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Advancing Nursing Excellence for Public Protection

The 2015 Environmental Scan

National Council of State Boards of Nursing

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Advancing nursing excellence for public protection

Mission

The *Journal of Nursing Regulation* provides a worldwide forum for sharing research, evidence-based practice, and innovative strategies and solutions related to nursing regulation, with the ultimate goal of safeguarding the public. The journal maintains and promotes National Council of State Boards of Nursing's (NCSBN's) values of integrity, accountability, quality, vision, and collaboration in meeting readers' knowledge needs.

Manuscript Information

The *Journal of Nursing Regulation* accepts timely articles that may advance the science of nursing regulation, promote the mission and vision of NCSBN, and enhance communication and collaboration among nurse regulators, educators, practitioners, and the scientific community. Manuscripts must be original and must not have been nor will be submitted elsewhere for publication. See www.journalofnursingregulaton.com for author guidelines and manuscript submission information.

Letters to the Editor

Send to Maryann Alexander at malexander@ncsbn.org

The 2015 Environmental Scan

Nurses are the front line of surveillance—they are key to monitoring and detecting signs and symptoms of infection and initiating appropriate treatment and referral. Assuring that there are sufficient numbers of nurses in health care settings, communities, and public health agencies is critical to any efforts to prevent transmission of Ebola virus.

American Academy of Nursing and American Nurses Association, 2014

As the U.S. health care system rises to meet new and ongoing challenges in 2015, nurses will indeed be at the front line. As members of the largest health care profession, nurses are not only the forefront of surveillance; in the coming years, they will play integral roles in population health, primary care, and the redesign of the U.S. health care system.

Ensuring that the care administered by nurses is safe and competent are the 59 boards of nursing (BONs) across the United States and its territories. Nursing regulators oversee licensure and scope of practice, approve nursing programs, and administer state and territory nurse practice acts and regulations. These regulators need current, critical information that addresses regulatory, workforce, political, economic, and social issues involving nurses and the environment in which they operate. This report was developed to provide current, critical information for BONs to fulfill their mission to protect the public while responding to the emerging issues and challenges of 2015 and to strategically plan for the future.

A variety of sources were used to develop this report, including research and scholarly articles, news articles, websites, databases, peer-reviewed journals, direct communications and presentations, annual BON reports, and the National Council of State Boards of Nursing (NCSBN) surveys of BONs. Certain consistent sources of data and graphs are used from year to year to help formulate comparisons and identify trends. New issues, problems, and data on the horizon for 2015 are also included. An abundance of information was reviewed and analyzed to provide a report that can be used to assess the regulatory environment and guide strategic planning. Not all applicable information and data can be captured in this report; however, every attempt was made to produce a well-documented, comprehensive report describing the state of nursing regulation and the environment in which BONs function.

Nursing Workforce

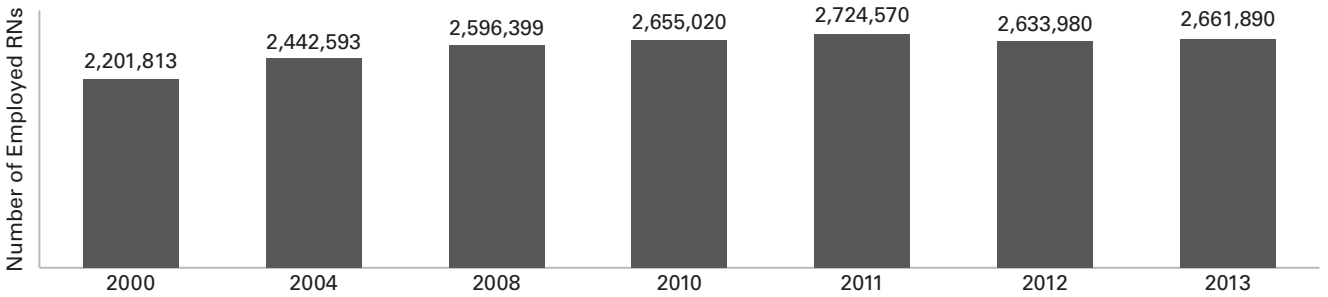
NCSBN's National Nursing Database tracks the number of U.S. licensed nurses from 55 BONs on a daily basis. As of November 2014, there were more than 4,548,331 nurses (registered nurse [RN] and licensed practical/vocational nurse [LPN/VN]) holding an active license in the United States (National Council of State Boards of Nursing [NCSBN], 2014b).

Registered Nurses

There are more than 3,680,612 RNs in the United States as of November 2014 (NCSBN, 2014b). Although a year behind, the most recent Occupational Employment Statistics data (through May 2013) indicate that 2,661,890 RNs were employed in the United States (U.S. Bureau of Labor Statistics, 2014b). As illustrated in Figure 1, the number of employed RNs in the United States is once again increasing after a decline in 2012.

FIGURE 1

Total Number of Employed RNs in the United States: 2000-2013

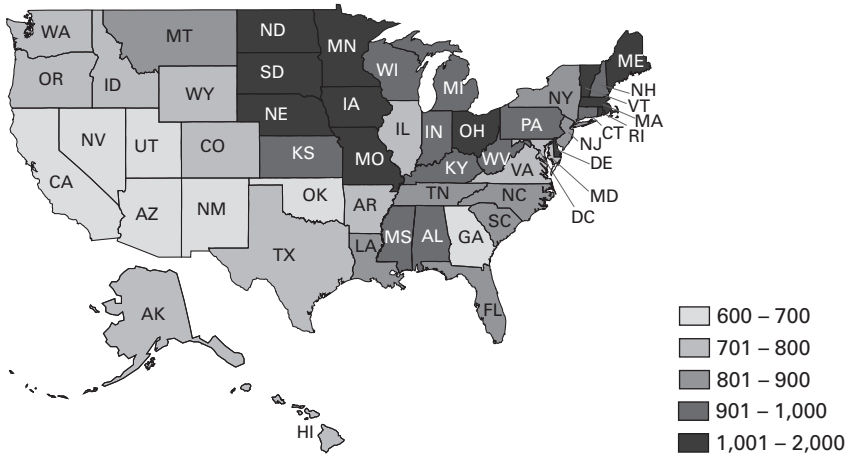


Note. The 2010, 2011, 2012, and 2013 statistics were taken from the semiannual Occupational Employment Statistics survey published by the U.S. Bureau of Labor Statistics (2014b). The 2000, 2004, and 2008 statistics were taken from the Health Resources and Services Administration's National Sample Survey of Registered Nurses (2010).

The U.S. Bureau of Labor Statistics (2014a) employment projections update for 2012-2022 predict that an additional 526,800 RNs, or a 19% growth rate, will be needed. However, the number of employed RNs per capita varies across the United States. The District of Columbia has the densest RN workforce, and the U.S. Virgin Islands has the sparsest. (See Figure 2 and Table 1 for state-by-state depictions of the ratio of employed RNs per 100,000 population as of May 2013.) (U.S. Bureau of Labor Statistics, 2014b)

FIGURE 2

Employed RNs per 100,000 Population, by State



Note. State population estimates are from the U.S. Census Bureau (2014). Population estimates for the U.S. territories are from the World Bank (2014).

TABLE 1

Total RNs Employed per 100,000 Population, by Jurisdiction

	RN Employment	Jurisdiction Population	RNs Employed per 100,000 Persons
Alabama	43,600	4,833,722	902.0
Alaska	5,790	735,132	787.6
Arizona	46,290	6,626,624	698.5
Arkansas	23,480	2,959,373	793.4
California	252,940	38,332,521	659.9
Colorado	41,860	5,268,367	794.6
Connecticut	34,820	3,596,080	968.3
Delaware	9,740	925,749	1052.1
District of Columbia	11,030	646,449	1706.2
Florida	162,530	19,552,860	831.2
Georgia	66,080	9,992,167	661.3
Hawaii	10,300	1,404,054	733.6
Idaho	12,150	1,612,136	753.7
Illinois	109,480	12,882,135	849.9
Indiana	59,730	6,570,902	909.0
Iowa	32,100	3,090,416	1038.7
Kansas	26,940	2,893,957	930.9
Kentucky	42,400	4,395,295	964.7
Louisiana	40,600	4,625,470	877.7
Maine	13,890	1,328,302	1045.7
Maryland	46,070	5,928,814	777.1
Massachusetts	79,270	6,692,824	1184.4
Michigan	91,840	9,895,622	928.1
Minnesota	57,920	5,420,380	1068.6
Mississippi	27,590	2,991,207	922.4
Missouri	64,870	6,044,171	1073.3
Montana	9,040	1,015,165	890.5
Nebraska	19,550	1,868,516	1046.3
Nevada	17,160	2,790,136	615.0
New Hampshire	12,180	1,323,459	920.3
New Jersey	75,410	8,899,339	847.4
New Mexico	14,540	2,085,287	697.3
New York	169,820	19,651,127	864.2
North Carolina	88,350	9,848,060	897.1
North Dakota	7,750	723,393	1071.3
Ohio	124,400	11,570,808	1075.1
Oklahoma	25,960	3,850,568	674.2
Oregon	28,490	3,930,065	724.9
Pennsylvania	124,750	12,773,801	976.6
Rhode Island	11,570	1,051,511	1100.3
South Carolina	41,950	4,774,839	878.6
South Dakota	11,540	844,877	1365.9
Tennessee	57,760	6,495,978	889.2
Texas	190,090	26,448,193	718.7
Utah	18,550	2,900,872	639.5
Vermont	6,710	626,630	1070.8
Virginia	60,120	8,260,405	727.8
Washington	53,060	6,971,406	761.1
West Virginia	18,440	1,854,304	994.4
Wisconsin	56,870	5,742,713	990.3
Wyoming	4,500	582,658	772.3
American Samoa	--	55,165	--
Guam	520	165,124	314.9
Northern Mariana Islands	--	53,855	--
Virgin Islands	300	104,737	286.4
Puerto Rico*	18,890	3,615,086	517.3
U.S. Total	2,681,580	320,159,265	837.6

Note. State population estimates are from the U.S. Census Bureau (2014). Population estimates for the U.S. territories are from the World Bank (2014).

*Puerto Rico is not a member of NCSBN.

The skills, knowledge, and diversity of the RN role make it one of the most flexible and most utilized positions in the health care professions. As seen in Table 2, general medical and surgical hospitals rank highest in employing RNs (U.S. Bureau of Labor Statistics, 2014b). Table 2 lists the five health care industries with the highest need for employment of RNs (as of May 2013).

TABLE 2

Total RNs Employed in Industry Setting and Percentage of Industry Workforce Composition, 2013

Industry/Workforce Setting	Total RNs in Industry/Workforce Setting	Percent of Industry Workforce Comprised of RNs
General medical and surgical hospitals	1,553,080 (29.5%)	29.5%
Offices of physicians	178,810	7.4%
Home health care services	166,910	13.8%
Nursing care facilities (skilled nursing facilities)	142,490	8.6%
Outpatient care centers	102,410	15.2%

Note. Data were taken from the semiannual Occupational Employment Statistics survey published by the U.S. Bureau of Labor Statistics (2014b).

Contributing to the continued growth of the RN workforce is the fact that RNs are retiring later in their career. A recent study by Auerbach, Buerhaus, and Staiger (2014) reported these findings. Specifically, from 1969 to 1990, 47% of RNs were still working at age 52; from 1991 to 2012, 74% of RNs were still working at age 62, and 24% continued to work at age 69.

This career longevity may also have an impact on the employment of new nurses. In the National Student Nurse Association (NSNA) 2013 survey of new graduate nurses, 68% (n = 5,910) of new graduates cited the delayed retirement of older RNs as a factor influencing their job search and decreasing their opportunities for employment (Mancino & Feeg, 2014).

Employment of New Graduate RNs

In March/April 2014, Mancino & Feeg (2014) reported on the 2013 NSNA annual survey of new graduate employment. NSNA collected data from 6,121 new graduates. There is an overall increase in new graduates being employed during the first 6 months after graduation. (See Table 3.)

TABLE 3

Percentage of New Graduates Employed Following Graduation: RNs

Graduation Cohort	2012 (n = 4,110)	2013 (n = 6,121)
	Percentage Employed	Percentage Employed
> 1 month (graduated summer)	51%	56%
> 4 months (graduated spring)	71%	76%
> 6 months (graduated in previous year)	86%	87%
All respondents	66%	76%

When respondents are grouped by educational level, increases in new graduate employment across all categories are apparent. Though graduates of baccalaureate programs are employed more quickly than graduates of associate-degree programs, accelerated BSN graduates still lag slightly behind. (See Table 4.)

TABLE 4

New Graduate Employment by Program Level (Spring Graduations)

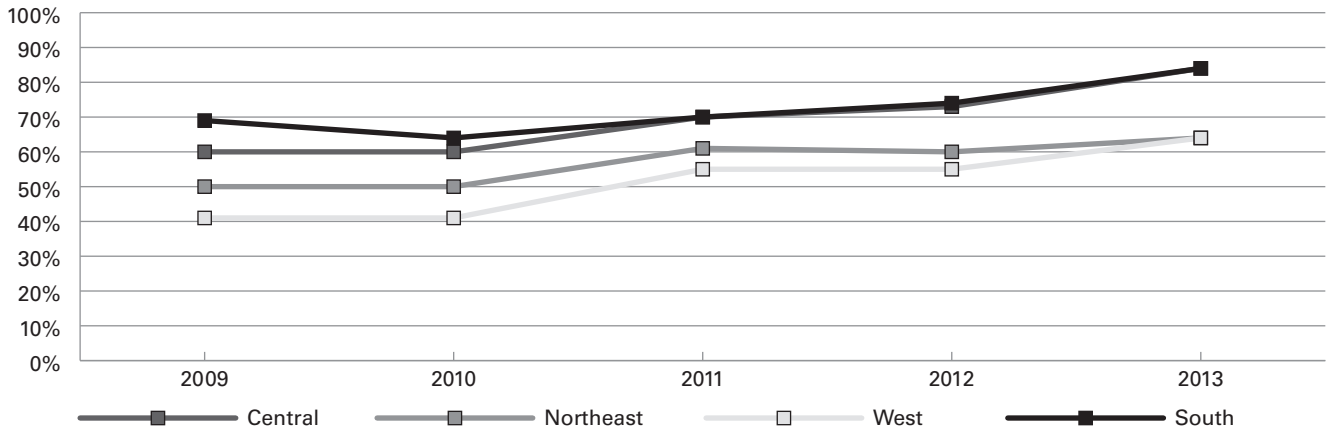
Currently Employed as an RN	2012		2013	
Program Level	**Percentage Employed**	**Number Employed**	**Percentage Employed**	**Number Employed**
Associate degree	61%	966	72%	1,316
BSN prelicensure	72%	1,686	81%	1,686
Accelerated BSN	58%	218	69%	386
Master's degree (prelicensure)	61%	27	84%	36
Clinical nurse leader master's (prelicensure)	50%	13	89%	25

Another interesting finding was that there is a slight difference in employment success based on the type of program. Those who graduate from private, nonprofit programs have a 77% employment rate, and those who graduate from public programs have a 76% employment rate. However, graduates from for-profit programs have a 68% employment rate.

