	B8C_NUMBER

Analysis of inquiries and responses regarding ARNPs:

We have analyzed 100 inquiries emailed to the NCQAC regarding ARNP practice. The questions range in date from January 2011, to June 2012. This work is ongoing; only a fraction of the questions in the dataset have been analyzed. Our initial work has been chiefly to establish a protocol for analysis.

We have sorted the inquiries into seven Major Categories: Education, Prescriptive Authority, Scope of Practice, Legal issues: laws, legislation, and rules, Out of State Issues, Licensing, and Miscellaneous.

Each question is also sorted into a Sub-Category: Preceptor issues (PRE), DNP Requirements (DNP), Practice Management (PM), Accreditation (AC), On-line programs (OLP), Malpractice Insurance (MPI), Marijuana Issues (MJ), Continuing Education requirements (CE), Student Questions (STU), Title Uses (TIT), General Question (GEN), Clinical Nurse Specialist (CNS), AACN/AANP cert exams (AEX), Continuing Competency (CC), Records Retention (RR), Out of state issues (OSL), Practice hours (PH), CRNAs and CNMs (NA), New Certifications (NC), HR requirements (HR), Pain Management (PMX).

Any Sub-Category can appear within any Major Category; for example, inquiries about Practice Management could appear under Scope of Practice or Legal Issues.

In our initial stage of category development and inquiry analysis, we have tallied 100 questions and answers, with results displayed below (Fig.1). Each inquiry can represent an average of 5 emails, as the questions and answers usually are not simple or straightforward. Multiple people are sometimes consulted with ensuing meetings and discussions to answer an inquiry. Some emails contain more than one question that may fall into different categories.

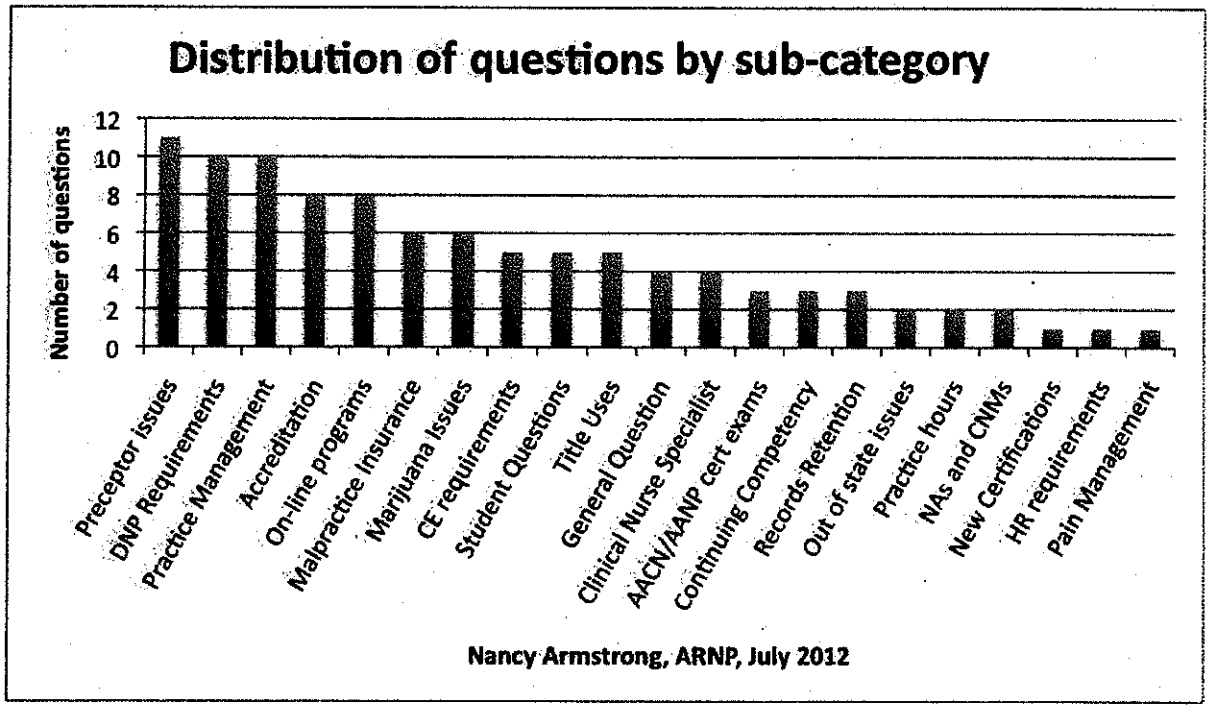

Figure 1

The most frequent sub-categories of inquiries across the board are Preceptor Issues, DNP Requirements, and Practice management (for the time period analyzed), with significant interest in Accreditation and On-line programs, and less interest in other issues.

More than half (56%) of the inquiries tabulated to date are Education questions. Analyzing this subset independently, we find a different distribution of sub-categories (Fig.2).

