SUNSET REVIEW

OF

THE COLORADO BOARD OF NURSING

Submitted by
The Colorado Department of Regulatory Agencies
Office of Policy & Research
June 1994

June 30, 1994

The Honorable Vickie Agler, Chair
Joint Sunrise/Sunset Review Committee
State Capitol Building
Denver, CO 80203

Dear Representative Agler:

The Colorado Department of Regulatory Agencies has completed the evaluation of the Board of Nursing. We are pleased to submit this written report, which will be the basis for my office's oral testimony before the Joint Legislative Sunrise/Sunset Review Committee. The report is submitted pursuant to Section 24-34-104 (8)(a), of the Colorado Revised Statutes, which states in part:

> *"The Department of Regulatory Agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...*
>
> *The Department of Regulatory Agencies shall submit a report and such supporting materials as may be requested, to the Sunrise and Sunset Review Committee . . . "*

The report discusses the question of whether there is a need for the regulation provided under 12-38-101 C.R.S. The report also discusses the effectiveness of the division and staff in carrying out the intention of the statutes and makes recommendations for statutory and administrative changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

Joseph A. Garcia
Executive Director

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EXECUTIVE SUMMARY

The Department of Regulatory Agencies has concluded its sunset review of the Board of Nursing and recommends continuation of the board and the regulation and licensing of nursing. The provision of nursing care involves life endangering situations that require the application of knowledge, skill, judgment and therapeutic ability. Patients are definitely exposed to significant risks on a daily basis. Incompetence in this area can have the most serious consequences and patients are not equipped with the knowledge or ability to "shop around" for competent care when they are ill. All of this justifies public regulation in the field.

OPR finds that the Board of Nursing and the Division of Nursing have pursued their statutory mandate of protecting the public with diligence and effectiveness.

This review will discuss some major changes to current practice. First and foremost is the recommendation to expand the prescriptive authority of nurses in Colorado. The current statutory language allows for some prescriptive authority, but how much is unclear, and many licensees have had to resort to practices that lack clarity, uniformity and prevalence in order to prescribe. Greater latitude for prescriptive authority is recommended for advanced practitioners. Secondly, OPR recommends that the Board composition be altered so that fewer educators are mandated as members. The Board's primary mission is discipline. Curriculum reviews are occasional. The Board needs more flexibility in membership composition in order to ensure that the changes in the profession are adequately reflected in its expertise. Lastly, the Diversion program for individuals with substance abuse and mental health problems that began in 1992 has statutory inefficiencies that cause increased workload and unnecessary bureaucratic processes. OPR recommends that the program be continued at least until it has been operational for 5 full years, but that it be modified to address current problems.

The report also addresses various statutory changes that are recommended by OPR or other constituencies. Many of these seem to be small things, but they carry great weight in affecting how the Board completes its mission.

BACKGROUND

The purpose of this review is to determine whether the State Board of Nursing should be continued for protection of the public and to evaluate the performance of the board. The specific evaluation criteria established by statute are appended (see Appendix A). The board is scheduled to be terminated on July 1, 1995 unless continued by the General Assembly.

The sunset review process included analysis of the statutes and rules; input from board members and staff, board licensees, nursing association representatives, assistant attorneys general, other licensing board administrators within and without Colorado, and research of related statutes and procedures in other states.

HISTORICAL PERSPECTIVE

The State Board of Nursing regulates professional and practical nurses, psychiatric technicians and nurse aides.

Professional Nursing

The Colorado General Assembly created the State Board of Nurse Examiners in 1905 to examine, license and revoke licenses of professional nurses (R.N.s). In 1957, the statute was repealed and reenacted. The Board of Nursing was expanded from five to nine members and given several new powers. In addition to its licensing, examination and disciplinary functions, it was empowered to accredit professional nursing education programs in Colorado and approve the curricula for those programs. The legislature also added a definition of the practice of the profession of nursing as adopted by the American Nurses' Association.

In 1973, the definition of the practice of professional nursing was revised, expanding the scope to include diagnosis, among other things. In 1978, both the Board of Nursing and the Board of Practical Nursing underwent sunset reviews and pursuant to such the two boards merged. Senate Bill 105 (1980) was passed to establish the current State Board of Nursing effective July 1, 1980.

In 1980, the Nurse Practice Act (NPA) that passed replaced both the existing RN statute and L.P.N. statute. Once again the definition of the practice of professional nursing was revised. It was defined in a broad way to include independent nursing functions and delegated medical functions.

At that time the board was also given the duty to list professional nurses who meet qualifications as advanced practitioners of nursing. Advanced practitioners are R.N.'s who have graduated from an approved postgraduate program and have passed a national certification examination in an area beyond that required for R.N. licensure. That duty became a statutory obligation in the 1994 Legislative session. In HB 94-1081 the Legislature created a registry for advanced practice nurses and authorized title protection for that group.

Practical nursing

Practical nurses (L.P.s) have the role of providing the technical nursing or bedside nursing care which was the original role of a nurse. L.P.N.s were first licensed in Colorado in 1957 with passage of the Practical Nursing Practice Act (Senate Bill 125, 1957).

The passage of the Practical Nurse Practice Act of 1967, added the authority for L.P.N.'s to administer selected treatments and medications prescribed by a physician or dentist under the direction of a professional nurse.

In 1977, the act was amended to strengthen the board's disciplinary authority by revising the grounds for disciplinary action and by giving it more disciplinary options, for example, placing a licensee on probation.

The Nurse Practice Act of 1980 authorized L.P.N.s to supervise other health care personnel. It also gave the new State Board of Nursing the authority to expand and control the practice of practical nursing by adopting rules "concerning qualifications needed to practice as a practical nurse."

STATUTORY SUMMARY

The Nursing Board is a Type 1 Board, and therefore administered by the Division of Registrations but independent in its decision making authority.

COMPOSITION OF THE BOARD

Section 12-38-104 of the NPA creates an 11-member State Board of Nursing to be appointed by the Governor with Senate confirmation. Specific qualifications are provided for each of the 11 members as follows: two public members without any connection with a health care facility, agency or insurer; three practicing L.P.N.s, one of whom works in a rural hospital; and six R.N.s. With respect to the R.N.s, one member must be engaged in professional nursing education at the baccalaureate level; one member must be engaged in professional nursing education at the associate degree or diploma level; one member must be engaged in practical nursing education; one member must be engaged in nursing service administration; and two members must be staff nurses. Members serve three-year terms but may not serve more than two consecutive terms.

Members may be removed by the Governor for negligence, incompetency, unprofessional conduct, willful misconduct or failure to meet the conditions established in 12-38-105, C.R.S.

POWERS AND DUTIES OF THE BOARD

The Nursing Board is given the normal powers and duties of a regulatory board such as the power to approve educational programs, the power to examine licensees and applicants, to grant renewals and permits, to adopt rules and most significantly, the power to discipline licensees where appropriate. C.R.S. 12-38-105.

