Washington State Nursing Care Quality Assurance Commission

2013 Report to the Governor and Legislature

As required by Second Substitute House Bill 1518

December 31, 2013

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Executive Summary

The Washington State Nursing Care Quality Assurance Commission (commission) is responsible for the regulation of more than 100,000 licensed practical nurses (LPN), registered nurses (RN), and advanced registered nurse practitioners (ARNP) in the state. Through its oversight of nurse education, licensing and discipline, the commission assures safe, high-quality nursing care in the state and serves to protect the public and maintain the integrity of the nursing profession.

Beginning in the early 2000's, concerns were raised that Washington's system for regulation and oversight of health professions was falling short, potentially placing patients and the public at risk, and that changes were in order. One of the most significant modifications involved the commission. Under Fourth Substitute House Bill 1103 (HB 1103), a pilot project was designed and put in place in 2008 transferring primary authority over the commission's budget development, spending and staffing to the commission from the Department of Health (DOH).

Following a favorable evaluation of the pilot project, the changes in HB 1103 were made permanent and supplemented in 2013 through Second Substitute House Bill 1518 (HB 1518). HB 1518 also directed the commission to submit by the end of 2013 a report, including recommendations, regarding: (1) evidence-based practices and their use by the commission, and (2) a comparison of the commission's outcomes with those of other states using a national database. This was a somewhat vague charge giving the commission leeway in developing a useful report.

In doing so, the commission gave considerable attention to the work of the National Council of State Boards of Nursing (NCSBN). Consistent with the idea that we only improve what we measure, its "Commitment to Ongoing Regulatory Excellence" (CORE) report allowed a comparison of Washington's outcome data with those of other states. The CORE data confirmed the commission's assumption that there remains room for improvement to meet its high expectations, with just one example being the amount of time it takes from the opening of a disciplinary case to its formal resolution.

The commission also looked to the NCSBN, a leader in the developing field of evidence-based nursing regulation, for ways to make improvements. Among other sources, the commission considered the recent work of the NCSBN "Promising Practices Consultants: Discipline" focus group. This focus group documented advice and opinions of a number of high performing state nursing boards to identify practices supporting quality outcomes with regard to the nurse discipline process. This is still a work in progress, but nonetheless demonstrates that although Washington already incorporates many best practices, other states and published research offer potential solutions to further inform our improvement efforts.

This report also allowed the commission and its staff to identify current management and operational practices believed to be detrimentally affecting performance. This in

turn affects the commission's ability to protect the public and the integrity of the nursing profession in Washington. Examples of this include the underutilization of investigators and overutilization of attorneys in a way that unnecessarily slows down the disciplinary process, a clumsy process to secure mental exams during an investigation, a cumbersome DOH rulemaking process, and inadequate implementation of criminal background checks. The commission expressed frustration with the lack of responsiveness of the DOH to the needs and concerns of the commission. For instance, the general lack of information technology support and a failure to accommodate our requests and unique interests in the Integrated Licensing and Regulatory System (ILRS). A strong desire exists for more transparency and accountability from the DOH surrounding financial and procedural practices effecting the commission, particularly regarding indirect costs and whether licensing fees paid by nurses are being well-spent.

To best address these concerns and the other opportunities for improvement identified in the work of the NCSBN, the initial inclination of the commission was to recommend further statutory changes giving it more authority and greater independence from the DOH. However, the commission subsequently decided this may be less about the need for additional authority and more about fully exercising the new authority granted under HB 1103 and HB 1518.

While additional authority and independence may yet prove necessary, the commission decided that exploring and acting on what more could be accomplished within our existing authority would be more constructive, particularly given what has been accomplished under the pilot project. This comes with the intent the commission be more assertive and acknowledges the recent legislative changes have not simply provided an opportunity to improve, but imposed the responsibility to do so in a proactive fashion. Prior to the adoption of HB 1103, the commission felt stymied in their direction to improve processes. HB 1103, and most recently HB 1518, removed some of the barriers, resulting in measurably improved outcomes. The commission recognizes and looks forward to working with a new DOH administration through the Nursing Commission Operating Agreement.