While all regions of the country have increased employment rates of new graduate nurses, the northeast (71%) and west (64%) regions lag behind the south (84%) and central (84%) regions. (See Figure 3.)

FIGURE 3

Employment of New Nursing Graduate Trends by Region



Reprinted with permission. Anthony J. Jannetti, Inc. *Dean's Notes,* March 2014.

The new graduates' observations regarding why they had difficulty finding employment in 2013 were similar to responses in 2012. The top three factors they cite are as follows:

1. Employers are filling positions with experienced RNs (75%).
2. Older RNs are not retiring (68%).
3. There are too many new graduates (59%).

Mancino & Feeg (2014) assert that with the decrease of inpatient admissions and the increase of outpatient admissions (MedPac, 2014; Vesely, 2014) as well as the impact of the Affordable Care Act (ACA), there will be an accelerated movement to the outpatient or community environment.

RNs: Emerging Issues for BONs

- As predictions are made about the needs of the future workforce, what will be the impact of the ACA on the RN role?
- Certain Canadian provinces have expanded the role of the RN to ordering specific medications. Expect this discussion to emerge at some point in the future for RNs in the United States.
- Discussions have arisen regarding the role of standing orders and the scope of practice of the RN. This issue may likely emerge as the Centers for Disease Control and Prevention (CDC) and state public health departments prepare for an emergency response to large-scale disease outbreaks. Also, the U.S. Department of Veterans Affairs (VA) is revising its policies on this issue and may be looking to BONs for review of current state regulations.
- Can the internal resources of BONs meet the demands of the potentially expanding RN workforce?

Licensed Practical Nurses/Vocational Nurses

According to NCSBN's National Nursing Database, as of November 2014, there are 916,384 LPN/VNs in the United States. The most recent employment statistics (May 2013) indicate that 705,200 LPN/VNs were employed in the United States, demonstrating a decline in the workforce from the previous year (U.S. Bureau of Labor Statistics, 2014b).

Predictions from the U.S. Bureau of Labor Statistics (2014a) updated in 2014 indicate that 182,900 additional LPN/VNs, or a growth rate of 25%, will be needed by 2022 to meet job growth, provided demand for LPN/VNs remains consistent. However, as seen in Table 5, actual employment of LPN/VNs in the United States shows a 1.9% decrease from 2012 to 2013. BONs also confirm this decrease, and as noted in the Nursing Education section below, there is a decrease in the number of LPN/VN programs across the country, which might indicate shrinking demand for LPN/VNs.

TABLE 5

Total Number of Employed LPN/VNs: 2012-2013

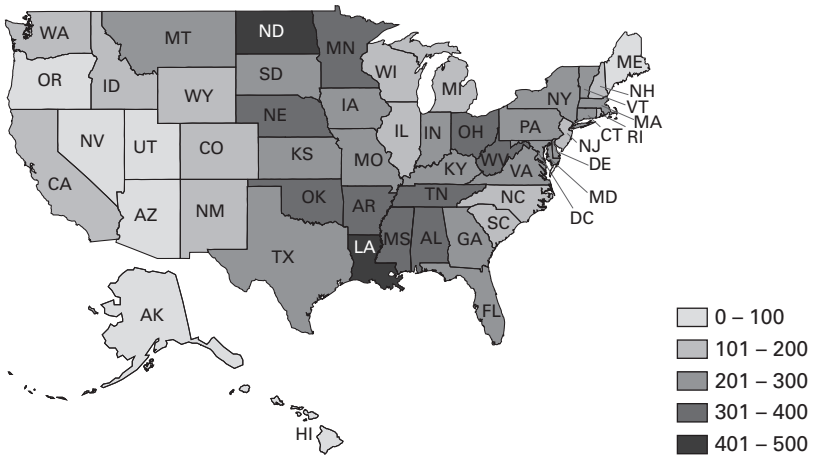
	2012	2013
Number of employed LPN/VNs	718,800	705,200

Note. The 2012 and 2013 statistics taken from the U.S. Bureau of Labor Statistics (2014b).

The per capita distribution of employed LPN/VNs varies substantially across states and territories. Guam has the fewest employed LPN/VNs per capita, and North Dakota has the most. (See Figure 4 and Table 6.) (U.S. Bureau of Labor Statistics, 2014b)

FIGURE 4

Employed LPN/VNs per 100,000 Population, by State



Note. State population estimates from the U.S. Census Bureau (2014). Population estimates for the U.S. territories from the World Bank (2014).

TABLE 6

Total LPN/VNs Employed per 100,000 Population, by Jurisdiction

	LPN/VN Employment	Jurisdiction Population	LPN/VN Employment per 100,000 Persons
Alabama	14,720	4,833,722	304.5
Alaska	580	735,132	78.9
Arizona	6,120	6,626,624	92.4
Arkansas	11,760	2,959,373	397.4
California	61,050	38,332,521	159.3
Colorado	5,750	5,268,367	109.1
Connecticut	8,640	3,596,080	240.3
Delaware	1,930	925,749	208.5
District of Columbia	1,220	646,449	188.7
Florida	43,910	19,552,860	224.6
Georgia	24,350	9,992,167	243.7
Hawaii	1,210	1,404,054	86.2
Idaho	2,920	1,612,136	181.1
Illinois	22,090	12,882,135	171.5
Indiana	19,350	6,570,902	294.5
Iowa	6,500	3,090,416	210.3
Kansas	6,590	2,893,957	227.7
Kentucky	10,490	4,395,295	238.7
Louisiana	21,930	4,625,470	474.1
Maine	1,300	1,328,302	97.9
Maryland	11,870	5,928,814	200.2
Massachusetts	17,050	6,692,824	254.8
Michigan	16,690	9,895,622	168.7
Minnesota	17,400	5,420,380	321.0
Mississippi	9,520	2,991,207	318.3
Missouri	16,190	6,044,171	267.9
Montana	2,440	1,015,165	240.4
Nebraska	6,030	1,868,516	322.7
Nevada	2,260	2,790,136	81.0
New Hampshire	2,110	1,323,459	159.4
New Jersey	14,640	8,899,339	164.5
New Mexico	2,190	2,085,287	105.0
New York	49,050	19,651,127	249.6
North Carolina	15,550	9,848,060	157.9
North Dakota	3,220	723,393	445.1
Ohio	39,310	11,570,808	339.7
Oklahoma	12,030	3,850,568	312.4
Oregon	2,820	3,930,065	71.8
Pennsylvania	36,060	12,773,801	282.3
Rhode Island	1,050	1,051,511	99.9
South Carolina	9,340	4,774,839	195.6
South Dakota	2,070	844,877	245.0
Tennessee	21,190	6,495,978	326.2
Texas	72,020	26,448,193	272.3
Utah	2,300	2,900,872	79.3
Vermont	1,430	626,630	228.2
Virginia	21,760	8,260,405	263.4
Washington	8,000	6,971,406	114.8
West Virginia	6,480	1,854,304	349.5
Wisconsin	9,990	5,742,713	174.0
Wyoming	740	582,658	127.0
American Samoa	--	55,165	--
Guam	90	165,124	54.5
Northern Mariana Islands	--	53,855	--
Virgin Islands	100	104,737	95.5
Puerto Rico*	4,180	3,615,086	115.6
U.S. TOTAL	709,580	320,159,265	221.6

Note. State population estimates are from the U.S. Census Bureau (2014). Population estimates for the U.S. territories are from the World Bank (2014).

*Puerto Rico is not a member of NCSBN.

Employment of LPN/VNs

The most recent statistics disseminated by the U.S. Bureau of Labor Statistics (2014b) contain data from 2013 indicating that the largest numbers of LPN/VNs are employed by skilled nursing care facilities. The five industries with the highest employment of LPN/VNs are shown in Table 7.

TABLE 7

Total LPN/VNs Employed by Industry Setting and Percentage of Industry Workforce Composition, 2013

Industry/Workforce Setting	Total LPN/VNs in Industry/ Workforce Setting	Percent of Industry Workforce Comprised of LPN/VNs
Nursing care facilities (skilled nursing facilities)	213,160	12.9%
General medical and surgical hospitals	112,480	2.1%
Offices of physicians	90,080	3.8%
Home health care services	77,290	6.4%
Continuing care retirement communities and assisted living facilities for the elderly	46,190	5.7%

Minnesota and South Dakota report an increase in the employment of LPN/VNs in 2014. Minnesota also notes an increased use of LPN/VNs in acute-care settings, where they are replacing medical assistants. Does this reflect an emerging hiring trend or a variance in workforce staffing by specific institutions?

LPN/VNs: Emerging Issues for BONs

- What is the future role of the LPN/VN? Who will fill the void in long-term care if LPN/VN workforce numbers continue to decline and education programs close?
- Is there a growing need for LPN/VNs in acute care?
- In 2015, the National League for Nursing (NLN) will convene discussions on the role and education of the LPN/VN. Expect more discussion in this area.

Advanced Practice Registered Nurses

In the United States, the four different roles of advanced practice registered nurses (APRNs) are certified nurse practitioner (CNP), clinical nurse specialist (CNS), certified registered nurse anesthetist (CRNA), and certified nurse midwife (CNM). Information about the numbers of APRNs in the workforce can be seen in Table 8. Table 8 also depicts the change in the number of APRNs from 2009 to 2013.

TABLE 8

Total APRNs by State Reported in the 25th Annual Legislative Updates, *The Nurse Practitioner* (www.tnpj.com) for the States and the District of Columbia

	Total APRN Number Reported (2013)	Change in Reported APRN Totals (Annual Legislative Surveys, 2009-2013)
Alabama	4,143	+790
Alaska	928	+161
Arizona	5,371	+1574
Arkansas	1,632	-187
California	24,651	+4,012
Colorado	5,221	+1,985
Connecticut	4,084	+977
Delaware	1,315	+322
District of Columbia[a]	1,348[b]	
Florida	19,213	+3,889
Georgia	8,787	+1,980
Hawaii	1,080	+234
Idaho	1,353	+308
Illinois	8,496	+1,998
Indiana	3,989	+1,148
Iowa	3,493	+1,663
Kansas	4,174	+1,015
Kentucky	5,053	+1,435
Louisiana	3,955	+460
Maine	1,819	+219
Maryland[a]	4,378[c]	
Massachusetts	10,001	+1,628
Michigan	7,902	+1,613
Minnesota	6,005	+1,373
Mississippi[a]	2,941[a]	
Missouri	6,993	+1,533
Montana	830	+120
Nebraska	1,842	+430
Nevada	880	+65
New Hampshire[a]	1,749[d]	
New Jersey	6,250	+741
New Mexico	1,538	+483
New York	17,975	+4,108
North Carolina	8,136	+1,924
North Dakota	960	+242
Ohio	1,1703	+3,124
Oklahoma	2,371	+684
Oregon	3,485	+830
Pennsylvania	8,555	+1,918
Rhode Island[a]	1,036[d]	
South Carolina[a]	3,275[c]	
South Dakota	1,110	+245
Tennessee	10,045	+1,997
Texas	16,221	+3,357
Utah	2,285	+430
Vermont	578	+19
Virginia	7,482	+1,026
Washington	5,458	+752
West Virginia	1,540	+212
Wisconsin	3,875	+923
Wyoming	490	+81
United States and District of Columbia Total[a]	267,994	+49,227/45 reporting

Note: APRN data from (Phillips, 2009, 2010, 2011, 2012).

[a]2012 state data.

[b]2011 state data.

[c]2010 state data.

[d]2009 state data and therefore not counted in the change total.

As Table 8 indicates, nearly 50,000 APRNs have been added since 2009. However, the U.S. Bureau of Labor Statistics (2014a) estimates another 50,000 could be needed between 2012 and 2022.

In 2015, both employers and policy makers will certainly focus on nurse practitioners. In January 2014, *U.S. News & World Report* ranked nurse practitioners second on a list of best health care jobs in the United States.

In 2014, the Health Resources and Services Administration (HRSA) released a report of a 2012 workforce survey that was specific to nurse practitioners (HRSA, 2014a). HRSA estimates that in 2012, about 127,000 nurse practitioners were providing patient care, and 60,000 were working in primary care. Of those, 94% held a graduate degree, and 96% had national certification.

Data reveal that CNPs continue to be the largest subgroup of APRNs. Also, the CNP role has the largest predicted need and the largest growth in student population of the four roles (U.S. Bureau of Labor Statistics, 2014a). In a 2013 report from the U.S. Bureau of Labor Statistics, nearly 75% of employed APRNs were CNPs; 23% were CRNAs; and 3% were CNMs (U.S. Bureau of Labor Statistics, 2014a). The majority (55%) of APRNs were employed in physicians' offices and outpatient care centers, and 27% worked in medical and surgical hospitals. The CNS role was not included and likely would have increased the number of APRNs employed by hospitals.