Licensure

The NPA contains the standard elements of professional licensure requirements - applicants must have completed an education program meeting the standards of the Board, must demonstrate a lack of current or recent substance abuse, and must pass an exam. Licenses by endorsement are also granted to nurses licensed in other states, as are temporary licenses when appropriate. The process is much the same for L.P.N. candidates. C.R.S. 12-38-111, 112.

Discipline

The Board also has the standard range of disciplinary options available to it - from a letter of admonition, to suspension or revocation of a license. C.R.S. 12-38-117.

SCOPE OF PRACTICE

Professional nurses

The NPA defines the practice of professional nursing as "the performance of both independent nursing functions and delegated medical functions, including the initiation and performance of nursing care through prevention, diagnosis, and treatment. . . which requires such specialized knowledge, judgment, and skill involving the application of principles of biological, physical, social and behavioral sciences as are required for licensing as a professional nurse. . . " (12-38-103(10), C.R.S.) Scope of practice also further specifically addresses and includes such things as evaluating health status, providing therapy, executing delegated medical functions (from physicians, podiatrists or dentists) and treating (among others). In executing delegated medical functions, the nurse must act pursuant to physician supervision. 12-38-103(10); (12)

Licensed practical nurses

The statutory definition of the practice of practical nursing ties the scope of practice to the training of a L.P.N. by stating that it is "the performance . . . of those services requiring the education, training and experience . . . as required in this article for licensing as a practical nurse . . . " in Colorado. A L.P.N. must practice under the supervision of a dentist, physician or professional nurse but may supervise other L.P.N.s or other health care personnel. (12-38-103(9), C.R.S.)

OTHER REGULATION

The BON also administers the Psychiatric Technician Licensing Program which is covered in a separate report. In addition, since last sunset the BON has been given jurisdiction over the Nurse Aides Program. That program is not encompassed in this review.

SUNSET ANALYSIS AND RECOMMENDATIONS

The mission of OPR is basically to review the applicable statutes and corresponding programs, determine whether the risk that generated the program still exists, and if so, determine if the program is operating in the most efficient but least restrictive manner possible.

With regard to the nursing program, OPR finds that a substantial risk to the public welfare still exists and would increase without regulation of professional and practical nurses. The caretaking responsibilities of these individuals have increased over time. Downward delegation from doctors has increased in many settings (acute care hospitals, routine specialty visits, etc.). A trend towards more education for nurses has developed, as physicians increasingly specialize and the ranks of the general practitioner have declined. New areas of need have developed (long term and home health care) as our population ages.

All of these trends have created a greater need for nursing skills of all types. Medical technology and knowledge of disease has increased, so that caretakers must be even more well informed and trained.

For these reasons it is clear that deregulating nursing care would be inappropriate. In order to attempt to safeguard the public welfare, at least minimum standards must be enforced for caretakers.

RECOMMENDATION 1: OPR RECOMMENDS THAT THE NURSE PRACTICE ACT BE CONTINUED.

MAJOR ISSUES

Composition of the Board of Nursing

Numerous constituents and interested groups believe that the composition of the Board is not representative in some fashion or another and should be changed. The most common complaint is that the Board has too many educators. Secondly, some believe the Board has too many L.P.N.'s. Currently, pursuant to C.R.S. 12-38-104(1) the Board is composed of 3 L.P.N.'s and 6 RN's. Three of the RN's must be educators - one at the baccalaureate level, one at the associate degree or diploma level, and one at the practical nursing level.

The Board does have responsibilities concerning the education of nurses in Colorado, so some influence from educators is most likely helpful. It is required to approve educational programs (nursing schools or programs) that prepare individuals for licensure. This includes examining the curricula, surveying institutions, and establishing standards for these educational programs. The Board also may determine whether out-of-state programs and graduates of such programs are acceptable for approval and licensure in Colorado. These responsibilities may have driven the Board composition into the current statutory mix of nurses.

The educational part of the Board's work, however, in reality, is a small proportion of what the Board actually does. Staff estimate that on the average, the Board considers a single new educational program application about every 2 or 3 years. When that occurs, the Board probably spends, overall, one to one and a half days reviewing reports of staff and considering approval of the program.

That is not to say that educators' sole contribution to the Board is in regard to program approval. Educators contribute in a variety of ways to the Board decision making process. They often are exposed to the latest research in fields that impact nursing practice, they have the time to read periodicals and keep abreast of national and regional trends, they may be employed in settings that allow for maximum integration of practice and theory. Their views and analyses could be very helpful to the Board's major work - that of establishing and enforcing the standards of practice in nursing and ensuring the public safety. The issue is whether a multiple number of educators really adds value to Board deliberations, more than some other type of representative.

Other states are no help in this regard. They have varied requirements on board composition. Everything from no Board educators to 4 Board educators is evidenced in statutes in Washington, Minnesota, Arizona, Oregon, Nebraska, and Kansas. Similar data would result from a national survey.

The issue is complicated in other ways. Home health care providers believe that the Board lacks their perspective. Some long term care nurses believe that the Board should have more long term care influence, since home health care is obviously the wave of the future. The Legislature passed HB 94-1081, establishing a registry for advanced practice nurses this session. With the continuing push for health care reform, it is logical to predict that this group of practitioners will eventually want to be specifically represented on the Board.

The Board cannot represent, in body, every constituency or employment situation in nursing. It is impossible. This should not be a "fairness" issue, but a competency issue. Health care has changed significantly in the last 20 years, and it will most likely change more dramatically in the next 20. At the time the Legislature determined Board composition the last time, much more practice was being done in the hospital setting than is currently true today. The trend today is toward out-patient, home health care and less expensive providers.

In order to be effective in a changing environment, the law must remain fluid enough so that the Board composition can change as times change, and thus represent the best mix of individuals to apply judgment to current practice situations. A law that is too specific lacks adaptability. If minimum requirements are encoded, public safety is maintained since the Board can respond to a changing environment without engaging in the political process every time a change is required. Constituency groups can file input with the Nursing Board and the Governor's Office when a vacancy occurs and in that fashion educate the Executive Branch with their knowledge of where the profession is headed. Later sunset reviews or other audits can evaluate whether or not the process is working as intended, or whether some other revision might be necessary.

RECOMMENDATION 2: OPR RECOMMENDS THAT THE LANGUAGE REQUIRING 3 NURSING EDUCATORS ON THE BOARD BE MODIFIED SO THAT ONLY 1 EDUCATOR IS MANDATED. THE OTHER TWO SLOTS SHOULD BE DESIGNATED ONLY AS RNS, WITHOUT ANY OTHER RESTRICTIONS.