Based on the information gathered and discussions in the development of this report, the commission recommends:

1. **No additional legislation regarding the commission's structure or authority be passed at this time;** allowing more time to implement, adjust to and assess the impact of the substantial number of recently made statutory changes.

2. **Continuous performance improvements remain a priority for the commission.**

    - The commission continues to have high expectations, monitor performance and identify opportunities to become more efficient, effective and accountable to the public using tools provided by the NCSBN and other means.

- The commission encourages and partners with the NCSBN in developing better and more comprehensive performance measures and evidence-based improvement practices. In particular, the link between specific practices and positive performance outcomes must be clearly documented.

- The commission works with the DOH to implement practices leading to performance improvement using its existing authority, and documents instances where the authority is either unclear or insufficient and performance suffers as a result.

3. **By December 31, 2015, the commission reports to the legislature and the governor.** At a minimum, the report should address:

    - The commission's work, including work with the NCSBN, to identify promising practices linked through research and evidence to improved performance;

    - The extent to which the commission has been able to implement those promising practices, and otherwise address management and operational concerns, using the authority granted it under HB 1103 and HB 1518;

    - Practices, and management and operational concerns the commission could not address under existing law, and what specific authority it would need in order to do so; and

    - Whether what the commission has learned, the improvements it has implemented, and the changes still needed are unique to its regulation and oversight of the nursing profession, or may have application to other health professions or the state's health professions quality assurance system generally.

    Prior to formally reporting in 2015, the commission would welcome the opportunity to appear at any time before the appropriate legislative committees to discuss performance improvement. This could be done at a work session also including other health profession boards and commissions, in particular those whose authority was modified under HB 1103 or HB 1518.

Introduction and Background

The Washington State Nursing Care Quality Assurance Commission (commission) is established in state law to be responsible, in conjunction with the Department of Health (DOH), for the regulation and oversight of more than 100,000 licensed practical nurses (LPN), registered nurses (RN), and advanced registered nurse practitioners (ARNP). Nurses account for the largest portion of the 380,000 individuals among 83 health professions regulated by the state. The commission is made up of 15 members appointed by the governor and purposed by statute to "regulate the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline." (RCW 18.79.010)

Beginning in the early 2000's, concerns were raised that Washington's system for regulation and oversight of the health professions was falling short, potentially placing patients and the public at risk. Similar concerns surfaced at the time in other states. In California, Oregon and Massachusetts safety concerns were severe enough the decision was made to dismiss existing boards and staff leadership. For much of the last decade in Washington, the legislature, governors, and health professionals engaged in efforts to address the concerns here, in part through statutory changes to the authority, structure and administration of the boards and commissions sharing regulatory responsibility with the Department of Health (DOH).

One of the most significant modifications placed the nursing commission in a pilot project beginning in 2008 when the legislature passed Fourth Substitute House Bill 1103 (HB 1103). The bill was four years in the making and addressed a number of issues related to health professions, including disciplinary actions related to sexual misconduct, conditional credentials, criminal background checks, a uniform sanctioning schedule, the reporting of unprofessional conduct, and post-conviction credentialing. The bill also created a five-year pilot project under which the commission and the Medical Quality Assurance Commission (MQAC) were given primary authority over their budget development, spending and staffing. The bill transferred this authority from the DOH to the nursing commission and the medical commission.

HB 1103 directed the DOH and the commission to evaluate and report on the outcomes of the pilot project using negotiated performance measures on licensing, disciplinary and financial outcomes. The DOH report, completed in January 2013, recommended the legislature make the pilot project permanent for both the NCQAC and the MQAC, with some conditions. The NCQAC portion of the report, completed in December 2012, made no recommendations but concluded "The Nursing Commission improved its performance with the additional authority over budget development, spending and staffing." In particular, the report noted in using the additional authority granted the commission was able to:

- Avoid denying access to potential participants of the Washington Health Professional Services program;

- Increase the number of completed investigations by 71%;

- Decrease the backlog of investigative cases by 34%;

- Decrease the amount of time used in investigations by 37%; and

- Increase efficiencies in licensing, with licensing decisions occurring on the same day as the receipt of final documents.