Predictions of growth for APRNs in primary care are informed by the American Association of Colleges of Nursing (AACN) annual survey of schools (Auerbach, Martsolf, et al., 2014), and future supply is predicted through HRSA's primary care projections through 2020 (HRSA, 2013). Five-year trends in growth of master's and doctoral programs are reported at 7,400 students per year. The majority (52%) of master's degree student enrollees chose the nurse practitioner role, and the largest growth was in the concentration of primary care. Nurse practitioner enrollees also accounted for the greatest growth in post-baccalaureate entry to Doctor of Nursing Practice (DNP) programs (Auerbach, Martsolf, et al., 2014).

The National Resident Matching Program, an organization that seeks to standardize the residency selection process for graduate medical education, revealed only 19 more graduate matches to U.S. residents for 2014 than in 2013. Fewer than 2,000 physician graduates matched to the primary care specialties in each of those 2 years (National Resident Matching Program, 2014; Pohl, Barksdale, & Werner, 2014). By contrast, 15,593 nurse practitioner graduates completed programs in 2012/2013, and more than 75% of them prepared in areas addressing primary care (Auerbach, Martsolf, et al., 2014). Of note, the percentages of nurse practitioners and physician assistants who practice in rural and medically underserved areas are higher than those for physicians in those areas. Primary care physicians are more frequently located in areas with higher numbers of insured people (United Health Center for Health Reform and Modernization, 2014). Increasingly, the solution to primary care access appears to be care by nurse practitioners (Inglehart, 2014).

AARP sponsored a *Solutions Forum* in September 2014 to examine the barriers to full practice for APRNs. Mark McClellan of the Brookings Institute complimented the consumer movement during his AARP keynote address for their support of the removal of APRN practice barriers by focusing on patient access to care. He emphasized that rhetoric should strongly make the case for the states' financial gains, stating that reducing the overall costs of care while preserving and improving outcomes is what resonates with legislators. He further opined that organized medicine's contention of a patient safety risk has not been demonstrated in states with full practice authority. McClellan suggests that this is where nurses have proven they can reduce costs and preserve quality. "The future is going to be different in health care," McClellan asserted, "the only question that remains is when" (AARP Solutions Forum, 2014).

NCSBN's Campaign for Consensus

NCSBN continues its initiative to assist states in the adoption of the Consensus Model for APRN Regulation, Licensure, Accreditation, Certification, and Education (Consensus Model). The 2014 legislative season brought a record number of bills seeking to align states' nurse practice acts with the Consensus Model. Arkansas and Washington expanded their recognition of roles, and South Dakota added the umbrella title of APRN. Others secured a second, separate license for APRNs, as Hawaii, Iowa, and South Dakota did for the CRNA role. Autonomous practice and prescribing were on the agenda for several states, and two states realized big gains:

- Connecticut now allows nurse practitioners to practice independently of a physician after a 3-year transition-to-practice period. During debates leading to the passage of this legislation, the Connecticut State Public Health Commissioner along with a scope-of-practice review team from 23 groups concluded that no documentation was found to suggest that the elimination of the collaborative practice agreement impaired safety, which had been the basis of objection from physician groups (Becker, 2014).
- Minnesota also passed legislation for APRNs in May 2014. The law requires a CNP or CNS to complete a transition period with oversight by a physician or another APRN, and it repeals restrictions on the ordering and administering of anesthetics by CRNAs, suggesting consulting and collaborating only as required by the needs of the patient (American Association of Colleges of Nursing, 2014; MN SF 511, 2014).

The actions of the Connecticut and Minnesota legislatures and governors follow suggestions from the 2012 National Governors Association (NGA) paper, which proposed that access to health care in states, and particularly in underserved areas, could be addressed by removing barriers to APRN practice, including those imposed by a required oversight by physicians (Schiff, 2012). The Federal Trade Commission's (FTC) comments in 2014 also urge legislators to carefully consider any bills that would further restrict or hinder APRN practice. The FTC suggests that allowing fair competition for health care services always leads to better outcomes for consumers (Federal Trade Commission [FTC], 2014).

Despite the NGA's suggestion regarding barriers to APRN practice, Nebraska's governor vetoed a bill that had the support of the state's House and Senate. His veto was made on the belief that a proposed transition period of 2,000 hours was not long enough. Citing concerns that patient safety is impacted by inadequate clinical experience, but providing no evidence, the governor coauthored his veto letter with the state's chief medical officer, Dr. Joseph Acerno. The bill was signed on the last day of the session, so lawmakers could not override the veto; however, proponents of the legislation have pledged to raise the issue again (Scalora, 2014).

The APRN "transition period with oversight" is viewed by many as a compromise to appease organized opposition from physician groups, but is it necessary? Brassard (2014) reports full and independent practice occurs with safety and quality in many states that do not require such a period of oversight. A paper by the FTC states that physician supervision requirements may allow one profession to restrict access to the market by another profession, resulting in limiting consumer choice and access. The paper contends that effective collaboration between professions does not require any supervision by physicians (FTC, 2014).

Requiring transition periods or other continued oversight by another professional group is not without its own complications. As mentioned in the FTC's letter to Connecticut State Representative Conroy, APRNs have testified about the costs of collaborative agreements in some states and the fear of losing their required collaboration when a physician retires or moves (FTC, personal communication, 2013).

The opposing argument to APRN autonomy offered by organized medical groups is that physicians have significantly greater years of education and therefore provide improved care to patients (American Academy of Family Physicians, 2012). That educational gap has closed in recent years, with all APRN role certifications requiring a minimum of a master's degree and a record number of APRN students completing doctoral programs (Auerbach, Martsolf, et al., 2014).

A study by the Rand Corporation demonstrates a significant increase in the number of APRNs educated at the DNP level. Nurse educators agree on the value of a DNP education for APRNs, and an increasing number of schools are graduating DNP-prepared APRNs (Auerbach, Martsolf, et al., 2014).

The 2014 legislative season added to the growing list of states and jurisdictions that have achieved the major elements of the Consensus Model. The following states and jurisdictions adopted the major elements of the Consensus Model:

- Connecticut
- Hawaii
- Idaho
- Minnesota
- Montana
- Nevada
- New Mexico
- North Dakota
- Northern Mariana Islands
- Rhode Island
- Utah
- Vermont.

Additional APRN legislation incrementally moved a few states closer to autonomous practice or prescribing:

- The Nurse Practitioners Modernization Act passed in New York removes portions of the collaborative requirement after 3,600 hours of practice. However, an attestation of continued collaboration is required, and the act specifies that in the case of a clinical disagreement, the physician's opinion stands (Roth, 2014).
- Kentucky APRNs worked hard to remove barriers to prescriptive authority. Under a bill passed in this session, those in a collaborative practice for 4 or more years will be able to prescribe legend drugs without a required collaborative practice agreement (Richardson & Sebastian, 2014).
- In California, the Hernandez bill (CA SB 491, 2013) removing the collaborative practice requirement was introduced during the 2013 legislative session, but failed to make it out of committee. The California Bay Area economists created a methodology to project the economic loss to the state of not removing the barriers to APRN practice. They estimated an additional 2 million preventive care visits could occur, potentially saving California $1.8 billion over the first 10 years of independence for nurse practitioners (Weinberg & Kallerman, 2014). It is hoped that such analysis will inform future attempts in California to remove barriers to APRN practice and prescribing. The same methodology could readily be applied in other states with restrictive practices.

Legislative attempts and legislative gains that align with the Consensus Model have increased each year since the publication of the Model and are available at www.ncsbn.org/5397.htm. The support of organizations who recognize the potential contribution of APRNs to improve access to care (NGA, FTC, Institute of Medicine [IOM]) is a great help in convincing legislators to look closely at the evidence and the outcomes of care as well as at the predictive models of state cost reductions.

States have realized gains in alignment following several sequential years of attempts (Vestal, 2013). Persistence appears to be one of the keys to the adoption of the Consensus Model. Pushback from organized medical groups, however, continues without evidence supporting their stated concerns (Gorski, 2014).

Full Practice Authority for Nurse Practitioners in the Veterans Administration System

One of the ongoing initiatives of the VA system is to grant full practice authority to nurse practitioners employed across all VA health care facilities. This initiative would differ significantly from current VA policy, which requires APRNs to adhere to the delineation of clinical privileges via VA facility-specific, setting-specific, and provider-specific criteria. Thus, nurse practitioners in the VA system currently have varying scopes of practice, depending on their facility, setting, and provider specifics. The full practice authority initiative would remove barriers for nurse practitioners across the VA system.

Grandfather Advisory for BONs

In 2014, NCSBN brought representatives from the BONs together for a 1-day meeting to determine grandfathering guidelines for the endorsement of APRNs. Many APRNs, especially those educated before the development of the Consensus Model and those who practiced primarily in a specialty area, do not align with newer state regulations. Although states are grandfathering their APRNs, there are questions about endorsing APRNs from other states that do not meet current state APRN regulations. The BON representatives developed guidelines for grandfathering these nurses using a modified World Café methodology. The *Grandfather Advisory for Boards of Nursing* was created from this process and serves as a tool to assist BONs in evaluating APRN applicants for licensure by endorsement (NCSBN, 2014a). The guidelines are available at www.ncsbn.org/Grandfathering_Guidelines_(3).pdf.

APRNs: Emerging Issues for BONs

Besides focusing on the adoption of the elements in the APRN Consensus Model, BONs should anticipate that the future may bring further discussion about APRN transition-to-practice programs and requirements. Is a transition period for APRNs needed? Is there sufficient data to make a decision about whether a period of transition should be mandated? Should this be studied? If a transition period is needed, how long should it be and who should have oversight during the transition period?

Emerging Roles

In 2015, BONs should expect more state and federal legislation related to access to care. One response to the access problem has been the proliferation of lay workers with limited training taking on various responsibilities related to health care.

Community Health Workers

Community health workers go into the community and facilitate increased health knowledge and self-sufficiency through outreach and counseling. HRSA defines community health workers as "lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments, and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve" (HRSA, 2007).

The role can vary depending on the specific needs of the community and the sector in which the worker specializes (such as social services), but generally it involves fostering a relationship between the community and the health care system. Workers may provide some direct services, such as first aid and health screenings, but they also manage care transitions for vulnerable populations; educate people in topics such as chronic disease prevention, nutrition, and physical activity; and provide informal counseling. Community health workers also promote the cultural competence of health care professionals serving their communities (HRSA, 2011).

The following bills concerning community health workers have been enacted:

- Illinois House Bill 5412 creates the Community Health Worker Advisory Board Act, which establishes the advisory board on community health workers. The bill sets the board membership; provides that the board consider the core competencies of a community health worker, including skills and areas of knowledge that are essential to bringing about expanded health and wellness in diverse communities and reducing health disparities; and requires a report from the board with recommendations regarding the certification process of such workers.
- Maryland House Bill 856 requires the Department of Health and Mental Hygiene and the State Insurance Administration to establish a certain stakeholder work group to study and make recommendations regarding the training and credentialing required for community health workers as well as the reimbursement and payment policies for such workers through the State Medical Assistance Program and private insurers. The bill also requires the work group to report its findings and recommendations to certain committees of the General Assembly.
- New Mexico Senate Bill 58 enacts the Community Health Workers Act, which provides for Department of Health certification of community health workers. The Act covers rule making, fees, criminal background screening, and discipline relating to certified community health workers, and creates a Board of Certification of Community Health Workers.

Community Health Emergency Medical Technicians and Paramedics

Community paramedicine is an emerging field that expands the roles of emergency medical technicians (EMT) and paramedics to address gaps in primary care services. Courses provided by accredited colleges and universities train first responders to serve communities more broadly in the areas of primary care, public health, disease management, prevention and wellness, mental health, and oral health. Community EMTs and paramedics are overseen by emergency or primary care physicians.

Based on local need, these roles allow personnel in volunteer or low-call-volume situations to more routinely utilize their clinical skills (HRSA, 2012). These programs are also being used in urban areas in an effort to provide preventive measures of care for chronic emergency department (ED) patients. Community paramedicine programs are tailored to the needs of their community and may focus on specific areas, such as diabetic monitoring or mental health (HRSA, 2012).

No bills related to community EMTs or paramedics were introduced in 2014, but BONs should remain cognizant of their role and their responsibilities.

Nursing Education

One of the best ways of predicting future workforce numbers is by examining the number of nursing programs and their enrollment. Despite shortages of clinical placement sites and faculty members in many regions, RN programs and enrollments are increasing.

An examination of NCLEX® program codes indicates 84 new RN and 32 new LPN/VN programs approved by BONs in 2014 (NCSBN, 2014c). Table 9 provides data on the number of new nursing programs through November, 2014 by jurisdiction. Florida leads all jurisdictions in the number of recently approved RN and LPN/VN programs.

In NCSBN's 2014 emerging issues survey, BONs reported both an increase and decrease in the number of programs, depending on the state. In particular, Oklahoma reported an increase in APRN programs, and North Carolina reported an increase in prelicensure programs seeking approval. Texas reported program closures. New Mexico reported closures of four LPN/VN programs in the last year, leaving only seven approved LPN/VN programs in the state. Minnesota reported closures of three LPN/VN programs in the past year.