Prescriptive Privileges for Nurses

The role and responsibilities of health care professionals of all sorts have changed over the last 20 years, for a variety of reasons. Where nurses once started as assistants to doctors they now perform a wide variety of tasks totally independently. From acute care in hospitals to performing midwife duties for a woman giving birth, nursing is not what it used to be. With the health care reform movement on the horizon, programs are being suggested to decrease the costs of health care while increasing the access to and quality of health care for patients. One such program is to expand the independence and numbers of mid-level practitioners in health care(physician's assistants and nurse practitioners, for the purposes of this review). Nurse practitioners are professional nurses with advanced training, experience and/or education.

The pertinent question is whether such expansions will alleviate the access problem, address the quality problem, and reduce overall health care costs. The subset issue is, if expansion is appropriate, how much expansion and into what areas?

Current Colorado Situation

The Colorado Legislature already acknowledged mid-level practitioners by passing HB 94-1081 this session. This bill sets up a registry for advanced practice nurses (hereinafter nurse practitioners) which allows them to register with the state Board of Nursing and protects their titles. The Board will be delineating the areas of specialty in Colorado. The statute, however, does not address scope of practice beyond what the Nurse Practice Act currently states.

The Nurse Practice Act seems to allow professional nurses to prescribe medication with physicians' oversight. Included in the definition of "delegated medical function" is "selection of medication" as one of the items listed as part of an appropriately delegated medical plan. C.R.S. 12-38-103(4). This is a form of dependent prescriptive authority. The right to prescribe is not explicit, however, and the language is vague and has created problems.

Pharmacists in Colorado will not necessarily honor the prescriptions of nurses due to the lack of specific statutory authorization. It is unclear from the language used in the statute whether such language should include controlled substances. These are medications that have addictive properties, and dispensation is regulated by the Drug Enforcement Agency (DEA) of the federal government. The DEA will not issue DEA numbers to nurses in Colorado due to the ambiguity of our statute, so any sort of independent authority is not possible.

Systems have been informally developed throughout the state between physicians and nurses regarding their prescriptive authority. Sometimes doctors sign a pad of prescriptions for the nurse's use. Sometimes nurses telephone pharmacists with prescriptions under the doctor's name and with his permission. Sometimes nurses write the prescriptions and sign the doctor's name pursuant to their agreement. These and numerous other ways to deal with the problem indirectly are most likely of questionable legality. Even if the informal arrangements worked in every case and covered individuals in urban areas, the process may not work so well in rural areas or inner city clinics where physicians are in short supply.

This lack of specific statutory authority creates costs in the system, both in the time of physicians and nurses, and fees if an individual needing a prescription must see two people to get it. Such a haphazard approach could also be dangerous in situations where the patient needs something immediately, the pharmacist will not honor the nurse's prescription, and a physician is not available. The situation also does not promote the use of mid-level practitioners as options for health care access to people unable to afford doctors.

Other States

There are numerous surveys attempting to gauge how states are dealing with the prescriptive rights issue. There is no consensus. Each state has dealt with it differently. Anywhere from 26 to 43 states authorize nurses by statute or regulation to prescribe, depending upon how you define prescriptive authority. Washington, Oregon, Alaska, New Mexico, Wyoming and Montana allow for varying degrees of independent prescriptive authority; that is, they may prescribe at least a certain type of drugs without the supervision of a physician. 1 The other states allow for some degree of prescriptive authority so long as the nurse has some sort of collaboration with or supervision by a physician. 1

Most of the limited types of authority restrict various things: the kinds of nurses who can prescribe (nurse practitioners), the type of drug that may be prescribed, the number of dosage units or refills, the places where a nurse may prescribe, requiring a written agreement with a physician regarding his/her supervision, and implementing protocols. Sometimes the state boards of nursing are required to be involved in some sort of approval process. 1

The variety of arrangements is unending, the only certainty being that states limit prescription of controlled substances to nurse practitioners. In addition, the language in these states' statutes is explicit; sometimes the statute or regulation even addresses the DEA issue.

Discussion

There is always a boundary dispute between professionals when one group wishes to expand its responsibilities, and another does not believe such movement is warranted. This situation is no different in that regard. Pharmacists, physicians and nurses often disagree on the subject. In addition to the problems noted previously, there are public policy reasons to consider changing the status quo. The best data available on the efficacies of utilizing nurse practitioners in an expanded role to help solve part of the health care crisis is a report done by the Office of Technology Assessment (a research arm of the U.S. Congress). That study considered the results of over 268 other published studies dealing with practice outcomes of mid-level practitioners (nurse practitioners, physician assistants and certified nurse midwives). It found that in the area of quality, nurse practitioners (NP) provide care whose quality is equivalent to that provided by physicians. 2 The study looked at both assessment and outcome data (such as a determination of what was going on, resolution of the patient's problem, improvement of his/her condition, reduction of pain, etc.) In all of these areas , NP's results were at least equivalent to physicians. In some of the studies, NP's provided a greater quality of care.

There has been no other study since that time that indicates that this research is incorrect. There is no data that demonstrates that it would be patently unsafe or in any other way jeopardize patient care for a nurse to have the ability to prescribe in a primary care or specialty situation. In fact, it has been occurring in Colorado for quite some time. That is not to say accidents or misjudgments could not happen. Physicians argue that nurses are not qualified by training to handle many of the matters that would come before them in primary care settings. They have, at most 6 years of education that is oriented to nursing care - emphasizing total patient care and health promotion and maintenance. Physicians have at least 11 years of education, oriented towards the diagnosis and management of illness. 3 From the physician's perspective, the types of judgments that need to be made in medical situations require far more education and training than that of a nurse. Physicians do have an economic interest in restraining the practice of other competing professionals, however. How much that drives their position regarding nurses is not clear.

Common sense dictates that nurses are not qualified to do everything physicians do. The studies have focused primarily on managed care settings, like Kaiser, where nurse practitioners have been used for quite some time. Dr. DeAngelis summarizes that "NP's (as currently practicing) generally are effective providers of health maintenance and acute care to patients with common minor illnesses and to those with certain chronic illnesses that require close monitoring and routine tests, education and encouragement." [1] This speaks to the primary care setting.

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[1]DeAngelis, Catherine D., M.D. Commentary: Nurse Practitioner Redux. J. Am. Med. Assoc. 11: 868-871; 1994

There is no data to support the idea that nurses can or cannot prescribe with successful outcome ratios that match physicians. A study of such limited nature would be difficult to create, since patient outcomes can turn on numerous things, some unrelated to treatment. The OTA study did demonstrate, however, their ability to provide successful patient care (including prescribing). It seems reasonable to assume that qualified professionals with experience could make educated and effective decisions about medication within their own known scope of practice.