Similar successes have continued since the HB 1103 report. For example, in the first quarter of fiscal year 2014, DOH data shows disciplinary investigations were completed by the commission within the targeted timeline nearly 91% of the time. This was best among all the health professions boards and commissions, and a substantial improvement over the previous year.

In 2013, the legislature passed Second Substitute House Bill 1518 (HB 1518), which among other things made the provisions of the HB 1103 pilot project permanent, with a few additions and modifications. It also required the commission to submit an additional report to the legislature and governor by December 31, 2013.

The Commission's Charge and Approach to the Report

Section 5(8) of 2SHB 1518 amends RCW 18.79.390 to direct the commission, by December 31, 2013 to "present a report with recommendations to the governor and the legislature regarding: (a) Evidence-based practices and research-based practices used by boards of nursing when conducting licensing, educational, disciplinary, and financial activities and the use of such practices by the commission; and (b) A comparison of the commission's licensing, education, disciplinary and financial outcomes with those of other boards of nursing using a national database."

This is a somewhat vague and broadly-stated charge the commission read as giving it substantial discretion to decide the exact nature, format and content of the report. The commission did not interpret the legislation to be calling for a formal performance evaluation, nor is it direction to simply catalogue the practices of other boards around the country and decide how to best replicate them in Washington. Instead, this presented an opportunity to: (1) identify ongoing concerns of the commission and its staff about how the commission is structured and operates, using as a starting point for this discussion the materials identified in the legislation; (2) consider the commission's existing authority, particularly in light of a number of recent legislative changes, and how the authority might be used to address the identified concerns; and (3) recommend to the governor and the legislature any appropriate next steps.

The commission's goal was to be responsive to the explicit requirements of HB 1518. Just as important was that the report be of real value to the governor and legislature. The report also serves to further improve public safety and the integrity of the nursing profession in Washington. This commission's responsibility is solely for the nursing profession. However, discussions were mindful of the broader obligations of the DOH to assure the quality of and safe practices by all health professionals in the state.

The commission also appreciated that for much of the last decade, the legislature has been closely engaged on the issue of how to best structure this system. While this alone is not reason to avoid pushing for further statutory changes if necessary, it does argue for spending time to take advantage and assess the merits of what has been done.

Finally, although the language of HB 1518 would seem to allow for it, the commission assumed it was not the legislature's intent for this report to simply repeat what was already submitted just last year under HB 1103. The commission was disappointed it was not allowed to make explicit recommendations in the HB 1103 report. That report nonetheless provides some context and additional details regarding what's presented here, and is useful to review. In some respects, this report builds on and supplements the HB 1103 report with a critical eye and the benefit of further analysis and discussion. It also takes into account what was done in HB 1518 to permanently enhance and clarify the standing and authority of the commission.

Assessing Our Performance and Opportunities to Improve

The CORE Report – A Comparative National Database

Among the key resources drawn on by the commission in completing last year's HB 1103 report was the "Commitment to Ongoing Regulatory Excellence" (CORE) data published by the National Council of State Boards of Nursing (NCSBN). CORE was initiated in 1998 as a comparative performance measurement and benchmarking process for state boards of nursing. The CORE report is intended to track the effectiveness and efficiency of nursing regulation nationally and within individual states in order to assist boards with improving performance and providing accountability. It evaluates and compares performance across a wide set of metrics in the areas of discipline, licensure, education and practice, based on survey and other data from relevant parties in each state.

As just one example in the area of discipline, CORE asked nurses, employers, and nurse educators in each state whether they agreed or disagreed with the statement "The Board of Nursing acted in a timely manner regarding the complaint/discipline process that you have been involved in." Responses are gathered for each state, and aggregated to show national results and results by the type of board – classified by the degree of independence with which the board operates. Outside of opinion surveys in

this area, the CORE report includes data reported by each state board of the average length of time in days from opening an investigation in the state to resolution of a formal hearing, and the average cost per investigation.