TABLE 9

State/Jurisdiction Increases in LPN/VN and RN Programs During 2014

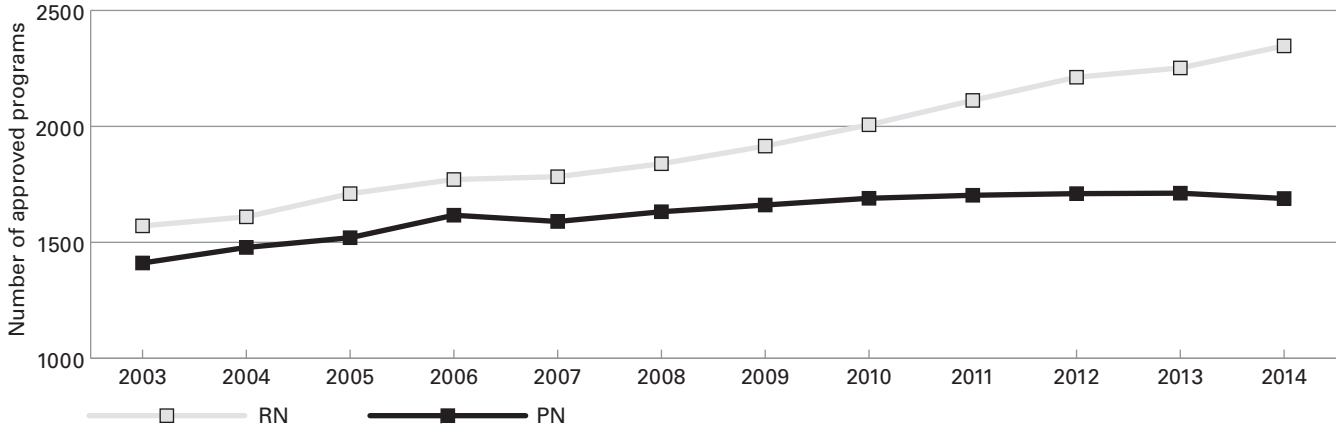
State/Jurisdiction	# of New RN Programs in 2014	# of New LPN/VN Programs in 2014
California	1	0
Connecticut	0	3
Florida	29	12
Georgia	4	0
Illinois	3	0
Indiana	2	1
Louisiana	0	1
Massachusetts	1	1
Michigan	1	1
Missouri	2	0
Montana	1	1
New Hampshire	0	1
New Jersey	2	0
New Mexico	4	0
New York	12	3
North Carolina	2	0
North Dakota	1	1
Ohio	2	0
Oklahoma	3	1
Pennsylvania	2	4
Texas	6	0
Utah	1	0
Vermont	3	0
Virginia	0	1
West Virginia	2	1
Total	84	32

Source: NCSBN NCLEX Program Code Database (NCSBN, 2014c).

While the national net growth of RN programs in 2014 is a gain of 95 programs, there has been a loss of 23 LPN/VN programs. (See Figure 5.) (NCSBN, 2014c)

FIGURE 5

Number of Approved Nursing Programs in the United States: 2003-2014



Source: NCSBN NCLEX Program Code Database (NCSBN, 2014c).

Data in Table 10 indicate an increase in RN test takers but a decrease in LPN/VN test takers. Although the RN pass rates decreased since 2012 (most likely because of a periodic upward adjustment in the passing standard on April 1, 2013), the LPN/PN pass rates remain stable.

TABLE 10

Three-Year Trend in NCLEX® Candidate Numbers and Pass Rates

	First-Time U.S.-Educated NCLEX-RN Test Takers		First-Time U.S.-Educated NCLEX-PN Test Takers	
	Number	Pass Rate	Number	Pass Rate
January-December 2011	144,583	87.89%	65,334	84.83%
January-December 2012	150,266	90.34%	63,350	84.23%
January-December 2013	155,098	83.05%	58,574	84.63%

As expected, associate-degree (ADN) graduates still account for the largest number of nursing program graduates. The number of diploma graduates has decreased over the 3-year period from 2011 to 2013, while the number of baccalaureate graduates has increased at a rate higher than the rate for ADN graduates. (See Table 11.)

TABLE 11

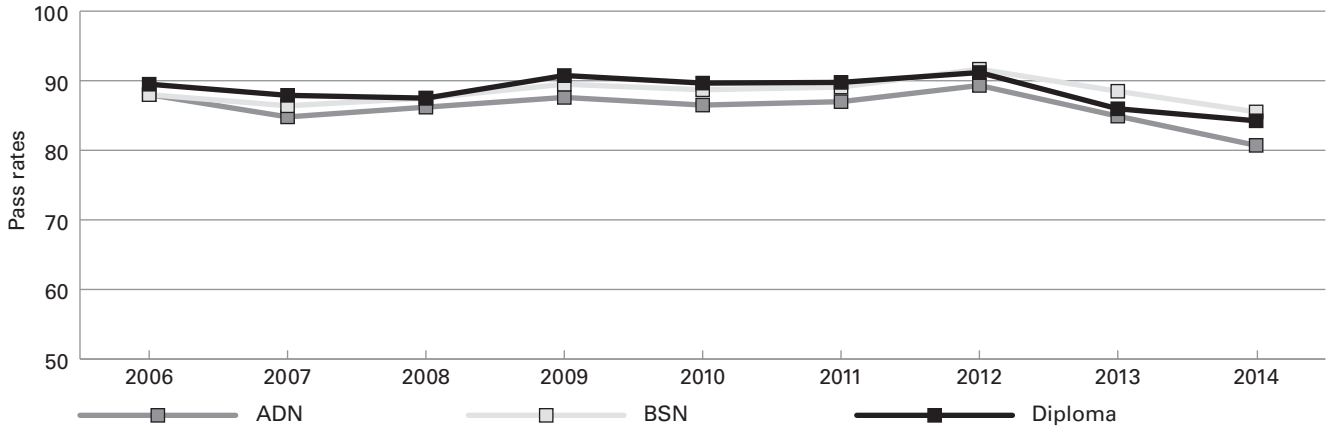
Number of NCLEX® Test Takers According to Program Type: 2011-2013

	2011	2012	2013
Diploma	3,476	3,173	2,840
Associate degree	82,764	84,517	86,772
Baccalaureate	58,246	62,535	65,406
Unclassified or special codes	97	41	80
Total	144,583	150,266	155,098

The 2014 NCLEX pass rates do show some variance when divided according to the graduates' level of education. In 2014, BSN-prepared graduates fared best on the examination, with an overall pass rate of 85.52%. Diploma-prepared graduates had a pass rate of 84.24%, and graduates of ADN programs achieved a pass rate of 80.71%. Figure 6 shows a comparison of the pass rates of the three program types for each year since 2006.

FIGURE 6

NCLEX® First-Time U.S.-Educated Pass Rates by Program Type



Nursing Faculty

The 2014 AACN Special Survey on Vacant Faculty Positions (Li & Fang, 2014) describes the current status and trends related to nursing faculty in baccalaureate or higher nursing education. (See Table 12.) As shown, the total number of budgeted faculty positions continues to increase. Although the full-time vacancy rate and the number of vacancies per school are the lowest since 2010, the percentage of schools that need additional faculty members but have no vacancies is the highest since 2010. The increase in the number of schools that need additional faculty members but have no vacancies is higher than in previous years, which could suggest that the nursing schools currently are experiencing more difficulty acquiring sufficient faculty positions.

TABLE 12

Nursing Program Full-Time Faculty Positions and Needs: 2009-2014

n = 714 Schools Responding	2009	2010	2011	2012	2013	2014
Budgeted faculty positions	12,184	12,783	14,166	15,574	16,444	18,010
Number of faculty vacancies (vacancy rate)	803 (6.6%)	880 (6.9%)	1,088 (7.7%)	1,181 (7.5%)	1,358 (8.3%)	1,236 (6.9%)
Number of filled faculty positions (filled rate)	11,385 (93.4%)	11,909 (92.3%)	13,078 (92.3%)	14,393 (92.4%)	15,086 (91.7%)	16,774 (93.1%)
Mean faculty vacancies per school	1.4	1.6	1.8	1.8	2.0	1.7
Range of faculty vacancies	1-13	1-16	1-16	1-20	1-29	1-20
Number of schools with no faculty vacancies, but need additional faculty	117	112	104	103	98	124
Number of schools with no faculty vacancies; do not need additional faculty	127	141	145	182	168	187

Source: Li & Fang, 2014.

Note. 2009, 2010, 2111, 2012, and 2013 data from previous environmental scans.

According to the AACN's Faculty Vacancy Survey (Li & Fang, 2014), nursing education programs are not hiring new faculty members for several reasons:

- Nursing programs have insufficient funds to hire additional faculty (61.3%).
- Administration is unwilling to commit to additional full-time positions (39.5%).
- The competition for jobs in other marketplaces causes an inability to recruit qualified faculty (31.5%).
- Qualified applicants for faculty positions are unavailable in the geographic area needed (25%).

Schools face the following critical issues related to faculty recruitment (n = 714) (Li & Fang, 2014):

- Noncompetitive salaries (32.1%)
- Limited pool of doctorally prepared faculty members (28.6%)

- Finding faculty with the right specialty mix (20.6%)
- Finding faculty willing and able to conduct research (5.3%)
- Finding faculty willing and able to teach clinical courses (4.5%)
- High faculty workload (2.9%).

In NCSBN's 2014 emerging issues survey, BONs in Arkansas, Kansas, Maine, Montana, and Pennsylvania reported concerns about their states maintaining a sufficient number of qualified faculty members. The following issues were raised:

- Lack of state and institutional funding to hire faculty
- Unqualified faculty (particularly with smaller ADN programs)
- Expectations of a high number of faculty retirements and not enough students in the pipeline
- Increased nursing program director turnover.

The nursing faculty shortage continues to be worrisome, particularly because increased faculty retirements are projected in the near future. The New Jersey Nursing Initiative Faculty Preparation Program implemented by the Robert Wood Johnson Foundation presents an innovative strategy for preparing nursing faculty (Gerolamo, Overcash, McGovern, Roemer, & Bakewell-Sachs, 2014). This program found that generous monetary support in the form of tuition and stipends, socialization to the faculty role, and formal courses in nursing education prepare faculty members who are dedicated and can readily assume a faculty position.

Nursing Education Challenges and Recommendations

The shortage of clinical placements presents an ongoing challenge for educators in undergraduate and graduate programs. According to NCSBN Education Knowledge Network calls with BON education consultants, nursing programs throughout the country report difficulty in acquiring clinical placement sites for students. Several states report that hospitals prefer to offer clinical placements for BSN students over ADN students. In turn, ADN programs are using more long-term care sites to fill the need for clinical experience, and this is negatively impacting the number of placements available to LPN/VN students. Another concern is the potential for decreased exposure of ADN students to acute-care practice.

NCSBN's National Simulation Study (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014) found that when there are sufficiently educated faculty members and appropriate resources, nursing programs can use up to 50% simulation to substitute for clinical experiences. This use of simulation could be one answer for the shrinking numbers of clinical spaces. However, nursing education programs are advised that proper simulation experiences for students are time and resource intensive.

Recommendations for nursing education may include nurse residencies in nonacute settings, more clinical experiences in nonacute settings, more simulation vignettes on nonacute situations, last-semester immersion courses including nonacute preceptors, and continued development of guidelines regarding distance education programs. (Mancino & Feeg, 2014)

BON Changes and Legislation

- The Florida BON now requires graduates to take the NCLEX within 6 months of graduation. If the requirement is not met, the graduate will be required to take a BON-approved licensing examination preparation course.
- Pennsylvania is considering general revisions to taking and passing the NCLEX; specifically, a proposed time limit during which students must take the NCLEX after graduating from their nursing program. Once the predetermined time period has passed, a remediation course would be required before authorization to test is granted again.
- Texas, after finding that large increases in program enrollment correlate with decreased NCLEX pass rates, is considering a rule requiring BON approval for programs that wish to increase student enrollment by more than 20%.
- Arkansas is considering limiting the number of years after graduation individuals have to take the NCLEX for the first time.
- Wisconsin has a new law that allows students to take the NCLEX before graduation with the dean of the nursing program's approval.
- In the 2014 NCSBN's emerging issues survey, several BONs identified increasing numbers of distance education programs as an issue in their states. Alaska, the District of Columbia, Oklahoma, Louisiana, and Missouri all report increasing numbers of distance education programs and the need to track out-of-state students. Georgia reports receiving increased calls about preceptor requirements from out-of-state programs. Tennessee now requires approval of all programs that provide education by distance, online, or via any electronic methodology.

Distance Education

In August of 2014, delegates representing all 59 NCSBN jurisdictions voted to accept changes to NCSBN's Model Act and Rules regarding distance education. These changes can be found at www.ncsbn.org/6662.htm. The following is a summary of the approved recommendations:

1. Distance education programs must meet the same approval guidelines as any other program.
2. Only the BON in the home state (state in which the program resides) approves a distance education program.
3. The BON in the home state ensures there is faculty supervision over clinical students in the host states.

4. (a) Clinical faculty members or preceptors are licensed where the patients and students are located.
   (b) Faculty members who only teach didactic content are licensed in the home state. (Licensure exemption language as added to NCSBN's Model Act to allow for this.)
5. BONs will include a question on their annual reports regarding whether students are engaging in clinical experiences in host states.

In addition, NCSBN now has a listing of state requirements for distance education programs on its website at www.ncsbn.org/671.htm.

Nursing Education Accreditation and Approval

In 2014, the NLN established a new national nursing accreditation body, the Commission for Nursing Education Accreditation, or CNEA. Similar to the Commission on Collegiate Nursing Education (CCNE), programs that require a Title IV gatekeeper will not be able to use CNEA for accreditation purposes. Title IV gatekeepers enable the institutions they accredit to establish eligibility to participate in the Federal Student Assistant Program. This requirement generally affects programs that are not housed in colleges or universities, such as many practical nurse programs. However, the Accrediting Commission for Education in Nursing (ACEN) is able to accredit programs that require a Title IV gatekeeper.

CCNE only accredits baccalaureate programs in nursing, whereas the new CNEA will accredit all programs from practical nurse programs that don't need a Title IV gatekeeper to doctoral programs. ACEN also accredits all levels of nursing programs. NLN anticipates that CNEA will be ready for accreditation activities in late 2015 or early 2016.

Since NCSBN's recommendation for BONs to require national nursing accreditation by 2020, there has been some movement toward that goal. An NCSBN survey in the spring of 2014 found that of the 34 BONs responding, 8 currently require national nursing accreditation, though 7 more reported they are planning to require accreditation.

Florida requires that professional nursing programs attain nursing specialty accreditation by July 1, 2019, and programs approved on or after July 1, 2014, are required to attain accreditation within 5 years after student enrollment. Georgia has a new rule for site visits to be made in conjunction with national nursing accreditation visits.