However, arguments can be used to support a position on either side. There are 5 states that have given nurse practitioners expanded and independent scope of practice regarding prescriptive rights. There have been no known problems to date in those states. There are at least 36 other states that have allowed nurses to prescribe in one manner or another, including Colorado. Again, there have been no known problems in allowing for that practice.

Although the evidence is spotty, predicting the outcome of change is not a science. Expanded prescriptive rights may increase patient access to the health care system; it may reduce overall system costs. Most nurses practice in conjunction with a physician already, so for the most part they are probably providing collaborative health care, not isolated judgments. Most professionals know enough to ask questions when they realize they don't know the answer to a problem. Regardless of what type of authority nurse practitioners have under Colorado law, they are always required only to practice within their known scope of ability. Under the new law, the specialty area of nurse practitioners will be identified. Scope of practice will be clearer. This would include prescriptive authority.

There are reasons to delay such a change. The current law, however vague, does allow nurses to prescribe now so long as they can find an agreeable physician and pharmacist. No showing of great irreparable damage was made by nursing groups advocating the change. Further specificity in the law might deprive some nurses who prescribe under the current unclear system from the authority to prescribe in the future.

The risks of waiting to change things, however, are sizable. There is confusion and unequal treatment occurring in the market place due to the vagueness of the law. Nurses prescribing controlled substances by whatever means are violating federal law without their DEA numbers. Some pharmacists are going along and some are not. Liability is unclear. If Colorado allows this situation to sort itself out in the courts, case law will determine what the law means and what should be done, not the Legislature. This is the least desirable way to create state policy, since the rule will turn on the facts of each case, instead of what is best for all Colorado citizens.

RECOMMENDATION 3: OPR RECOMMENDS EXPANSION OF THE PRESCRIPTIVE AUTHORITY OF NURSE PRCTITIONERS, AND AMENDMENT OF THE LANGUAGE CONCERNING OTHER NURSES' ABILITY TO PRESCRIBE SO THAT CURRENT AUTHORITY IS MADE EXPLICIT. SPECIFICALLY:

RECOMMENDATION 3a): OPR recommends that the scope of practice for advanced nurse practitioners be specifically stated in the statute to include the authority to prescribe, including controlled substances.

RECOMMENDATION 3b) In addition, OPR recommends that the current statute concerning all professional nurses be modified to specifically authorize prescriptive authority.

However, this is not a recommendation for carte blanche authority to prescribe without limits.

When changing state policy with regard to prescriptive rights, there are many questions that must be answered to formulate an appropriate result. They are as follows:

- Which providers will be authorized to prescribe? (nurses?, nurse practitioners?)
- What drugs and devices may be prescribed? (legend drugs?, controlled substances? only those in a state formulary?)
- Will the authority given be dependent or independent (of physicians)?
- What type of regulatory scheme should oversee the subject (Board of Nursing?, Board of Medical Examiners and Nursing? New Board?)

The subject is very complex. As stated before, other states have reached all combinations of answers on this issue. OPR does not have the expertise, time or the authority to develop Colorado's program. This should be done by specialists in the medical profession.

RECOMMENDATION 3c) OPR recommends that the Committee direct the Director of Registrations to convene a task force on the Committee's behalf. Such a task force should be comprised of nurses who are directed to consider the issues as stated above, solicit input from physicians and pharmacists, and propose legislation to the Committee next summer to address the issue.

The task force should be required to produce its proposal for the Committee next summer, so the Committee can determine whether or not the directive has been successfully fulfilled, and legislation should be undertaken.

Nursing Peer Health Assistance Diversion Program

This program was created in 1989, although due to several technical problems, it was not implemented until October of 1992. To date it has been operating for 20 months, although the summarized data about it is from the 18th month.

The Legislative intent for the program was for it to "safeguard the life, health, property, and the public welfare of the people of this state....(by) help(ing) nursing practitioners experiencing impaired practice due to psychiatric, psychological, or emotional problems or excessive alcohol or drug use or addiction" C.R.S. 12-38-131(1). The General Assembly went on to state that it was their intent that this program be used by the BON as an alternative to discipline, and to alleviate the need for such discipline. (2).

A review of the literature demonstrates that such assistance programs are being used with increasing frequency throughout private industry and in regulation of professionals of various sorts (nurses, doctors, pharmacists, etc.). 5,6,7 The underlying rationale for such programs is that addictions and substance abuse are conditions that impair people's abilities to be effective at home and at work, that drain our health care system in treatment costs and our business systems in productivity. Thus, long term investment in treatment should benefit many aspects of society. 5 ,8.

The Legislature obviously believed such a treatment approach was necessary for nurses and would be useful. The sunset review perspective, is therefore to determine whether or not the program complies with the law and whether or not it has met Legislative intent, in the least restrictive manner possible.

Statutory Requirements of Operation

Concerns have been raised by the BON concerning whether the program is too expensive for the benefits provided by it. The specific issue is whether insufficient numbers of nurses entered the program and were treated to justify the costs of the program. A subcommittee of the Board recently became involved in examining the program and one major criticism is that there has been insufficient marketing by the contractor to bring adequate numbers of nurses into the program. In addition, the Board staff believe there is a conflict of interest exhibited by the contractor in that the contractor prioritizes the rehabilitation of nurses in the program higher than watch dogging public safety. The staff believes that this orientation jeopardizes public health.

The data provided from all sources is somewhat conflicting. It appears that as of March 31, 1992, 73 assessments have been completed by the contractor, which should mean that 73 applications have been filed. Of those 40 were admitted. Of those 40 (for various reasons) 30 remain in the program. Of the licensees in the program, 12 so far have a year or more of recovery. 4 have had a relapse but continue in recovery. The program has not been operational long enough to determine how many licensees will actually successfully finish the program (it lasts 2 years). Based on the current literature on successful treatment of substance abusers, relapse is a common occurrence in treatment and large percentages of participants relapse several times prior to abstinence. 5. In some cases the end result is not abstinence but controlled use to a successful extent. 5

The start up costs for the program were $215,400 which funded staff, a computer system and office equipment, supplies, etc. The ongoing budget of the program on an annual basis is $150,000, the majority of which pays for salaries. This program has been funded as required by statute from a licensee renewal fee increase of $10 per licensee. There are approximately 43,000 nurses who could take advantage of this program. Board estimates of the cost per licensee range from $7000 to $11,000 depending upon which numbers are used. Contractor estimates of costs range from $3000 to $5000 and it believes that costs are decreasing as the program grows.

It is difficult to analyze these pieces of the program due to many factors (the lack of concrete outcome requirements, the shifting data numbers, the short time the program has been in existence). In investigating programs in other states, it became clear that no two programs were exactly alike. However, assuming a comparison between apples and apples, startup data from 8 other programs around the country indicates that Colorado's program is ballpark. Start up census in all of the states polled was less than 1%, the same as Colorado. 9. Even at the end of 5 or 7 years of operation the census data of licensees in some of those programs remained below 1% of their total census. The administrators in those states, however, felt that the programs were very worthwhile and useful for the state. OPR could get no comparable or consistent budget data from these states.