The CORE data is the "national database" to which HB 1518 refers when it directs the commission to report regarding "A comparison of the commission's licensing, education, disciplinary and financial outcomes with those of other boards of nursing using a national database."

In again reviewing the CORE data for purposes of this report, the commission considered more closely both the data's value and its limitations, wanting to avoid making any recommendations based on inappropriate conclusions or a misreading of the information presented. Some of the limitations of the data include an often very low number of survey respondents in individual states, and incomplete or unreported data. The commission distinguished between objective and subjective information. For example, whether a board's actions are viewed as "timely" in any given state is a function of both expectations in the state and the actual number of days it takes for a given action to occur or be completed. Each has different implications with regard to evaluating and improving performance.

Although all reporting states are included in the aggregated data, individual state data is only available from the NCSBN with the permission of the state, and then is not provided in a format facilitating easy comparison among states. In addition to Washington, for this report the commission compared performance with the Arizona State Board of Nursing and the North Carolina Board of Nursing. Both Arizona and North Carolina have consistently demonstrated high performance in the previous CORE reports. While interesting to compare, the commission hesitated to draw any firm conclusions about our performance based only on this limited perspective. The comparison invited the commission to dig deeper and discover differences in laws, finances, personnel and administrative procedures.

The NCSBN also explicitly includes in the CORE report cautions about the data and how it's interpreted and used, stating:

> "It should be understood that the results presented in this report are descriptive data only. While almost all of the data presented represent indicators of the performance of their respective BONs [Boards of Nursing], the data are indicators only and are therefore subject to possible problems regarding measurement validity and reliability. Furthermore, these performance measures have not been subjected to analysis of associations or relationships among them, nor does this report constitute a cause/effect evaluation of BON performance. Thus, the data presented in this report should be taken at face value and not over-interpreted."

Nonetheless, it would also be a significant mistake for the commission to simply ignore the CORE data or suggest it has no value to this report or as a tool in improving

performance. As the CORE report itself notes following this set of disclaimers, "Nevertheless, the data presented in this report do provide a clear, comprehensive and well-balanced indication of what the performance of the Washington Board of Nursing [commission] looks like and how that compares with its counterparts around the country."

What does the CORE report say, and not say, about the Washington State Nursing Care Quality Assurance Commission? On most performance measures the commission compares favorably to other state boards, coming in either at or above the national averages. The CORE report also suggests nurses in Washington generally provide safe and competent care comparing favorably to nurses nationwide. There are however, some noticeable outliers indicating areas of both low and high performance, for example:

- In fiscal year 2012, the average length of time from the opening of an investigation to resolution of formal hearings in Washington was 801 days. For other "umbrella boards" (those under the umbrella of a state agency) the number was 539, and for all boards the average time was only 360 days.

- In Washington, the average length of time to process applications for nurse licensure from the receipt of all required information to authorization of the license was one day. For umbrella boards the number was 9.3 days, for independent boards it was 18.1 days, and for all boards together it was 16.1 days.

The CORE report confirms the sense of the commission and its staff that while the commission is on the right track, there is room for improvement. To the extent some boards perform in some areas at a higher level, there are still achievable improvements to work towards. In and of itself, however, CORE does not provide evidence of any causal relationship between the formal authority or governance structure of a nursing board and its performance. Additionally, CORE does not identify the particular practices resulting in one board performing better than another board on a given quality measure. For this, the commission looked elsewhere, including another product of the NCSBN.

Evidence and Research Based Practices

In addition to outcome comparisons using a national database, HB 1518 directs this report consider the commission's use of evidence and research based practices used by other boards of nursing. Some issues we identified in doing so:

- Evidence-based nursing regulation is a relatively new and developing field, led by the NCSBN. *The Journal of Nursing Regulation,* published by NCSBN, serves as a primary source of information, research and dialogue in this area. As noted in an article in the first issue of the Journal from April 2010 "With the body of knowledge in nursing regulation still emerging, regulators do not have a great deal of evidence on which to base regulatory decisions."