Advancing Nursing Education

New studies published in 2014 provide evidence that BSN-educated nurses have an impact on patient outcomes:

- Aiken et al. (2014) retrospectively reviewed discharge data from 422,730 patient records in 300 hospitals in 9 European countries and found that for each 10% increase in the number of baccalaureate-educated nurses, there was a 7% decrease in the likelihood of mortality.
- Cho et al. (2014) linked hospital facility data from 14 teaching hospitals in South Korea with staff nurse survey data (n = 1,014), finding that each 10% increase in the number of baccalaureate-educated nurses was associated with a 9% decrease in mortality.
- Yakusheva, Lindrooth, and Weiss (2014) found that a 10% increase in the proportion of baccalaureate-prepared nurses on hospital units was associated with lowering the odds of patient mortality by 10.9%. They also found that increasing the proportion of baccalaureate-prepared nurses to 80% would result in significantly lower readmission rates and shorter lengths of stay, thus creating cost savings and improving the return on investment for hiring more baccalaureate-prepared nurses.

The BONs are continuing to work with their state coalitions and the nursing community to meet the IOM challenge of converting 80% of the nursing workforce to BSN-educated nurses by 2020. BONs, on the 2014 NCSBN emerging issues survey and on the NCSBN Education Knowledge Network calls, report that many hospitals are hiring only BSN graduates, particularly in the urban areas. Further, Berkow, Vonderhaar, Stewart, Virkstis, and Terry (2014) found that one-quarter of their health care leader respondents (n = 4,495 from 1,178 facilities) report that their hospitals require RNs to earn a BSN within 5 years of hire, while more than one-sixth report that their hospitals hire only nurses with BSN degrees. Additionally, New York and New Jersey have pending legislation relating to the "BSN in 10" initiative.

There are some challenges being reported because of this push for BSN graduates. Montana reports that while there is a push for BSN graduates, programs are lacking articulation agreements. Washington State reports that some programs with ADN-to-BSN programs have challenges because of lack of resources, availability of qualified faculty members, and low faculty salaries.

Nursing Education: Emerging Issues for BONs

- The shortage of clinical placement sites will continue to be an issue for nursing programs at all levels, including graduate APRN programs. BONs should anticipate questions and requests from educators concerning this issue, with a focus on substituting simulation for traditional clinical hours.
- BONs should also anticipate issues related to distance education. Adopting NCSBN's distance education requirements may assist with some of these issues.

Health Care in the United States: 2014

Access to Care

Improved access to care—the use of personal health services in a timely manner to achieve the best health outcomes—depends on coverage, services, and timeliness. It is also influenced by factors such as an available and qualified workforce. Improved health care services require an ongoing source of care such as a primary care provider, increased access to and use of evidence-based preventive services, and the provision of timely care when a need is recognized (Healthy People 2020, 2014).

The Department of Health and Human Services (HHS) launched *Healthy People 2020* in 2010 as a 10-year agenda to improve America's health. The priorities for national health include the following wide-ranging indicators of the state of American health (Healthy People 2020, 2014):

- Access to health care services
- Clinical preventive services
- Environmental quality
- Injury and violence
- Maternal, infant, and child health
- Mental health
- Nutrition
- Physical activity and obesity
- Oral health
- Reproductive and sexual health
- Social determinants
- Substance abuse
- Tobacco.

Recent progress updates show that several of the *Healthy People 2020* (2014) indicators demonstrate improvement: preventive services; environmental quality; injury and violence; maternal, infant, and child health; reproductive and sexual health; social determinants; and tobacco. However, access to care, physical activity and obesity, and substance abuse showed little to no change; mental health and oral health indicators showed a decline. Although improvements are noted in several *Healthy People 2020* indicators, other improvements in the health of Americans will not occur until access to health care services improves, especially services offered by primary health care providers.

Though access to providers by telephone is increasing, access to care overall is worsening (Agency for Healthcare Research and Quality [AHRQ], 2014). This area must be addressed to achieve the goals of the federal government of improved health outcomes at lower costs.

Coverage

In September 2014, the National Center for Health Statistics released its 2014 results for the National Health Interview Survey. The data indicate that in the first 3 months of 2014, 41 million persons of all ages were uninsured. Additionally, 55.5 million (17.8%) of all persons living in the United States were uninsured at least part of the year, and 29.9 million (9.6%) were uninsured for more than a year at the time of the interview. Of people younger than age 65, 20.5% (54.8 million) were uninsured at least part of the year, and adults ages 18 to 64 were more than twice as likely (24.3%) as children (10.4%) to be uninsured. There were, however, significant decreases in the percentages of people who were uninsured between the beginning of 2013 and the first 3 months of 2014. The largest decrease was for adults ages 19 to 25, from 26.5% in 2013 to 20.9% in 2014 (Cohen & Martinez, 2014). Regional differences exist in the United States: The largest groups of uninsured adults ages 18 to 64 are in the South (22.7%) and West (19.4%). The Northeast had the highest rate of public coverage (19.9%), and the Northeast (67.6%) and the Midwest (70.8%) had the highest rates of private coverage (Cohen & Martinez, 2014).

Services

According to the Health Resources and Services Administration, nearly 20% of Americans live in areas without sufficient access to primary care physicians, particularly in rural areas. There are 65 primary care physicians per 100,000 Americans in rural areas compared with 105 physicians per 100,000 residents in urban areas (HRSA, 2014b).

Higher costs for health care do not ensure quality and definitely impede access to care. The Commonwealth Fund, a private foundation, recently analyzed the health care systems of 11 countries, and found that the U.S. health care system ranks last on measures of access, equity, quality, efficiency, and healthy lives. More than 37% of U.S. adults, especially those with below-average incomes, reported they did not have a recommended test, treatment, or follow-up care because of cost (Mahon & Fox, 2014). This study ranked the United States last on all measures of cost-related access, concluding that needed health care is foregone more frequently in the United States because of cost than in the other countries in the survey. The absence of universal health insurance coverage in the United States was the major difference between the United States and other industrialized countries in this study.

Timeliness

In 2014, the VA faced scrutiny regarding the quality and timeliness of care provided to U.S. veterans. Incidents at the VA hospital in Phoenix, Arizona, drew attention to systems and personnel issues that may have incentivized delays in care for some veterans (Kesling, 2014). This and other stories of delayed access to care for U.S. veterans prompted a review of veterans' health care services by a panel of military and civilian experts. Their analysis concluded that access to care was generally good at VA facilities but found that the quality of care was mixed. Defense Secretary Chuck Hagel ordered the military to improve access to care and to improve quality and safety at VA hospitals and clinics (LaFranier & Lehren, 2014).

Affordable Care Act

With great fanfare, state-based and federal government health insurance exchanges were launched on October 1, 2013. These exchanges are the result of the ACA, a combination of two bills passed by Congress and signed by the president in 2010. The purpose of the ACA is to provide health care insurance to all residents of the United States. The law seeks to accomplish this goal by mandating that all uninsured U.S. residents select a health insurance plan via a federal government or state-based website, prohibiting insurers from denying coverage based on a preexisting condition, and expanding the Medicaid program.

Influence of the ACA on Access to Care

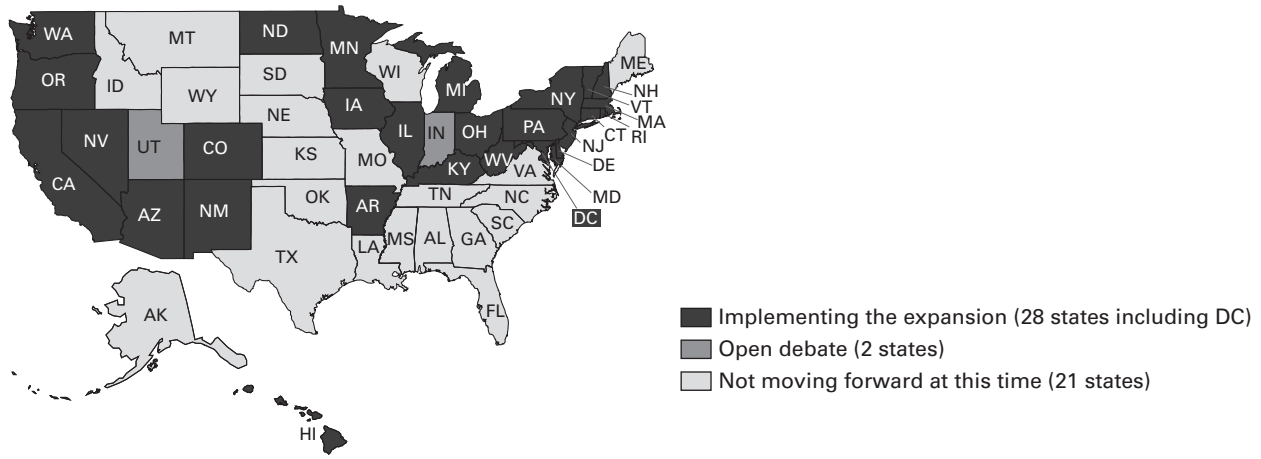
As of August 15, 2014, 7.3 million paying customers had signed up for subsidized insurance through the ACA (Radnofsky, 2014). A Kaiser Foundation study estimated that nearly 6 in 10 people who purchased health insurance through the ACA exchanges had been uninsured just before obtaining coverage (Hamel et al., 2014). Overall, studies by Gallup, Harvard, the Urban Institute, and the Commonwealth Fund have estimated that 8 to 10 million adults gained coverage during the enrollment period, reducing the proportion of uninsured Americans by 22% to 26% ("Obamacare: Experimental medicine," 2014).

Researchers attribute the majority of the progress to the expansion of the Medicaid program. A Gallup study found that the 10 states exhibiting the largest drops in the percentage of uninsured adults (Arkansas, Kentucky, Delaware, Washington, Colorado, West Virginia, Oregon, California, New Mexico, and Connecticut) all expanded Medicaid and established a state-based marketplace exchange or state-federal partnership (Witters, 2014). Correspondingly, an Urban Institute study found that almost 20% of the adults in states that did not expand Medicaid are uninsured; the percentage in states that did expand Medicaid is half that figure. The difference is assumed to be a result of the provision of subsidies to the new enrollees (Kenney et al., 2014).

Efforts to expand Medicaid continued, and two more states opted to join. In March 2014, New Hampshire established a 2½-year pilot program providing health insurance to low-income adults using private health insurers who are paid by Medicaid ("Medicaid expansion," 2014). In August, Pennsylvania joined 26 other states and the District of Columbia in expanding Medicaid by also using Medicaid dollars to pay for private insurance plans (Millman, 2014). Two more states, Utah and Indiana, are considering expanding Medicaid, while the 21 others have no plans to do so at this time (Rudowitz, Snyder, Smith, Gifford, & Ellis, 2014). (See Figure 7.)

FIGURE 7

States Implementing Medicaid Expansion, 2014



Source: Kaiser Family Foundation (2014).

Despite the progress in the overall expansion of insurance coverage through the ACA, legal disputes could undermine access to care. The case of *Halbig v. Burwell* centers on a claim that language in the ACA prohibits moderate-income residents from receiving federal subsidies for insurance if their state does not run its own health insurance marketplace. With the majority of states having opted to let the federal government run their marketplace, a decision for the plaintiff would prevent an estimated 7.3 million of the 11.3 million people expected to use the federal exchanges in 2016 from receiving subsidies and would disrupt participation in the insurance pools designed to insure coverage for all (Blumberg, Holahan, & Buettgens, 2014). Conflicting opinions on the Halbig case and similar cases being tried in other states have led court watchers to opine that this issue will ultimately be settled in the U. S. Supreme Court (Morgan & Viswanatha, 2014).

The ACA expansion has contributed to a rise in health care spending in the United States, although not at the pace seen from 1990 to 2008 (Sisko et al., 2014). Higher enrollment and spending growth is seen in Medicaid for FY 2014 and FY 2015, but with the federal government fully funding the expansion, state Medicaid spending is growing more slowly than total Medicaid spending. This difference between state spending and overall spending is primarily seen in the states that expanded Medicaid. These states report that the expansion could allow a reduction in state spending for such services as mental health, correctional health, and services for the uninsured (Rudowitz et al., 2014).

The 2015 enrollment period will have new providers entering the insurance marketplace as enrollment is expected to be near 13 million. New insurance coverage will come from insurers who had previously opted not to participate in the ACA and from current ACA participants who are opting to offer policies in new states (Abelson, 2014, May). The inclusion of new providers may lower the rates of the premiums in some states, but overall, price volatility is expected as implementation moves forward (Abelson, 2014, September; Cox, Levitt, Claxton, Ma, & Duddy-Tenbrunsel, 2014).

Effect of the ACA on the Nursing Workforce

The effect of health reform via the ACA on the demand for health professionals, primarily physicians, has been debated in the popular media. Some analysts have focused on the role of the APRN and health reform, but little attention has been paid to the effect of health reform on the demand for and jobs held by RNs. Recently, Spetz (2014) postulated that although the demand for RNs is projected to continue, the ACA will likely have little effect on overall growth. Rather, the ACA will have more of an effect on where RNs work; for instance, there will be higher growth in outpatient settings, such as physician offices and home health care, with such nursing roles as care coordinators, case managers, patient educators, and chronic-care specialists. The near future demand for RNs will be driven mostly by population growth and an increasing number of older Americans, rather than by the ACA. Spetz further concluded that the relative importance of hospitals as an employer is likely to decline and that people's use of hospitals does not vary much whether or not they have health insurance; hence, a neutral effect on hospital utilization is predicted.

ACA: Emerging Issues for BONs

- The ACA's evolution will continue to alter the health care environment in 2015 and beyond. States participating in the Medicaid expansion have seen a rapid decline in the proportion of uninsured in their states as well as an increase in health care spending. As part of the health care community, nurses may see more job opportunities in those states.

- The *Halbig v. Burwell* (2014) and *King v. Burwell* (2014) court cases could have a rapid and dramatic impact on the budgets of state health departments. The U.S. Supreme Court has agreed to hear both cases. At issue is whether tax credits to help individuals pay for health care coverage should be available in all 50 states or only in some states. The legal question rests on a phrase in the law that authorized subsidies for coverage purchases via an "exchange established by the state." The battle is over whether subsidies are also available through federally run exchanges, which represent approximately 75% of the marketplaces in the states.
- Dillman, Mancas, Jacoby, and Ruth-Sahd (2014) also predict that the ACA will impact critical care nurses. Finding that critically ill patients without insurance have poorer outcomes (including a higher death rate) than those with insurance, Dillman et al. assert that critical care nurses may see millions of new patients presenting with or at risk for complications because of their previous uninsured status. The challenge this presents underscores the importance of practicing evidence-based care.