Colorado's program is comprised of the following services: assessment, referral, group meetings and follow-up services, marketing services (via brochures, education programs, telephone contacts, mailings), post treatment monitoring and support services, particular interventions in appropriate cases, 24 hours a day support services, and outreach services, as well as administrative matters and interfacing with the BON and the REC committee (Rehabilitation Evaluation Committee, a legislatively required intermediary). The contractor reports quarterly to the BON, meets monthly with the REC and discusses all cases under monitoring in order to readjust plans as appropriate.

These functions are the required functions pursuant to law. C.R.S. 12-38-131 (5)(b). In addition, they are the recognized components of a successful diversion program. 10. The contractor's performance pursuant to mandatory requirements appears adequate. The issue of whether the program is too costly is a policy decision for the Legislature. Since it was a policy decision to offer the program to assist impaired nurses, only the Legislature can determine at what cost such assistance is bad public policy.

OPR finds that the program is in compliance with statute, is capable of rendering services which could lead to successful outcomes, but has been operating for too short a period to demonstrate volume outcomes. In addition, the program is similar in scope and nature to programs in other states and $10 is not an excessive or unreasonable fee from which to operate the program, regardless of whether that money helps all nurses or not.

Discipline vs. Diversion Problems

The program does experience inefficiencies that result in some ineffectiveness. This is not primarily due to inappropriate staff action, but due to the statutory structure of the program.

Other assistance programs of this nature were created more simply. The BON in those states handles disciplinary action and the program handles substance abuse treatment. The two functions are primarily separate, only intertwined when the program determines that an applicant or participant is unsafe to practice, a risk to himself or others, or has performed substandard care. At that point, the program is required to refer that participant to the Board. In some cases the participant can be undergoing disciplinary action and still remain involved in the diversion program. 11.

The BON program has an intermediary - the Rehabilitation Evaluation Committee (hereinafter REC). This committee acts as a screen concerning admissions, monitors the monitoring of the contractor, and refers participants to the BON when they believe some sort of disciplinary or other action is appropriate. The BON remains entangled with the whole process by taking in the complaints, reserving the right to deny admission to the program to applicants for its own reasons, and following up on the action recommended by the REC. Most of this is statutorily required.

In addition, the role of the two entities is further muddied by the fact that the BON staff that handles all disciplinary substance abuse cases also sits on the REC committee and is integrated in that fashion into everything the diversion program does. (See Appendix C comparing this structure to Board of Medical Examiners diversion program structure). This brings the disciplinary view into all REC proceedings, which are not intended to be disciplinary.

The staff from the BON is grounded in the disciplinary context. This is their area of expertise and they are very good at it. With so much staff integration into the diversion program business, however, the program loses some of its identity and the purpose of it becomes blurred. For example, the BON has pre-set ideas about when licensees should or should not be given an opportunity to enroll in the program. They disapprove of a licensee entering the program if he/she has had prior instances of discipline for substance abuse. It was explained that the reason for this is that the Board would not be able to tell an employer if he called that a licensee is in the diversion program, and since the licensee has past infractions he/she is assumed to be a bigger risk. Therefore the BON keeps that applicant in the disciplinary structure. The unwritten policy, however, is not applied each time. The BON reserves the right to evaluate each applicant for the program and decide if the past discipline warrants this result or not.

Thus, applicants to diversion end up dealing with the disciplinary process regardless of diversion program intent. That is not to criticize the BON's assessment of the situation. It is to demonstrate that the discipline is not really separate from the program. From an applicant's perspective, they believe they are entitled to seek treatment from the program, not the BON, pursuant to law. There are numerous other safeguards in the system to handle inappropriate admission. The REC committee could recommend denial of admission if they believed the applicant was inappropriate. That is part of their statutory duty, and they are the experts on substance abuse recovery. In the situation cited above, diversion program policies require any new participant to inform her employer of her participation in the program. There really is no need for BON to control admissions. The Medical Board has no such oversight in its diversion program.

The particular contractor for the BON program and the BON staff are at odds. This causes some problems in the administration of the program. A lack of trust and open communication hinders collaborative administration so that both parties engage in more work, and this situation detracts from efficient work processes, since control becomes a primary goal. This state of relations also makes it difficult to analyze how much of the above would be a problem with a different contractor. One could assume that the REC was created to be a check and balance on the activities of the contractor - that is to say, to ensure that the contractor's role of advocacy for the licensee did not supersede its responsibility to ensure public safety. In that role, the REC has done an excellent job. The check and balance has operated successfully. However, the Medical Board program does not have such a check and it has also operated successfully.

This problem demonstrates the difficulty in attempting to have the disciplinary body implement a program whose main mission is not discipline. While one could conclude that the contractor has not marketed adequately to procure nurses into the program, one could just as easily conclude that the example of BON pre-admission control has kept the census inordinately low in the program. In addition, the contractor raises another concern - that placing licensees into discipline rather than diversion may actually endanger the public welfare, since it takes 6 to 9 months to process a disciplinary case through all the administrative steps, while a diversion applicant could be admitted in the same month, start the program ASAP, and be subject to monitoring.

The way the system is set up statutorily, the BON must approve or oversee every step of the way. This is so even though the members of the REC committee are the substantive experts in substance abuse treatment. It is not clear that the public welfare or safety is served by this dual supervision scheme.

The Board of Medical Examiners has a simpler system that appears to work quite well. All of the other eight states OPR contacted also had simpler 2-tiered systems like BME. There is always the threat, of course, that the diversion organization will protect members of its own group to the disadvantage of public safety. That conflict is inherent in the concept of rehabilitation for substance abusers instead of punishment. The tension is appropriate. The two tiered model of the Medical Board offers less oversight on that issue. The Board does not know who applies, and it does not get involved in the business of the diversion program unless an applicant is deemed unsafe to practice, or unless it refers the applicant in the first place. The two entities operate on trust, a contract and the absence of negative outcomes.

The BON model does add an element of safety to the process. However, it may also slant the program results due to the disciplinary overtones in the process, and it is certainly less expedient, more complicated and takes more staff time and energy than a two tiered system. It also could be discouraging nurses from applying as they see it as part of the disciplinary process.

Summary

OPR is required by its statute to determine whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms. In the case of the diversion program, OPR concludes that the current statutory program is not the least restrictive program consistent with the public interest. Other programs exist successfully in a less restrictive environment without bad public outcome. However, the Legislature may have intended a more restrictive program here when it developed the 3 tiered program including the REC committee as an intermediary between the BON and the contractor. For that reason, OPR makes recommendations in the alternative:

RECOMMENDATION 4:

A.) FIRST ALTERNATIVE - If the Committee agrees that the current situation is too restrictive, creates unnecessary administrative functions and inefficient governmental processes, and may hamper the ability of the diversion program to provide services successfully:

OPR recommends that the current diversion program be revised to resemble a two tiered model like that of the Board of Medical Examiners, as in C.R.S. 12-43-118.