- Although related conceptually, evidence-based regulation of health professionals is not the same as evidence-based medicine. Both look to research to inform decision-making. However, the first addresses best practices by regulatory entities while for the second it's best practices by professionals in the clinical setting.

- It is also important to distinguish between the use of evidence to establish the law itself, which reflects policy choices made largely by the legislature, and the use of evidence by the commission to guide administrative and management practices and the enforcement of laws once established. Deciding to require criminal background checks prior to licensing a nurse is an example of the former. How to best implement the requirement so it serves its intended purpose is the purview of the latter.

Although still a developing field, in doing research for this report the commission discovered evidence and research-based management practices used by nursing boards. An example of this, is the "Promising Practices Consultants: Discipline" focus group convened and facilitated by the NCSBN. The commission determined to use this document and closely examine upcoming products from this group.

Using CORE report survey data and other documents, the NCSBN in early 2012 named a set of high performing member boards and organized their representatives into a focus group to identify promising practices for the nursing discipline process. The group first met in April 2012 where they were guided through a series of questions to facilitate their brainstorming and discussion. They began by exploring the differences between umbrella and independent boards. While some differences exist, the group agreed the differences did not significantly impact the effectiveness of the discipline process, with differences among the state laws and practices having a greater impact than board structure.

The result of this focus group was a prioritized list of promising practices. Included in the list are routine staff and board training, and implementation of a deferred discipline process where private reprimands and other means are used to more quickly resolve minor violations or violations not including harm or injury to patients.

The NCSBN reconvened the focus group in November 2012 and noted its initial results were beneficial, but "the recommendations and list of promising practices were not detailed or evaluated to determine whether they truly had potential for improving performance." The November meeting took a somewhat more formal and detailed approach, including the development of an initial list of criteria to identify promising practices. The outcome was a list of 26 promising practices, including some for each step in the discipline process. Examples include "establish a list of minor incidents and empower staff to close cases with board approval," "use tools and templates as a guide for decision-making; define when and how staff can take action depending on the type of complaint," and "allow investigators to make non-disciplinary recommendations based on policies."

This effort is still a work in progress, as reflected in the observations and comments of the NCSBN CORE members when briefed on its work. Among other things, CORE members asked for more clarity on what each promising practice is supposed to impact or measure. The CORE members requested more thought be given to how to evaluate whether the recommended practices actually achieve the intended purpose. The commission plans to actively participate with the NCSBN in its development. The commission hopes this effort eventually extends beyond the disciplinary arena to also cover licensing, education and finances. In the meantime, the commission will routinely refer to and incorporate what's being done with the NCSBN and other research and studies in the growing body of work on evidence-based nursing regulation. The desired outcome is continually improving performance.

Additional Opportunities for Improvement

In addition to looking to the NCSBN CORE report and work of the Promising Practices Consultants, development of this report offered the commission and its staff the opportunity to identify for itself some ongoing performance issues and operational concerns and consider how they might be addressed. These largely reflect our experience on a day-to-day basis working with the DOH and its Division of Health Systems Quality Assurance (HSQA) to carry-out our responsibilities under the law.

We were also helped by an on-site visit in June of this year to the Arizona State Board of Nursing by commission members and staff. While there, we observed their operations and spoke extensively with relevant staff to identify any of their practices which could inform our work here, either by reinforcing the merits of our current approach or suggesting to us a better way to operate. It helped clarify that while the commission has no interest in – and Washington would not be well served by – a wholesale replication of the process or procedures of another state such as Arizona, we can learn from them, with on-site visits and direct communication among the best ways to do so.

There are current management and operational practices the commission believes are detrimentally affecting performance, and in turn affecting the commission's ability to protect the public and the integrity of the nursing profession in Washington. Examples of this include the underutilization of investigators and overutilization of attorneys in a way that unnecessarily slows down the disciplinary process, a clumsy process to secure mental exams during an investigation, a cumbersome DOH rulemaking process, and inadequate implementation of criminal background checks. Continuing to use these processes potentially jeopardizes the public and may leave affected nurse in limbo.