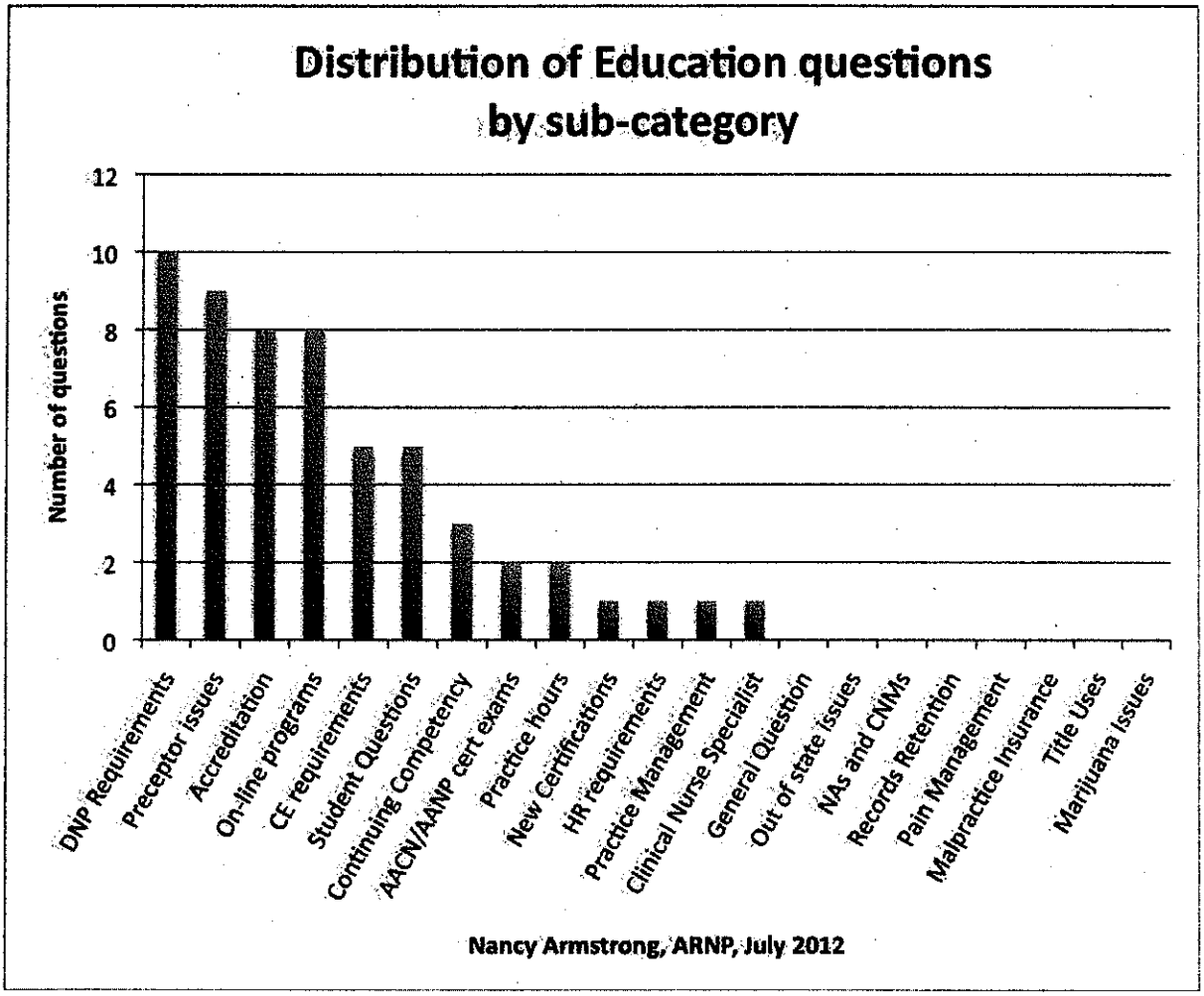

Figure 2

For Education inquiries only, Fig.2 shows that the primary sub-categories of interest (for the period analyzed) are DNP requirements, Preceptor issues, Accreditation, and On-line programs.

As our analysis continues, we will be able to provide such information for each major category of inquiries, e.g. Prescriptive Authority, Scope of Practice, etc.

Our database of questions and answers, and our analyses of frequency of inquiries for various categories will provide a foundation for:

- the creation of a tracking system for management of inquiries
- a FAQ system for efficient dissemination of key information, and
- insight into primary and emerging issues of concern to ARNPs.

Acknowledgements

The Washington State Nursing Commission acknowledges and expresses sincere gratitude to the following people for their work and support of this report:

Kathy Apple

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Teresa Corrado

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Mary Dale

Barbara Elsner

Lindsey Ericksen

Julie George

Wolfgang Opitz

Dr. Linda Olson

Dr. Theodore Poister

Sandra Prideaux

Joey Ridenour

Catherine Woodard

Dr. Martha Worcester

Dr. Susan Woods

Gail Yu

Each person contributed their time and talents on this report. Without them, an adequate factual comparison would not exist.