OPR recommends that the Legislature strike 12-38-131(5) through (7), rewrite the remainder as necessary to embody the two tiered model, and revise sections (8) and (9) so as to comport with the new program. OPR recommends that excessive program detail (such as required features of the program or qualifications of the contractor) be stricken permanently, giving the BON discretion to determine such things.

OPR recommends that BON continue to use the REC committee as an advisory committee on substance abuse matters, and delegate all such cases to them for investigation and recommended action, to make BON disciplinary actions more efficient.

B.) SECOND ALTERNATIVE - If the Committee believes that a more conservative approach is appropriate in this area and wishes to maintain a check and balance between the contractor and the BON for some reason:

Maintain the three tiered system but modify it so that the REC committee has more independent authority, and need only seek BON approval when it believes a suspension or revocation of a license is appropriate;

Strike 12-38-131(5) through(7). rewrite only one subsection directing BON to create the REC, to maintain separateness of programs, to develop guidelines for diversion program content, etc. (See Appendix D). This approach would allow the diversion contractor to take in complaints, assess applications, accept licensees or not, implement the program, monitor, and recommend anything necessary to REC. It would allow the REC to reject inappropriate applicants from the program, monitor all diversion contractors cases, make changes in treatments provided, and take any escalation necessary to deal with participants except suspension or revocation of a license, which must be referred to BON.

C.) THE DIVERSION PROGRAM SHOULD BE CONTINUED FOR ANOTHER THREE YEARS AFTER ANY REORGANIZATION. AT THAT POINT IT WILL HAVE HAD SUFFICIENT TIME TO STABILIZE AND DEMONSTRATE OUTCOMES. THE COMMITTEE SHOULD EVALUATE AT THAT TIME WHETHER IT IS SUFFICIENTLY COST EFFECTIVE TO JUSTIFY FURTHER OPERATION.

OTHER STATUTORY REVISIONS

Board Performance

The Board of Nursing primarily deals with educational matters (certifying new and existing schools or nursing programs), licensing new nurses (a function primarily handled by staff) and discipline of licensees. By far, its disciplinary function absorbs most of its time. The number of complaints received by the Board over the last four years has remained somewhat stable, although the nature of cases has changed over time and this drastically affects staff work. The first change is that the number of licensees involved in each complaint has increased dramatically reflecting the increased incidence of cases in which multiple nurses are involved in one incident of substandard care (for example, a case of poor care in a nursing home). See Appendix E.

Secondly, the Board has seen the largest increase in cases of probation. If the Board has reason to believe a licensee's practice can be strengthened, it will often use probation for these cases. Substance abuse cases often end in probation. This means the staff must keep a running record of the licensee's ongoing compliance with his/her stipulation and make presentations to the Board periodically, to get further Board direction. This increases single case exposure to the Board, which is less direct and efficient case administration than other types of infractions. In addition, many probation cases last longer than one year, so the Board's workload increases exponentially year to year. BON has computed that since 1984 there has been a 569% increase in the number of stipulations entered into by the Board. There also has been a 350% increase in the number of hearings for infractions of the code. Both of those types of actions require increased staff and Board participation. Hearing cases require increased time from the Attorney General's Office.

The Board also absorbed the Nurse Aides program in 1991, an act which by 1994 had added 19,077 individuals to their program. Although there is a special committee that oversees discipline for this group, the Board does have to ratify that action, so it requires staff work and Board oversight.

The Board typically disciplines about .4% of the total number of its licensees. This percentage may seem low but is comparable or higher than the percentages in the Medical Board, the Pharmacy Board, and the Dental Board. Also, when the number of actions taken by the Board is compared to the number of complaints filed, the Board is actually taking action on about 50% of the complaints brought before it, and dismissing the remainder. This record is very good, especially in light of the Board's increasing workload. By and large, the numbers indicate that the Board is attending to its statutory duties conscientiously and attempting to provide a high level of safety to the public. It is not engaged in an effort just to protect the members of the profession.

Due to all of these facts, some problems exist. The Board meets every two months for a 2 day meeting. The agenda and file reading required for that meeting takes about 12 to 18 hours. At the meeting, it is observable that the Board begins to tire at the end of the first day, and by the second day, full concentration is jeopardized. Numerous things can happen when members are too tired to listen attentively, or ask questions. Inconsistency in decisions, uneven prioritization and attention, lack of thorough discussion due to everyone's wish to complete the agenda - all of these things can plague the Board's ability to do its best work. In addition, since the Board only meets once every two months, if a case is not resolved at the scheduled meeting (for instance, due to Board questions that cannot be answered) the licensee must wait another 2 months to have any action taken on her case. This wait is in addition to the 6 to 8 month wait she may have had already, due to investigations backlog.

Since so many more cases are going to hearing, the Board's need for legal services has increased. In 1990 the Board had 34 cases pending hearing in the Attorney General's Office. In 1994, even though the Division reallocated legal services money from the Medical Board to the BON in the interim, BON has 101 nursing cases pending hearing in that office. At each BON meeting the Board routinely refers anywhere from 15 to 35 cases to the Attorney General. There is no indication that this trend will slow.

For all of the above reasons, it is clear that the Board cannot simply proceed as is in the future and complete its work effectively. The workload is simply too great, and continues to grow. This Board is extremely hardworking and has performed well. However, a change in its meeting schedule would increase the efficiency and effectiveness of the Board and address some of the lag time in completing cases. OPR recommends that the Committee consider advising the JBC that this problem requires greater legal services appropriations.

RECOMMENDATION 5: THE COMMITTEE SHOULD DIRECT THE BON TO MEET AT LEAST MONTHLY IN ORDER TO ACCOMPLISH ALL OF THE TASKS BEFORE IT EFFECTIVELY. IN ADDITION, THE BON SHOULD HOLD ADDITIONAL QUARTERLY MEETINGS TO CONSIDER POLICY MATTERS (RULEMAKING, POLICY GUIDELINES, ETC.).

See Appendix F concerning BON chart on workload.

1.A. Section 12-38-117(1)(i)

This section sets forth the grounds for discipline regarding nurses that are addicted to drugs or alcohol. Currently the Board must prove that a nurse is presently addicted to or dependent on alcohol or habit-forming drugs or is an habitual user of such at the time of the hearing in order to charge this violation.