The commission is also at times frustrated with the lack of responsiveness by the DOH and the HSQA to the needs and concerns of the commission. For instance, the general lack of information technology support and a failure to accommodate requests from the commission and unique interests in the Integrated Licensing and Regulatory System (ILRS). ILRS is the database used to track all licensing applications and decisions and all disciplinary activity on those licenses.

The commission also has a strong desire for more transparency and accountability from the DOH and the HSQA surrounding financial and procedural practices effecting the commission, particularly regarding indirect costs and whether licensing fees paid by nurses are being well-spent. The large number of nurses licensed in Washington creates a substantial amount of revenue. The commission and the DOH share the responsibility to assure public funds are used appropriately.

Doing with What We Have: The Commission's Authority Following 2SHB 1518

A significant by-product of what the commission examined and discussed in developing this report was the recognition that the tools and the authority needed to address many of the existing concerns may have been given to the commission in HB 1103 and HB 1518. The commission confirmed that the tools related to management and administration are especially valuable to engage in the continuous improvement contemplated by the state, by the NCSBN in issuing the CORE report, and in the focus group identifying promising practices. The commission realized that some of the promising practices identified and the issues raised during the discussions may be going unaddressed simply because of an untested assumption. The assumption being that the actions needed could be beyond the current authority granted to the commission.

The commission's historical structure and operating procedures routinely deferred to the DOH and the HSQA, even when the nursing commission felt doing so was detrimental to their core mission. The initial inclination was to then use this report to call for additional legislative authority with even greater independence. The commission subsequently decided that continuing to operate this way may be less about the need for additional authority and more about our fully understanding, appreciating and exercising the new authority granted under HB 1103 and HB 1518.

While additional authority and independence may yet prove necessary, the commission decided to explore and act on what more could be accomplished within our existing authority, particularly given what has been accomplished under the pilot project. This approach is more constructive at this point, especially given a new DOH administration. This acknowledges the recent legislative changes have not simply provided the commission an opportunity to improve, but imposed the responsibility to improve in a proactive fashion.

Rather than focus on what was lacking, the commission decided a better use of this report would be to briefly itemize the tools now available, how the tools differ from what existed prior to HB 1103 and HB 1518, and the commission's intentions in using them to further their purpose and mission:

- **Commission staffing.** Before HB 1103, the commission's executive director was appointed by the Secretary of the Department of Health after consultation with the commission, and directed to "carry-out this chapter." It was a civil service position with the salary established by the Secretary. Other commission staff members were also employed by the Secretary.

  Under the HB 1103 pilot project, the Secretary was removed from the process and the executive director was hired by and served at the pleasure of the commission. It was an exempt position with the salary established by the commission. The executive director was charged with performing "all administrative duties of the commission, including preparing an annual budget, and any other duties as delegated to the executive director by the commission." Staff of the commission were hired and managed by the executive director.

  This was made permanent under HB 1518.

  With the ability to hire and direct our own executive director, the commission is able to focus his or her work on the commission's priorities. The executive director acts as a strong advocate on behalf of the commission. The executive director represents the commission before the DOH rather than the other way around. Likely this will prove even more beneficial outside the cloud of a pilot project where there was the possibility the executive director would again report to the DOH once the project ended. The commission will also have a greater role in determining allocation of staff resources, and addressing inefficiencies detrimental to performance.

- **Budgeting and fees.** Before HB 1103, the commission's budget was simply developed and submitted as part of the overall DOH budget. The Secretary established licensing fees under the Administrative Procedures Act but without any explicit requirement to consult or otherwise engage with the commission.

  Under the HB 1103 pilot project, the executive director was responsible for preparing the commission's annual budget consistent with appropriated funds. The commission itself proposes its own biennial budget and the DOH Secretary must submit it to the Office of Financial Management. Prior to adopting fees, the Secretary was to collaborate with the commission to determine the appropriate fees necessary to support its activities.