Telehealth

Connections to health care via telecommunications are a significant and rapidly growing component of health care. Telehealth includes the use of electronic information and telecommunication technology to support health care education and long-distance health care.

Evidence suggests that telehealth may offer solutions to the problem of access to care on several levels. In 2012, for example, the University of Pittsburgh Medical Center conducted a pilot study of their patient-centered medical home, a model of care that includes 24-hour electronic access to a member of the care team. The study produced ideal results, including lower medical and pharmacy costs, lower hospital admissions and readmissions, reduced use of emergency medical services, and a 160% return on investment, compared with outcomes from sites that did not follow this model (Rosenberg, Peele, Keyser, McAnallen, & Holder, 2012). In light of a growing body of evidence, legislators have begun to see the benefit in supporting telehealth-based care models.

Throughout 2014, members of Congress continued to introduce and sponsor telehealth legislation, hold hearings and briefings on the issue, and advocate for adoption of more telehealth-friendly policy by federal government agencies, such as the Centers for Medicare & Medicaid Services (CMS) and the VA. In a time of extreme partisan divisiveness in Washington, particularly in terms of health care policy, telehealth appears to be one of the few issues that can bring legislators together to advance common interests.

In the 114th Congress, which commenced this month, legislators are expected to continue pushing for adoption of bills that address telehealth reimbursement in federal programs such as Medicare and using federal supremacy to impact provider license portability. Although Congress has not passed significant health care legislation since the ACA in 2010, the next opportunity may come in 2015 with the expiration of a 1-year patch of the Medicare sustainable growth rate (SGR) formula, the policy that determines payment rates for providers receiving reimbursement through the Medicare program.

In 2014, congressional leaders were able to reach a bipartisan, bicameral agreement on how to permanently fix the SGR formula; however, that legislation was not passed by Congress because of concerns about how much it would cost. Consequently, Congress passed another 1-year patch so providers would not see a significant cut in their Medicare reimbursement. The current 1-year SGR fix expires on March 31, 2015. Many in Congress hope to permanently fix the SGR problem before then; however, it is unclear whether the 2014 bipartisan agreement is still intact. Regardless of whether the agreement stands or Congress pursues another short-term solution, many health care policy advocates, including those seeking implementation of policies that will grow telemedicine, will be working to make sure that provisions benefitting their interests are attached to that legislation.

The bills addressing telehealth policy that were introduced but not passed in the 113th Congress will likely be introduced again in the new Congress.

- H.R. 3077, TELEMED Act of 2013, permits certain Medicare providers licensed in a state to provide telemedicine services to Medicare beneficiaries in a different state. The bill has 64 cosponsors (16 Democrats, 48 Republicans) and broad bipartisan support.
- H.R. 5380, Medicare Telehealth Parity Act of 2014, provides a phased-in expansion of telehealth coverage under the Medicare program. It does not contain any licensure provisions and is endorsed by NCSBN.
- H.R. 2001, Veterans E-Health and Telemedicine Support Act of 2013, allows health care professionals who are authorized to provide health care through the VA and are licensed to practice in any state, U.S. territory, or the District of Columbia to provide treatment via telemedicine, regardless of where the professional or patient is located.
- H.R. 5294, Health Equity and Accountability Act of 2014, instructs the Secretary of HHS in consultation with stakeholders such as states to create policy that facilitates the provision of telehealth services and multistate practice across state lines. It also creates a telehealth pilot project to improve rural access to telehealth services.
- H.R. 3507, 21st Century Care for Military and Veterans Act, expands the use of telehealth under the military's TRICARE program and the VA.
- H.R. 3499, Rural Veterans Mental Health Care Improvement Act, instructs the Secretary of the VA to commence a study of telemedicine services in the VA. State regulations that impact VA telemedicine policy, such as licensure, will be included in the study.
- H.R. 3306, Telehealth Enhancement Act of 2013, expands the application of telehealth under Medicare and other federal health care programs.
- S. 2662, Telehealth Enhancement Act of 2014, is the Senate companion bill to H.R. 3306.

- S. 2359, Craig Thomas Rural Hospital and Provider Equity Act of 2014, seeks to expand health care opportunities in rural areas and instructs the Secretary of HHS to work with states, providers, and health care advocates to encourage and facilitate the adoption of policies that allow for the provision of telehealth services across state lines in the Medicare program.

In addition, federal agencies, including the CMS and the VA, have taken action or plan to take action addressing telehealth policy. The CMS also expanded the number of services deemed Medicare-reimbursable, including geographic expansions for providing telehealth services in rural areas closer to urban areas.

As a result of the annual CMS policy review process, final CMS rules for telehealth include particular psychoanalysis and family psychotherapy visits and particular medical office, outpatient, and annual wellness visits. The CMS declined to include certain cardiac and psychiatric testing services in the rules. Inclusion as a telehealth service depends on whether the proposed service is sufficiently similar to a service currently on the telehealth list as well as whether the service includes a technical component that needs to be furnished in the same location as the patient (Code of Federal Regulations, 2013). The CMS rule changes related to telehealth reflect the telehealth model policy recently approved by the Federation of State Medical Boards (2014).

HRSA announced a series of grants awarded to support health care in rural areas, including nearly $3 million that will provide resources and expertise for telehealth programs. Six organizations received nearly $2.4 million of the $3 million to expand capabilities in remote EDs and to study the effectiveness of tele-emergency care for rural patients and providers. Two telehealth resource centers will split $650,000 to assist health care organizations, networks, and providers with the implementation of telehealth programs in rural areas. The series of grants were part of a $22.1 million HRSA program dedicated to rural health. Mary K. Wakefield, HRSA administrator, stated that rural communities have some of the greatest needs for expanding access to health care and that these grants will support partners on the ground to strengthen health care delivery in every area of the country (HRSA, 2014c).

The VA has increased the utilization of telehealth services to their veteran patients. In FY 2014, the VA performed more than two million telehealth visits to more than 690,000 veterans, approximately 12% of the veteran population enrolled in VA health care. Of the 690,000 veterans, approximately 55% lived in rural areas and had limited access to VA health care (U.S. Department of Veterans Affairs [VA], 2014a). According to a VA press release, with more veterans seeking health care, telehealth is becoming an attractive option for those who don't have a health care facility near their home. Additionally, the VA plans to roll out new Clinical Video Telehealth scheduling software in the coming months, further easing access to telehealth services for veterans (VA, 2014b).

The shift toward telehealth will likely require adaptation and redefined roles for all health care providers. Telehealth nursing has shown a huge potential for success in coaching people caring for chronic conditions or caring for themselves at home; numerous studies have shown an increase in self-efficacy and positive outcomes compared with traditional care (Barley, 2014; Gagnon et al., 2014; Young et al., 2014). Damgaard and Young (2014) also saw telenursing as a potential solution to the increasing lack of school nurses; the successful virtual supervision of unlicensed assistive personnel (UAP) by RNs provides preliminary evidence for a regulatory change in the administering of insulin.

To prepare nurses for this model of care, regulators are encouraging the inclusion of telehealth topics in both nursing education and professional development (George & Shocksnider, 2014; McLaughlin, 2014; Reynolds & Maughan, 2014). The success or failure of telehealth, however, will depend on the buy-in of the provider, and a removal of barriers plays a key role in developing such a buy-in (Taylor et al., 2014).

Telehealth: Emerging Issues for BONs

- Licensure issues related to telehealth will continue to be discussed at the federal level in 2015.
- The Nurse Licensure Compact, as one answer to the issue of telehealth nurses needing multiple licenses, will have a strong focus in the upcoming year with changes going to NCSBN's Annual Delegate Assembly for approval.
- It is anticipated that an APRN Compact will be introduced in August of 2015.
- In the next few years, it is likely that telehealth nursing concerns will become global issues as telehealth continues to expand into the international market.

Quality and Safety of Health Care

Recognizing that patient safety is central to health care quality, the federal government through HHS challenges all in health care at the local, state, and national levels to take deliberate action to reduce harm from health care in the United States. Access to care as a reduction to harm is a health care quality priority (AHRQ, 2014; Centers for Medicare & Medicaid Services, 2014; The Joint Commission, 2014).

The Agency for Healthcare Research and Quality (AHRQ) National Healthcare Quality Report annually tracks areas in need of improvement. In 2014, cancer screening, maternal and child health, disparities in care, and access to care were areas still needing improvement. AHRQ maintains an online, searchable database (AHRQ, 2014) that offers an overview by state of areas that show quality improvement or those that need improvement. Across states, access-to-care issues are among those in the category of "far from the benchmark" (AHRQ, 2014).

States that allow full practice for nurse practitioners demonstrate improved outcomes and fewer hospital admissions than those with greater restrictions on their scope of practice. Additionally, states with full practice authority for APRNs appear to rate favorably on state health outcomes rankings (Oliver, Pennington, Revelle, & Rantz, 2014). One clear solution to the primary care access debate is for states to continue

to remove barriers to APRN practice. That sentiment, expressed in the IOM report "The Future of Nursing" (IOM, 2010), was repeated by the NGA (Schiff, 2012) and, more recently, in a policy paper by the FTC (2014). The FTC cautioned legislators to avoid restrictions on scope of practice for APRNs and other nonphysician health professionals who might alleviate some of the access problems if allowed to practice to the full extent of their education and training.

Current Social and Health Care Issues for Nursing

Ebola Outbreak

The Ebola virus first entered the world stage in 1976 and has caused disease outbreaks in Africa at least 20 times since then, with the present outbreak being the worst. Ebola is transmitted through contact with bodily fluids and is one of the viruses causing hemorrhagic fever leading to an unacceptably high case fatality rate (Centers for Disease Control and Prevention [CDC], 2014a).

The first person in the United States diagnosed with the Ebola virus was an individual who had recently traveled to the United States from Liberia. The receiving hospital examined and treated the patient for fever of unknown origin in the ED and discharged him. Only when he returned to the hospital later was the diagnosis made (CDC, 2014b). The receiving hospital used an electronic medical record system in which a receiving nurse indicated that the patient had traveled recently from an Ebola area, but the note was not discovered by the receiving physicians. According to reports, that information was not communicated verbally between health team members (Lowes, 2014). The patient was hospitalized, and after his demise, two nurses who had contact with him tested positive for the Ebola virus, despite following the current CDC recommendations for contact precautions. This danger for health professionals has led to questions for BONs about nurses' ability to refuse assignments and the definition of abandonment. The definition of abandonment may vary by BON; however, important elements generally include the withdrawal of care after an assignment has been accepted and without an arrangement for another nurse to resume the responsibilities of caring for the patient. Refusal to care for a patient prior to the assignment is generally not considered a violation of the nurse practice act. Nurses are, however, encouraged to check with their state BON on issues related to this matter.

Many questions emerged related to whether a nurse exposed to the Ebola virus who does not follow state or CDC guidelines should be reported to the BON and whether her or his license should be disciplined. A nurse who resided in Maine was quarantined in New Jersey on her arrival from Africa where she had treated patients via the Doctors Without Borders program. She submitted to viral testing and was found negative on two occasions and had no symptoms, but she was still within the 21-day observation period. Unlike the physicians and nurses who had returned earlier, she was not allowed to return to her home and self-quarantine. Instead, she was kept in a facility in New Jersey. After legal arguments, she was allowed to return home to Maine. However, Maine also imposed temporary restrictions and posted state police guards at her home. The nurse continued to oppose the quarantine publicly. This created questions about professional conduct and a state governor's authority to impose restrictions for public safety reasons. The CDC does have that authority, but it did not agree that quarantine was warranted.

Authority for imposing quarantine is not taken lightly. Ethicists stress that voluntary isolation is most likely to engender cooperation and transparency. Those who feel isolation is imposed on them, particularly if without evidence of necessity, may feel their civil liberties are taken without reason ("Ebola outbreak," 2014). States may impose restrictions within their borders to protect citizens, unless the federal government or HHS declares a national disaster, as was the case in 2009 with the H1N1 virus (McKay, McCain-Nelson, & Armour, 2014).

The American Nurses Association Ethics Statement addresses nursing's role in situations of public health surveillance and quarantine by stating, "Individuals are interdependent members of the community. The nurse recognizes that there are situations in which the right to individual self-determination may be outweighed or limited by the rights, health, and welfare of others, particularly in relation to public health considerations. Nonetheless, limitation of individual rights must always be considered a serious deviation from the standard of care, justified only when there are no less restrictive means available to preserve the rights of others and the demands of justice" (American Nurses Association, 2014).

The CDC has issued specific, updated guidance for monitoring people suspected of having contact with the Ebola virus, refining the language applicable to the levels of exposure and reflecting the revised personal protective equipment guidance (CDC, 2014c). The CDC also requested that Johns Hopkins create an educational video to assist nurses and others in learning of the new guidance (Johns Hopkins Medicine, 2014).

Clearly, nursing's role in caring for Ebola patients here and in other countries is impactful and not without risk (CDC, 2014d). For national guidance, the CDC will continue to update information and data pertaining to the Ebola outbreak and will continuously monitor its guidance on national protections. All state and federal agencies stand to gain knowledge and experience from the present outbreak in ways that will inform our future responses.

Through media sources and on professional organization websites, nurses have expressed concern about their safety and the possible need for postexposure monitoring. Some have directly contacted their BON or NCSBN. Currently available nursing resources on best practices for the prevention of the spread of the Ebola virus can be found through BON websites. Most states have created website advisories for citizens of their states.

As U.S. health facilities ensure that their workforces are trained and equipped to accommodate a possible case of Ebola, the role of the BON in the face of this epidemic is one of clear communication and support. The case of a man diagnosed with Ebola in Texas gave the Texas BON the opportunity to be the first in this supportive role. Faced with an influx of questions and concern from their licensees, particularly with regard to patient abandonment and possible disciplinary action, the BON issued an update that clarified nurses' rights and responsibilities and provided links to numerous resources on the virus itself and the policies in question (Texas Board of Nursing, 2014).