Experience has shown that in cases where individuals are involved in abusive or addictive activity, it is not uncommon to find them diverting drugs from their place of employment in order to support the habit. While proving addiction or habitual use may be difficult at the time of hearing, diverting drugs is often a simpler case to prove. Although drug use might be rarely witnessed at a facility, diverting can be proven based on documentation sometimes.

It is reasonable to believe that someone would probably only divert drugs from their employer primarily for personal use. The Board could improve on its ability to safeguard public welfare if it were enabled to charge "diverting," since the person using the diverted drugs may be unsafe to practice, but the Board may lack the proof of the other charges. Therefore, addition of that language is recommended.

B. Section 12-38-119(2)(a)

This section addresses a situation where the Board can require a licensee to submit to a mental or physical examination by a Board designated physician if it has reasonable cause to believe that a licensee is unable to practice with reasonable skill and safety to patients due to a substance problem or mental condition.

Cases have occurred, however, where the Board has ordered such exams and the licensee has not been cooperative in disclosing information that might be relevant to the issue of safety to practice. The Courts and ALJ's have upheld the right of licensees to withhold their personal medical records through their own physicians or facilities so the Board's physician is unable to reach a conclusion about the person's safety to practice.

While an individual's right to privacy is paramount in most situations, it must be balanced with the rights of innocent patients who might be subjected to inappropriate or substandard care by an impaired nurse. The situation could be remedied by requiring the licensee to disclose past personal medical records that are relevant to the issue at stake, (i.e. if the question is one of mental illness, for instance, the doctor or facility must turn over those record of any mental condition; if it is a question of substance abuse, the same would apply. The Administrative Law Judge could examine those records in confidence and rule on which, if any, are relevant to the situation at hand.)

The appropriate language to be inserted is:

> ***"or to release all medical records necessary to determine the licensee's ability to practice safely";*** insert after "physical examination" in last sentence.

This compromise would protect the licensee from full and open disclosure of private records, yet it would allow the Board to assess the safety of the licensee to practice. This is reasonable in light of the threat of public danger.

In order to properly amend the act, similar language would be needed in Section 12-38-120(7), concerning the Board's subpoena power in disciplinary proceedings.

C. ***Section 12-38-119(2)(a)***

This section also addresses the Board's ability to order a mental or physical examination when it has reasonable cause to believe that a licensee is unable to practice with reasonable skill and safety due to a substance problem or a mental condition. The section allows for independent examination by a Board designated physician.

There are numerous professionals besides physicians that have developed expertise over the years in substance abuse counseling and treatment for mental illness. Many of these are psychologists, social workers, psychotherapists, drug counselors, etc. The Board should have the ability to appoint an appropriate professional to complete the needed examination, regardless of specific training.

OPR recommends deleting the word physician from this section, and inserting language that will allow for appointment of the best trained professional for the task.

D. Section 12-38-108(1)(h)

This section addresses the power of the Board to conduct hearings upon disciplinary charges, and to impose disciplinary sanctions. Common sanctions provided are those like suspension, revocation, probation, etc.

The Board currently lacks the ability to impose one sanction that is critical. The Board cannot currently limit a license. That is, if the Board finds that a licensee is impaired in some fashion, but might otherwise be safe to practice (like a recovering drug addict that could not be trusted to practice alone nights, but might function perfectly well under supervision on the day shift)—the Board lacks the ability to impose conditions on the license that would restrict the practice of that person to a safe scenario. This situation benefits neither party. The licensee is totally restricted from practice, which is a detriment financially and professionally. The public lacks for another qualified nurse who can perform well under limited conditions.

Therefore, OPR recommends that this section be amended to allow the Board to limit licenses (adding language such as "including but not limited to limiting the license in accordance with appropriate restrictions on the scope or nature of practice as necessary" after the word "sanctions" in that section).

E. Section 12-38-117(1)(b)

This section addresses the Board's authority to discipline a licensee when he has committed a felony. The section does not speak to deferred sentence situations. Such a situation would involve a defendant that pleads guilty to a felony offense in return for which he successfully completes some amount of time in public service ordered by the court. Upon successful completion of the term, the defendant is released from the jurisdiction of the court and the entire criminal offense is dismissed with prejudice.

The Board would like the ability to discipline nurses who are accepting deferred sentences for felonies (as in a nurse diverting drugs from her employer). The Board could use the plea in the deferred sentence during the period of public service as proof of a criminal act which merits consideration of discipline. This would end the incentive for any nurse to accept a deferred sentence in order to avoid action on their license, as well as hold the nurse accountable for her behavior.

OPR recommends that the following language change to that section:

> ***Conviction of a felony or conviction of any crime that would constitute a violation of the Nurse Practice Act. For purposes of this subsection, a conviction shall include a plea of guilty, a plea of nolo contendere or a deferred sentence prior to final sentencing or dismissal with prejudice;***

F. Section 12-38-113

This section also addresses the Board's ability to deny a license. Currently the Board can enforce a one year waiting period after license revocation prior to allowing the nurse to apply for re-licensure. After a year, the Board must consider issuing a new license to the applicant.

In practice, it often takes the Board anywhere from nine to 18 months, or longer, to revoke a license, depending upon whether or not the case goes to hearing or is settled. One year is a short time period considering the length of time of disciplinary proceedings, the investment of energy by staff and the cost to the state to discipline that nurse. The waiting period is intended to serve the purpose of reminding the licensees of their accountability for their behavior and the fact that it is a privilege to be licensed, not a right. Without a substantial wait that message is lost.

Both the Medical Board and the Optometrist's Board require a two-year wait that is becoming the regulatory standard. OPR recommends that the Nursing statute be conformed to those statutes, and that all medical professionals endure the same wait for reapplication.

G. Section 12-38-115

This section addresses the Board's ability to issue temporary permits to practice where the circumstances warrant it. Two such situations are addressed. Over time, as conditions change both in Colorado and around the country (such as a nursing shortage here, a surplus elsewhere, NAFTA, etc.) the need for other permitting arises. Individuals whom the Board deems qualified to practice for a temporary period prior to licensing need a permit and the Board has no authority to help them.

Further discretion in this area would benefit the Board and the licensees. They could begin their Colorado employment sooner, and the Board could be assured that the new applicants would take the refresher course and the next licensing exam.

OPR recommends that a new provision be added to that section that states "*The Board may authorize a permit to practice under supervision as it deems reasonable.*"

H. Section 12-38-120(4)

This section addresses disciplinary proceedings. Although licensees who are disciplined have always been involved in due process proceedings, the issue of what and how much discipline has become a bit blurred due to the creation of diversion programs. The Board now must recognize dual roles since the nursing diversion program was enacted in its code. That program was created to assist licensees with substance abuse problems, by referring them for treatment rather than disciplining them. The theory behind diversion programs is that addicted individuals are ill and need the chance to get well, rather than to be disciplined for their problems.