  This was made permanent under HB 1518.

  As the HB 1103 report indicates, this provision has had the most impact to date on improving the performance of the commission, giving it the additional resources needed to make improvements to the licensing and disciplinary process. An increase in licensing fees supported hiring new investigators, nursing consultants, an Advanced Registered Nurse Practitioner Consultant, and disciplinary staff. The commission will continue to use this to clearly and independently identify and

advocate forcefully for the resources it needs to perform at a high level while also considering the impact on fee-paying nurses.

- **DOH rules and guidelines.** Before HB 1103, under the state's Uniform Disciplinary Act the DOH Secretary was required "in consultation with the disciplining authorities" to develop uniform procedural rules regarding the disciplinary process.

  The HB 1103 pilot project imposed a broader and more rigorous obligation on the Secretary, requiring "prior to adopting uniform rules and guidelines, or any other actions that might impact the licensing or disciplinary authority of the commission" the Secretary was to first meet with the commission to determine the impact on the commission's ability to carry out its duties. If the impact was determined to be negative, the commission was to collaborate with the Secretary to develop alternative solutions to mitigate the impact. Any disputes were to be resolved through mediation by an agreed-upon third party.

  This was made permanent under HB 1518.

  Traditionally, the commission reacted more to the process used by the DOH to adopt rules than the substance of the rules themselves. Under the Uniform Disciplinary Act, RCW 18.130.065, the Secretary reviews and coordinates the rules process. The Secretary has a thirty day time period to complete the review and provide comments. This time period is subject to interpretation and has been inefficient. HB 1518 invites this process to change. The commission would also like to explore its application to rules and guidelines adopted before HB 1103. Some of these rules concern the commission and could have a negative impact on the ability to carry out essential duties.

- **Performance expectations.** Before HB 1103, the performance expectations the DOH might have of the commission, and that the commission might have of the DOH, were not addressed in statute.

  HB 1103 directed the commission to negotiate with the Secretary of the DOH to develop performance-based expectations, including the identification of key performance measures. Any disputes were to be resolved through mediation by an agreed-upon third party.

  This language was maintained in HB 1518, which also added the "calculation and reporting of timelines and performance measures" as an item to be included in the operating agreement between the DOH and the commission.

  The commission welcomed the development of performance expectations, which provided a foundation for the evaluation of the pilot project and the HB 1103 report. The intent of the commission is that these expectations remain current and related to the performance measures used in the NCSBN CORE report. The commission looks to implement practices shown to achieve the expectations. The commission also

intends to discuss the role of the DOH in helping the commission achieve its expectations, and to discuss more formally the expectations the commission has of the DOH. The statutory language appears to accommodate these expectations.

- **Interaction with the legislature.** Before HB 1103, state law was silent regarding the substance, manner and degree of any engagement by the commission or its staff with the legislature. In practice the DOH discouraged any direct engagement by the commission, but when it occurred, took responsibility for the content.

  Under HB 1103, commission members were allowed to express their professional opinions to an elected official about the work of the commission even if those opinions differed from the official DOH position. It further directed that such communication must be "to inform the elected official and not to lobby in support or opposition to any initiative to the legislature."

  HB 1518 kept in place the language of HB 1103, but provides that in addition to this existing authority, "the commission, its members, or staff as directed by the commission, may communicate, present information requested, volunteer information, testify before legislative committees, and educate the legislature, as the commission may from time to time see fit."

  The interplay between the language of HB 1518 and existing law under HB 1103 is confusing and perhaps even conflicts, and may eventually need to be clarified. In the meantime, however, the commission assumes it now has much greater latitude outside the shadow of the department to take issues directly to the legislature and discuss with legislators both concerns and successes. The commission feels this is necessary to assure safe and high quality nursing care in this state.

- **Operating agreement.** Among the statutory provisions put in place when the Department of Health was created in 1989 was a requirement that the Secretary and each health professions board enter into written operating agreements on administrative procedures with input from the regulated professions and the public. The agreements are intended to provide a process for the department to consult each board on administrative matters and to ensure that the administration and staff functions effectively enable each board to fulfill its statutory responsibilities.