Ebola Outbreak: Emerging Issues for BONs

If cases of Ebola continue to emerge in the United States, BONs should be prepared to address these questions:

- What is the BON's definition of abandonment?
- Can a nurse refuse an assignment?
- If a nurse ignores state or federal requirements for quarantine, should his or her license be disciplined?

If more patients suffer from Ebola in the United States, BONs should also be prepared to acknowledge their licensees' concerns, to provide guidance, and to equip licensees with the tools to practice informed patient care.

Opioid-Related Morbidity and Mortality

Opioid-related death is currently known as a national epidemic and public health emergency (Franklin, 2014). Opioids pose serious risks of overdose, dependence, or addiction when used long term (Franklin, 2014).

Opioid Prescription Rates

Acknowledging that people in the United States consume opioid pain relievers (OPRs) at a higher rate than those in any other nation, the CDC recently reported their analysis of state prescription rates for OPRs (Paulozzi, Mack, & Hockenberry, 2014). The CDC notes that regional variations in prescribing practices are unlikely to result from differences in the health status of the population, but more likely to result from a lack of consensus among health care providers on whether and how to use OPRs for chronic, noncancer pain. The CDC suggests that information on local prescribing rates can alert state authorities, including licensure boards, to atypical use and prompt action.

Prescription Drug Monitoring Programs

State regulatory, administrative, or law enforcement agencies house prescription drug monitoring programs (PDMPs) that maintain statewide electronic databases of controlled substance prescriptions. These databases can support access to and medical use of controlled substances; identify or prevent drug abuse and diversion; facilitate identification, intervention, and treatment of prescription drug–addicted individuals; and outline drug use and abuse trends (Finklea, Bagalman, & Sacco, 2014). Opposition by a small group of lawmakers, who cite the prescription drug databases as a violation of personal privacy rights, results in Missouri being the only state to resist a prescription drug database (PDMP Center of Excellence, 2014).

The PDMP Center of Excellence at Brandeis University noted in its recent report that, as suggested by the evidence, PDMPs are effective in improving clinical decision making, reducing doctor shopping and diversion of controlled substances, and assisting in other efforts to curb the prescription drug abuse epidemic (PDMP Center of Excellence, 2014). Specifically, Brandeis noted an association between the PDMPs and improved health outcomes in certain jurisdictions:

- In 2012, Kentucky had 1,004 opioid overdose deaths, down from 1,023 in 2011, the first decline in a decade.
- Following the implementation of the Florida PDMP and adoption of other measures to address prescription drug abuse and diversion, deaths attributable to oxycodone overdose fell by 41% from 2011 to 2012, and deaths caused by any prescription drug fell by 18%.
- Oklahoma saw a decline in drug-related overdoses from 807 in 2011 to 578 in 2012.
- In Washington State, the number of prescription drug-related deaths decreased 27% from 2008 to 2012.

State PDMPs vary regarding whether and how information is shared with other states. As of December 2013, 45 states allowed some amount of sharing of information with other states (PDMP Center of Excellence, 2014).

The National Association of Boards of Pharmacy (NABP) PMP InterConnect facilitates the transfer of PDMP data across state lines to authorized users, allowing participating state PDMPs across the United States to be linked. As of February 2014, 26 states have executed a memorandum of understanding with NABP to participate in the NABP PMP InterConnect: Arizona, Arkansas, Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, and Wisconsin (National Association of Boards of Pharmacy (NABP), 2014a).

Another tool that helps identify doctor shoppers and those seeking narcotics for illegitimate purposes is NARxCHECK®. This automated prescription drug abuse assessment and management tool for hospitals, pharmacies, private practices, government, and insurers was developed by an ED physician in collaboration with hospital associations and state pharmacy boards. In 2012, NARxCHECK was acquired by the NABP Foundation. The technology supports health care practitioners by accessing patient prescription information from dispensed

prescription databases, analyzing the data, and providing a risk-based score to assist practitioners in their health care decision making. Not only does this tool help restrict medication access for suspected abuse, but it also helps those who legitimately need controlled substances to receive them (NarxCheck, 2014).

In 2014, the NABP convened a task force to develop standards to ensure regular, consistent, and appropriate use of PDMP data. The goal is to increase utilization as well as to facilitate cooperation among state PDMPs, NABP PMP InterConnect, state health data exchanges, and other health care entities (NABP, 2014b).

Opioid Use: Emerging Issues for BONs

- BONs should be aware of "pill mills" in their states.
- BONs should work with state pharmacy boards to ensure APRNs have access to NABP PMP InterConnect and the NARxCHECK system when implemented in their states.

Social Media and the Expansion of Health Care Knowledge

Social media continues to evolve in all aspects of health care. Patients are increasingly seeking health care information and support via social media, and such platforms allow patients and providers to connect in new ways. For certain demographics, social media may be the preferred method of health communication. Jones, Eathington, Baldwin, and Sipsma (2014) conclude that social media and text messaging show great promise for increasing health knowledge among teens and young adults ages 15 to 24, although whether behavior is affected is inconclusive, and more research is called for in this area. In their survey of users of hospital social media platforms, McCarroll et al. (2014) likewise found that social media health information resonated in particular with young, female respondents and call for further research into how hospitals can reach all patient demographics via this avenue. These may be statistics that will help BONs disseminate information to targeted groups.

Each year, more BONs adopt social media to reach out to their licensees and consumers. Nineteen BONs or their umbrella agencies currently promote a social media presence. Facebook and Twitter are the most popular platforms; however, a few BONs have expanded their presence to media such as YouTube, Flickr, LinkedIn, Instagram, Pinterest, and blogs. BONs use these accounts to state available resources and BON policies and best practices; describe changes to nursing practice; publicize news, meeting minutes, and changes to the BON; and collect feedback from licensees.

Some health care agencies are finding interesting ways to reach out. Several BONs are utilizing YouTube to post public service announcements about disease prevention and awareness and health and safety topics, and the Connecticut Department of Health posts some of its videos in Spanish and American sign language. YouTube is also useful for providing a visual walkthrough of a new process to nurses, as the Kansas BON has done with their nurse notification system. The Washington Department of Health established their blog, Adventures in Health, in 2014, which covers a variety of health and safety topics.

Human misuse of private health information continues to be a problem on social media. Though many BONs have taken steps to increase awareness of social media and inappropriate use, a 2014 NCSBN survey revealed that 48% of responding BONs (n = 33) are facing challenges related to social media. Specifically, certain respondents noted an increase in boundary violations, and several respondents reported continued issues with private patient information shared via social media, in particular, photos of wounds or procedures taken on mobile phones. The Arizona BON has had continued difficulty with a licensee vocally protesting a disciplinary decision via a social media campaign.

Social Media: Emerging Issues for BONs

- BONs should recognize that social media is now a mainstay. An active social media account is proving to be a powerful method of spreading public health messages and is also becoming a preferred way to find qualified employees.
- Though patients are becoming more open to the idea of sharing their own health details publicly via social media, health care providers must keep such details private. Health care institutions should maintain strong cybersecurity standards and practices.
- BONs should continue to adopt robust social media policies and spread the message of safe social media use to licensees—a message that is perhaps best disseminated via a social media platform.

Veterans

In response to the White House report, The Fast Track to Civilian Employment: Streamlining Credentialing and Licensing for Service Members, Veterans, and Their Spouses, Idaho is among the BONs making licensing decisions to help veterans safely and competently enter civilian careers in nursing. Five BONs (Virginia, Illinois, Wisconsin, Minnesota, and Nevada) have received a grant from the NGA to start LPN/VN bridge programs for veterans in their state. Iowa is using funds for an RN program. These BONs are participating in the NGA Veterans' Licensing and Certification Policy Academy. The BONs meet periodically with members of the NGA and other experts to discuss their progress. NCSBN's work in this area, NCSBN Analysis: A Comparison of Selected Military Health Care Occupation Curricula with a Standard Licensed Practical/Vocational Nurse Curriculum (NCSBN, 2013) serves as a resource for these states. Arizona, Michigan, and other states also have a bridge program for returning veterans.

Veterans Bills Enacted in 2014

- Oklahoma House Bill 2554 requires the BON to develop guidelines for transitioning veterans with prior military medical training and experience into nursing education programs.
- Delaware House Bill 296 allows professional licensing boards to recognize military education, training, and experience when reviewing credentials and issuing licenses and aims to assist service personnel and their spouses in obtaining or renewing professional licenses when transitioning from active duty. This bill also allows BONs to issue service personnel temporary licenses when they hold a valid license from another state.
- Ohio House Bill 488 requires state institutions of higher education to award credit for military training and requires each licensing agency to prioritize and expedite certification or licensing for an applicant who is a service member, veteran, spouse, or surviving spouse of a service member or veteran.
- Oregon House Bill 4057 directs certain boards and agencies to report on implementation of new requirements to accept substantially equivalent military training or experience for certain education, experience, or training requirements to obtain a license or certificate. The bill includes spouse or domestic partner.
- West Virginia House Bill 4151 on professional licensing requirements for certain military members and their spouses requires certain boards to consider military education, training, and experience upon application for licensure, certification, or registration; provides for licensure renewal during active duty for service members and their spouses without meeting requirements of continuing education in certain circumstances; and provides for expedited temporary licenses for spouses of active duty service members.

Regulatory Actions for Patient Protection

Licensing

BONs continually strive to adapt to the needs of current and potential licensees. The mandate to regulators to provide an efficient and fair system for licensure for the large population of licensees causes various challenges. A recent review of jurisdictions provides insight into the current challenges resulting from the processing of licenses. Some challenges are met by technology, others by rule making.

Several states (Colorado, Hawaii, Maine, North Dakota, and Vermont) are in the process of implementing or enhancing online licensure applications, renewals, or late notices. Although the paperless approach to licensure is effective for the licensee and the BON, the change to this approach requires funds, development and implementation of online portals and processes, and licensee and staff education.

Fraud within licensure application and credential presentation remains a challenge to several BONs (Alabama, Colorado, Missouri, and Virginia). BONs face fresh challenges as they implement new enhancements to their licensure processes, such as criminal background checks (CBCs), further evaluation of CBC data, and foreign-educated nurse credential verification and evaluation (Idaho, Montana, Utah, and Virginia). Additional immigration issues can occur and require evaluation with the foreign-educated nurse (Alabama).

Continued competence requirements can help support nurse accountability for lifelong learning and foster improved nursing practice and patient safety. BONs have the regulatory authority for establishing continued competence requirements, and several states recently implemented specific requirements addressing particular topics: substance use disorder (Delaware), pharmacology for APRNs (Illinois), and child abuse recognition and reporting requirements (Pennsylvania). Both Idaho and Oregon are examining and responding to the challenge of measuring continued competence.

BON Advisory Statements: Guidance for Safe Patient Care

BONs may provide position or practice statements, clinical practice advisories, advisory rulings or opinions, and interpretive guidelines (hereinafter referred to as advisory statements) to interpret or further clarify the state nurse practice act and regulations. Although BON advisory statements do not have the force of law, they are a means of providing direction to nurses on issues of concern to the BON regarding public protection. These statements often provide safe parameters within which to work, and they protect patients from unprofessional and unsafe nursing practice.

A recent review revealed that 21 states approved or revised advisory statements in 2014. Some topics were addressed by multiple BONs. For example, several BONs recently developed statements regarding cosmetic and dermatologic procedures and delegation. The Arizona, Massachusetts, North Dakota, and Wyoming BONs adopted or revised their cosmetic and dermatologic advisories, which guide the practice of RNs and LPN/VNs performing certain cosmetic and dermatologic procedures. Additionally, New Hampshire reaffirmed that administering Botox for hyperhidrosis is within the APRN scope of practice as long as the APRN has demonstrated specific competencies. New Hampshire also affirmed that the RN scope of practice includes Botox administration based on proper training, competency, and facility policy.

The administration of medications for conscious sedation and supervision of the administration were addressed by advisory statements in Alaska, Kansas, Massachusetts, and Ohio. Issues related to delegation in school nursing settings or insulin administration in schools were addressed by Kentucky, Nevada, and Washington.

Arizona, Massachusetts, and Wyoming adopted RN First Assistant advisory statements. Arizona, New Hampshire, Oklahoma, and Wyoming addressed care of the patient during obstetric delivery. The Kentucky, North Carolina, Vermont, Washington, and Wyoming BONs directed nursing behavior regarding delegation to UAP in advisory statements.

For an inventory of the advisory statements approved and revised by BONs in 2014, see Appendix A.

Discipline: Ensuring Accountability

According to a recent NCSBN survey, the number of disciplinary complaints continues to stabilize for the majority of BONs. However, several BONs report a 5% to 20% increase in complaints, and several others report a 5% to 20% decrease in complaints. (See Figure 8.) Substance use disorder (SUD) and diversion represent the most frequent subject of complaints to the BON. Other frequent complaints are boundary violations, social media–related violations, and practice issues.

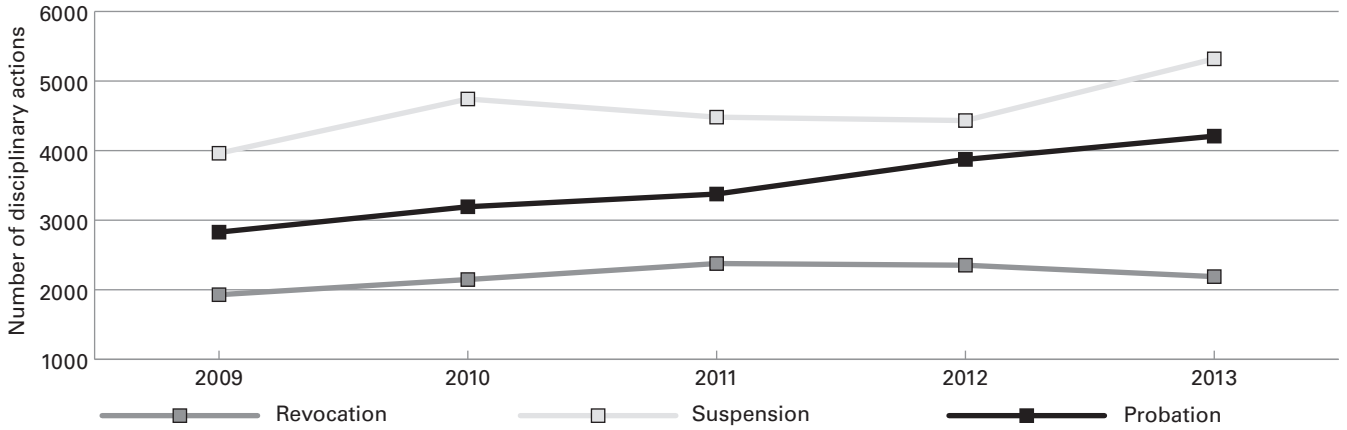
Complaints are investigated by the BONs, and a course of action, which may involve discipline, is recommended based on this investigation. Those violations that most commonly result in disciplinary action involve practice issues, diversion or SUD, and criminal convictions. Though not as frequent, other common causes of disciplinary action include HIPAA violations, practicing without a license, boundary issues, unprofessional conduct, and theft.