The Board therefore must allow the diversion of appropriate licensees or decide that the licensee is not capable of practicing in a safe manner and refer the matter for disciplinary proceedings. These decisions are not easy and often involve complicated judgments and applied experience. Many cases of discipline go on to hearing regarding the Board's decision about the licensee's safety to practice.

The Board has received some ALJ decisions in substance abuse cases that are unsatisfactory regarding this dual role. The judge determined that the licensee's rehabilitation was the paramount concern in a disciplinary matter. This means that the safety of the public was secondary. Although this certainly may be true from the individual perspective of the licensee, the role of the Board of Nursing has always been, first and foremost, "to protect the people of this state from the unauthorized, unqualified, and improper application of services by individuals in the practice of nursing"... C.R.S. 12-38-103. The Board must always balance the rights of the individual and the general public good, but if any question exists about the appropriate course of action, it is correct for the Board to err on the side of public welfare. Individuals have other, private rights of action pursuant to other laws if they have been wronged. The diversion program is a benefit given to licensees by the Legislature. Creation of that program was not intended to somehow shift the Board's primary responsibility from protecting the public welfare to protecting licensee's welfare.

To remedy this misconstruction of the law, OPR recommends an amendment to the statute that clarifies this issue. The below language would satisfy this concern:

> ***"In determining what action is appropriate, the disciplining authority must first determine what sanctions are necessary to protect or compensate the public. Only after such provisions have been made may the disciplining authority consider and include requirements or reliefs designed to rehabilitate or relieve the license holder. Public protection is the primary concern in all licensee disciplinary matters."***

I. Section 12-38-120(7)

This section addresses Board subpoena power. The second sentence requires certain confidentiality procedures concerning medical records. These have become cumbersome to facilities over time, as there are many ways to ensure patient confidentiality currently. Either state or federal law already guarantee confidentiality of such records.

OPR recommends the sentence be stricken and the facilities be allowed to determine themselves the best way to provide confidentiality to subpoenaed records.

J. Section 12-38-103(10)

Nursing representatives in the community have requested that the definition of the practice of professional nursing be changed, updated and amended. Although neither OPR nor the Board of Nursing found evidence of a problem with the current definition, constituents believe it is outdated and does not reflect the current state of practice.

OPR is neutral on this request, but has attached a copy of the language submitted as Appendix G, should the Committee choose to make this change.

ADMINISTRATIVE RECOMMENDATIONS

1. OPR recommends that the BON delegate authority to a Board member to engage in settlement negotiations on behalf of the Board and settle cases if possible prior to the need for hearing. This can be done after the case has been investigated and the full BON has already determined that the case should be referred for hearing. The BON can refer the case with recommendations about how they want it handled, and the settlement officer for the Board can attempt to settle in that fashion. This process could reduce cases going to the Attorney General's Office for representation. The Real Estate Division has implemented such a policy, and is currently settling 65% of the cases that get referred to hearing.

2. The Board of Medical Examiners used to send a list of all revoked physicians to hospitals and long term care facilities periodically in order to enable them to check their staff listing and ensure that no one is still working without a license. This can be a problem in between renewals, since the facilities would not necessarily have a mechanism to keep updated monthly or quarterly, etc. The BON should adopt this policy, as there are more nurses than physicians and the risk could be equally as great to the public if an impaired nurse continued to practice.

APPENDIX A

SUNSET STATUTORY EVALUATION CRITERIA

I. Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;

II. If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;

III. Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices of the Department of Regulatory Agencies and any other circumstances, including budgetary, resource and personnel matters;

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

V. Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;

VI. The economic impact of regulation and, if national economic information is available, whether the agency stimulates or restricts competition;

VII. Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;

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

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

APPENDIX B

MULTI-STATE DIVERSION ANALYSES							
STATE	Program Initiated	Number of Nurses at Inception	Number of Nurses in Program	% of Nurses in Program at Inception	Current Population of Nurses	Current number of Nurses in Program	% of Nurses in Program
AZ	1991	41,000	30	0.07%	55,000	100	0.18%
MD	1989	50,000	24	0.45%	60,000	75	0.12%
NM	1987	N/A	37[1]	0.27%	13,647	80	0.58%
OR	1991	36,000	45	0.12%	37,000	109	0.29%
TX	1987	109,460**	231	0.21%	130,000[2]	377	0.29%
					87,000[3]	96	0.11%
					217,000[4]	473	0.20%
WA	1991	N/A	236	0.40%	58,000	356	0.61%
CO	1993	43,000	32	.07%			

1 Used current nurse number to calculate percentage.

2 Number indicates Registered Nurses only.

3 Number indicates LVNs (same as LPN) only.

4 Number indicates combined RNs and LVNs.

APPENDIX C

APPENDIX D

APPENDIX E

APPENDIX F

CHARTS ON WORKLOAD, PROVIDED BY BON

	1989	1990	1991	1992	1993	1994
PERSONS PLACED ON PROBATION	58	84	76	78	59	54
PERSONS COMPLETING PROBATION	16	19	24	28	26	36
NET PERSONS ON PROBATION	42	65	52	50	33	18
PERSONS ON PROBATION FROM PRIOR YEAR	---	42	107	159	209	242
TOTAL PERSONS ON PROBATION	**42**	**107**	**159**	**209**	**242**	**260**

	1989	1990	1991	1992	1993	1994
LICENSES REVOKED	4	8	12	17	14	20
LICENSES RELINQUISHED	15	8	13	11	13	19
LICENSES SUMARILY SUSPENDED	10	8	12	9	10	12
LICENSES SUSPENDED	10	16	24	42	33	30
TOTALS	**39**	**40**	**62**	**79**	**70**	**81**

APPENDIX G

"Practice of professional nursing" means the performance of both independent nursing functions and delegated medical functions, according to accepted practice standards. Such practice includes the initiation and performance of nursing care through health promotion, supportive or restorative care, disease prevention, diagnosis and treatment of human disease, ailment, pain, injury, deformity, and physical or mental condition which requires such specialized knowledge, judgment, and skill involving the application of biological, physical, social, and behavioral science principles as are required for licensure as a professional nurse pursuant to section 12-38-111. The practice of professional nursing, according to general practice standards, shall include the performance of such services as: . . .

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READER RESPONSE FORM

TO: Colorado Department of Regulatory Agencies
Office of Policy and Research
1560 Broadway, Suite 1550
Denver, CO 80202

RE: Sunrise/Sunset Report on
(Report Title and Date)

FROM:
(Your Name and Address)

DATE:

I have read your report and found it:

Excellent _____ Good _____ Fair _____ Poor _____

Here are my suggestions for improving the report:

The report was thorough in its coverage of the subject:

Yes _____ No _____

Comments:

The report was fair in its treatment of the issues:

Yes _____ No _____

Comments:

Thank you for your response. We hope you found our report useful.
Revised January, 1994.