  This section of law was not addressed in HB 1103.

  HB 1518, in addition to some relatively minor changes to the intent and scope of the operating agreement, provides a formal dispute resolution process; directing that any dispute between a board and the department, including the terms of the operating agreement, must be mediated and determined by a representative of the Office of Financial Management.

  Next to the control given the commission over its staff, the addition of a dispute resolution process in development of the operating agreement may be the most

significant management tool with which the commission now has to work. This formal dispute resolution was not available for the pilot project. While the commission does not expect frequent use, having such a process available changes the dynamic of the negotiation of the agreement, giving the commission more say in the final product.

Rather than defer to the DOH, the commission will initiate drafting the agreement. The commission anticipates the agreement will address more details. One issue the commission will address is the level and use of indirect costs and the accountability of the DOH for what the commission has "purchased" using these fee-generated dollars. The commission will seek to decrease unnecessary oversight which causes time delays and additional costs. The commission also wants to consider provisions regarding enforcement of the agreement and how to best assure adherence to the terms.

In general, prior to HB 1103 and HB 1518, the commission was positioned largely as a resource for the DOH to use in its regulation of the state's nursing profession. As the venue for disciplinary actions and the approval of education programs, the commission's primary role was important, but had relatively little to do with overall program operations or administration. On these issues, the commission had an advisory role, and could make concerns known, but in practice was often left to simply acquiesce to the decisions of the DOH. This has changed with the restructuring done under HB 1103 and HB 1518, with the commission now having the authority and the corresponding obligation to work with the DOH in proactively managing its program and be accountable for their serving their statutory purpose.

The commission intends to move forward assuming the legislature granted this authority with the expectation the commission would use it to its fullest extent. The commission looks forward to helping define the parameters. While the commission will be more assertive than in the past, it's not the intention to be confrontational. Most important will be a productive working relationship with the DOH, and the commission is encouraged by the strong evidence showing the new administration is open to proceeding. While the purpose of the nursing commission is focused solely on the nursing profession, the commission will not be indifferent to the interests of colleagues charged with the oversight of other health professions. The commission shares with them and the DOH a strong commitment to patient safety and protection of the public.

Recommendations

Based on the information gathered and discussions had in the development of this report, the commission recommends:

1. **No additional legislation regarding the commission's structure or authority be passed at this time;** allowing more time to implement, adjust to and assess the impact of the substantial number of recently made statutory changes.

2. **Continuous performance improvements remain a priority for the commission.**

   - The commission should continue to have high expectations, monitor performance and identify opportunities to become more efficient, effective and accountable to the public using tools provided by the NCSBN and other means.

   - The commission should encourage and partner with the NCSBN in developing better and more comprehensive performance measures and evidence-based improvement practices. In particular, the link between specific practices and positive performance outcomes must be more clearly documented.

   - The commission should work with the DOH to implement practices leading to performance improvement using its existing authority, and document instances where the authority is either unclear or insufficient and performance suffers as a result.

3. **By December 31, 2015, the commission report to the legislature and the governor.** At a minimum, the report should address:

   - The commission's work, including work with the NCSBN, to identify promising practices linked through research and evidence to improved performance;

   - The extent to which the commission has been able to implement those promising practices, and otherwise address management and operational concerns, using the authority granted it under HB 1103 and HB 1518;

   - Practices, and management and operational concerns the commission could not address under existing law, and what specific authority it would need in order to do so; and

   - Whether what the commission has learned, the improvements it has implemented, and the changes still needed are unique to its regulation and oversight of the nursing profession, or may have application to other health professions or the state's health professions quality assurance system generally.

   Prior to formally reporting in 2015, the commission would welcome the opportunity to appear at any time before the appropriate legislative committees to discuss performance improvement. This could be done at a work session also including other health profession boards and commissions, in particular those whose authority was modified under HB 1103 or HB 1518.