BON actions range from letters of concern to revocation of license. According to a recent NCSBN survey of BONs, the most frequent disciplinary actions are suspension, reprimand, probation, and revocation. Warnings or letters of concern, voluntary surrender, conditions on licensure, remediation, and summary suspension are not as frequent.

The majority of disciplinary cases are settled without a formal hearing. However, the number of hearings in a year varies from 0 to 99 among BONs. Most BONs responding to an NCSBN survey indicated the frequency of hearings has increased over the past year.

FIGURE 8

Trends in Disciplinary Actions for RNs and PNs Across All Jurisdictions



Source: The National Nursing Database (NCSBN, 2014).

Important Issues and Challenges for BONs in the Next 5 Years

In 2015, the regulatory, health care, and social environment presents numerous challenges and opportunities. When asked what they predict to be the most important issues facing BONs in the next 5 years, the executive officers of the BONs cited the following:

- Telehealth and its regulatory implications related to licensure
- The Nurse Licensure Compact (NLC)
- Scope of practice issues (blurring of the lines between nurses, other practitioners, and UAP; the need for increased delegation to UAP; expansion of scope of practice for RNs, LPN/VNs and UAP/removal of barriers to practice; redefining of nursing practice)
- Continued adoption of the APRN Consensus Model by all jurisdictions; full practice authority for APRNs
- Access to care
- The APRN Compact
- Nursing education (shortage of clinical sites; standardized curriculum; the role of the BON in nursing education regulation; accreditation of nursing programs; distance education; relationships among regulators, educators, and accreditors; baccalaureate education as entry-level education).

In 2015, as part of its public policy agenda, NCSBN will continue to follow and monitor legislation and communicate in telehealth discussions with congressional staff. As part of this communication, NCSBN will be educating policy makers on the role of BONs, the importance of state-based licensure, and alternative solutions to telehealth licensure issues, such as the NLC. NCSBN's new Washington, DC, office provides timely access to key players in the policy arena addressing issues of concern for nursing regulators.

NCSBN will continue to facilitate discussions among executive officers of BONs related to the NLC. The NLC addresses many of the concerns of employers, nurses, and policy makers related to telehealth, case management, and practice across state lines, and it does so while still offering public protection. One concern expressed by nonparticipating BONs is the fact that all states do not have uniform licensure requirements. Issues such as CBCs emerged as being vital components that needed to be added to the NLC, if additional states were to join. Changes to the NLC have been agreed upon, and throughout 2015 work will continue, culminating in the revisions being brought before the 2015 delegates to NCSBN's Annual Meeting for a vote. The APRN Compact, still undergoing minor revisions, will be addressed and voted upon at the same time. NCSBN will actively work with BONs to adopt CBC legislation.

The APRN Consensus Model is vital to public protection as well as access to care. Throughout 2015, NCSBN will continue to lead the Campaign for Consensus, work with stakeholders, and encourage the adoption of the main components of the Consensus Model. Currently, 12 states have fully adopted the model, with many other states at least 50% or more towards full implementation.

NCSBN is committed to assisting nursing education programs in finding innovative approaches to meet their challenges. In 2014, in response to educators' calls for new solutions to the increased scarcity of clinical opportunities, NCSBN's National Simulation Study provided strong evidence that up to 50% simulation can be substituted for clinical hours in the undergraduate nursing curriculum with the appropriate resources and education of faculty. As nursing education continues to evolve to meet changing demands on the nursing workforce, NCSBN encourages the collaboration of accreditation, education, and regulation at the state level, in order to integrate the new methodologies originating from these innovations.

In the years ahead, BONs can be assured of NCSBN's continued support as they address the challenges and opportunities of the future. NCSBN is also available to nursing professionals, consumers, and policy makers and has a host of resources available on its website.

Key Findings of This Report

- The number of LPN/VN programs is decreasing. This trend warrants monitoring in the upcoming year. LPN/VNs play a valuable role in providing nursing care and are the mainstay of long-term care.
- The number of APRNs continues to rise. There is a shortage of clinical sites for APRNs, just as there is for undergraduates. Many potential sites are also used by physician assistants and medical students; thus, faculty members are struggling to find appropriate placements for their students.
- Transition to practice for APRNs is increasingly being discussed at many levels. Though no meaningful evidence supports a strong need for APRN transition-to-practice programs, discussions of the topic are occurring at the local, state, and federal levels.
- In addition to the shortage of clinical sites for undergraduate nursing students, there is a potential shortage of faculty looming as many near the age of retirement.
- Distance education issues continue to arise as more programs proliferate. It is important that these programs be held to the same regulatory and education standards as other programs.
- Access to care remains a key issue in the United States. This impacts nursing and regulation in many ways. It increases the need for telehealth; it increases the need for APRNs and the need for them to have full practice authority; and it has led to discussions about the role of UAP and staff from other professions taking on roles that were traditionally nursing roles.
- Federal legislation impacting state-based licensure and the regulation of nursing is an issue calling for close monitoring and communication, with members of Congress and BONs working together to provide feasible solutions.

APPENDIX A

Inventory of the Advisory Statements Approved or Revised by BONs in 2014

Alabama

Revised

- Collaborative practice standard
- Specialty protocols and standard & specialty formularies for certified registered nurse practitioners (CRNPs) and certified nurse midwives (CNMs)

Alaska

Adopted

- Assistance in dialing a dose of insulin for a blind person
- Continued approval of the Alaska Native Medical Center Colorectal Screening program with the new standards of screening high risk patients at the age of 40
- American Nurses Credentialing Center (ANCC) will award contact hours for content in "repeat" courses such as Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and other advance courses for registered nurses (RNs) and advanced nurse practitioners (ANPs).
- Board of nursing (BON) will accept continuing education units for renewals of ACLS, PALS, and other advance courses for RNs (not ANPs) beginning December 1, 2014.
- Peripherally inserted central catheter (PICC) line insertion proposal from Basser Army Hospital
- Competency tool for nursing care during procedural conscious sedation at Anchorage Endoscopy Center
- Procedural sedation education program at South Peninsula Hospital
- Denial of petition filed by Planned Parenthood of the Great Northwest that requests ANPs to perform uterine re-aspirations to manage early pregnancy loss
- Determination that a nurse who would like to practice under the advanced practice registered nurse (APRN) designation would need to meet the educational requirements outlined in the Consensus Model
- Intravenous (IV) drug administration of ketamine by RN for the treatment of postoperative, opioid-tolerant adult patient

Revised

- Registered nurse administration of sedating and anesthetic agents

Arizona

Adopted

- RN and LPN roles in immunization administration by using a nursing protocol in an ambulatory setting
- RN and LPN roles in intranasal administration of versed (midazolam) for treatment of signs and symptoms of acute seizure outside the clinical setting
- RN and LPN roles during ionizing radiation for diagnostic and therapeutic purposes
- RN and LPN roles in initiating medication refills using a nursing protocol in an ambulatory setting
- Registered nurse practitioner (RNP) role in prescribing off label drugs, devices, and therapeutics
- RN role in performing punch and shave biopsies

Revised

- RN role in performing amniotomy
- RN role in operating blood cell salvage devices
- RN role in applying and removing fetal spiral electrodes to a fetus if the membranes are ruptured
- RN role in performing therapeutic ultrasounds
- RN role in administering medications that provide palliative sedation at end of life
- RN role in practicing as registered nurse first assistant (RNFA)
- RN role in intravascular sheath removal, placement of mechanical compression devices, and deployment of vascular closure devices

Arkansas

Adopted

- The performance of stapling, suturing, or application of tissue adhesive for superficial wound closure by RNs in the emergency department

Revised

- Telenursing

Connecticut

Adopted

- Whether APRNs can perform physical examinations for commercial driver's licenses

Kansas

Adopted

- Administration of IV conscious sedation (moderate sedation/analgesia) by the registered professional nurse

Revised

- Delegation of specific nursing tasks in the school setting for Kansas

Kentucky

Revised

- Performance of advanced life support procedures by nurses
- Roles of nurses in the supervision and delegation of nursing acts to unlicensed assistive personnel (UAP)
- Components of LPN practice
- School nursing practice

Massachusetts

Rescinded

- Medical aesthetic procedures
- Nonablative and nonlaser sources device use

Adopted

- Cosmetic and dermatologic procedures

Revised

- APRNs as first assist at surgical procedures
- Role of the licensed nurse as trainer or consultant for the Department of Public Health medication administration program
- Administration of medications for sedation/analgesia
- RNs as first assistants at surgery

Nevada

Adopted

- Insulin delegation in the school setting

New Hampshire

Reapproved

- APRN and RN scope of practice in administering Botox

- APRN certified nurse midwife (CNM) role in providing vaginal birth after Cesarean (VBAC) deliveries

Adopted

- RN scope of practice in insulin management
- RN scope of practice to perform physical examination to medically certify a driver as physically qualified to drive a commercial motor vehicle in interstate commerce
- Licensed nursing assistant (LNA) scope of practice to convey unopened/packaged medication under the supervision of a licensed nurse
- LNA scope of practice to apply pressure to an arterial line, clamp nasogastric (NG) tube, or perform other functions associated with NG tubes

North Carolina

Adopted

- Delegation of medication administration to UAP

Revised

- Adult care settings
- Assisting clients with self-administration of medications
- Delegation and assignment of nursing activities
- Delegation of nonnursing functions
- Delegation of nurse aide II (NAII) credentialed as emergency medical technician-intermediate/paramedic (EMT-I/P)
- Dialysis in the acute care, community centers, and home settings
- LPN scope of practice
- Medication aide education & role in long-term care/skilled nursing facilities
- Office practice setting–UAP delegation
- RN scope of practice

North Dakota

Revised

- Aesthetic cosmetic and dermatological procedures by licensed nurses

Ohio

Reapproved

- Guidelines for RN filling and unfilling a patient's gastric band
- RN role in care of patients receiving intravenous moderate sedation for medical and/or surgical procedures
- RN utilization of the Sapiens tip confirmation system (TCS) or other comparable device to confirm peripherally inserted central catheter (PICC) tip placement in adults

Revised

- RN role in emergent intubation performed by an authorized provider

Oklahoma

Revised

- Meeting requirements for continuing qualifications for practice for license renewal
- Certified registered nurse anesthetist (CRNA) inclusionary formulary
- Exclusionary formulary for advanced practice registered nurses with prescriptive authority
- Placement of nasogastric tubes by registered nurses in postbariatric or anatomy altering (upper gastrointestinal tract and stomach) surgical patients
- Registered nurse administering, managing and monitoring nonobstetrical patients receiving analgesia/anesthesia by catheter techniques (e.g., epidural, PCEA and intrathecal catheters)
- Registered nurse monitoring obstetrical patients receiving analgesia/anesthesia by catheter techniques (epidural, PCEA and intrathecal catheters)

Oregon

Revised

- Employment orientation for a nursing position prior to licensure
- Scope of practice competencies for the registered nurse who performs sexual assault forensic examinations

Rhode Island

Adopted

- Guidelines regarding scope of practice, supervision, and minimum expectations of conduct of medical assistants

Vermont

Revised

- Role of the nurse in delegating nursing interventions
- APRN prohibition on prescribing oral buprenorphine (Suboxone or Subutex) for the treatment of opioid dependence
- Abandonment
- Patient choice at end of life

Virginia

Revised

- Guidance on massage therapy practice
- By-laws of the advisory board on massage therapy

Washington

Adopted

- Registered nurse delegation in school settings
- Neonatal intubation and related procedures

Wisconsin

Revised

- APRNs should collaborate with a physician who is capable of delivering health care services within the scope of the APRN's professional expertise.
- Nurse Licensure Compact coverage does not extend to APRNs.

Wyoming

Adopted

- APRN prescriptive authority
- CNA Level II (CNA II) training and competency evaluation course
- CNA assistance with self-administration of medications
- CNA hired by private party
- Delaying CPR to ascertain code status
- Diagnosis & treatment of sexually transmitted diseases (STDs)
- Intraosseous cannulation
- LPN and RN scope of practice
- LPN basic & advanced IV therapy refresher training and competency evaluation course
- Medication assistant-certified (MA-C) training and competency evaluation course
- Nursing extern programs
- Nursing interventions that may not be delegated

- Refusing patient care assignment
- RN first assistant

Revised

- APRN population focus
- C-Arm (radiologic equipment) positioning and operation
- Central lines and peripherally inserted central catheters
- Cervical ripening agents and prostaglandin suppositories
- Chest tube, mediastinal tube and pleural drain removal
- Certified nursing assistants (CNAs) in other roles
- Cosmetic and dermatologic procedures
- Determination of ruptured membranes
- Educational preparation for licensure, certification & recognition
- Exam by sexual assault nurse examiner (SANE)
- Gastrostomy tube reinsertion into a mature site
- IV chelation therapy
- Intraperitoneal catheters
- Intraventricular implanted devices & temporary intracranial catheters
- Licensed nurse/CNA functioning as endoscopy technician
- Management of analgesia by catheter in the pregnant client
- Medication administration during pandemic
- Nurse-client relationship
- Paid feeding assistant
- Patient-controlled analgesia by proxy
- Relaying physician orders
- Rhogam administration by the LPN
- Reversal of advisory opinions
- Spirometry in occupational safety & health

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