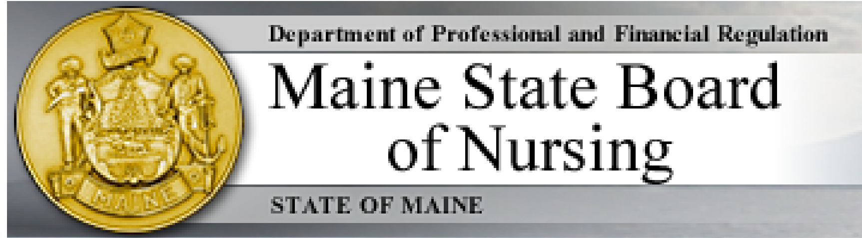

Program Evaluation Report

As Required by the Government Evaluation Act (3 M.R.S. § 955)

Submitted to the

Joint Standing Committee on Health Coverage, Insurance and Financial Services

November 1, 2019

MAINE STATE BOARD OF NURSING

Program Evaluation Report

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MAINE STATE BOARD OF NURSING

Board Overview

The mission of the Maine State Board of Nursing (Board) is to protect and promote the welfare of the people of Maine by ensuring that each person holding a nursing license in the State of Maine is competent to practice safely. The Board fulfills its mission through the regulation of the practice of licensed practical nurses (LPN), registered professional nurses (RN) and advanced practice registered nurses (APRN). In addition, the Board approves programs that prepare nurses to enter into the profession. This mission, derived from the Nurse Practice Act, supersedes the interest of any individual, the nursing profession, or any special interest group.

MISSION STATEMENT

The mission of the Board of nursing is to protect the public health, safety and welfare by regulating the licensure of nurses, the practice of nurses, and nursing education programs.

The Board strives to achieve its mission by:

- Carrying out activities authorized by Maine statutes and rules (licensing, discipline, nursing program approval and rule-making).
- Maintaining current knowledge relevant to the education and practice of nurses.
- Disseminating information to nurses and the public.
- Operating an agency which utilizes human and fiscal resources efficiently and effectively.

History and Organization

In 1915, the first law pertaining to licensure of nurses in Maine was enacted. The State Board of Nursing was originally created as the Board of Examination and Registration of Nurses and received its present name in 1959.

The statute only pertained to registered nurses and was a "permissive" law. Voluntary or permissive laws simply disallowed the use of an occupational title, e.g., R.N., while permitting unlicensed persons to practice nursing. In 1945, "licensed nursing attendants" were included in the statute. This term was replaced in 1955 by "licensed practical nurses."

In 1959, a major revision of the nurse practice act and regulations pertaining to registered nurses and practical nurses were combined in one law. At that time, licensure of registered nurses became mandatory; however, licensure of practical nurses remained permissive. It was not until 1969 that the long-standing goal of mandatory licensure of all who practice nursing became a reality in Maine.

In 1991, the Board of Nursing was affiliated with the Department of Professional and Financial Regulation. In 1995, an advanced practice registered nurse member was added to the Board of Nursing, which changed the composition of the Board as follows: six registered professional nurses, one licensed practical nurse, and two representatives of the public. All members are appointed by the Governor for terms of four years. The Board annually elects from its membership a chairperson and a secretary. Also, the Board appoints and employs an executive director, assistant executive director, and other qualified persons, not members of the Board. A current list of Board members can be found in Attachment A.

Staffing and Composition

Board staff includes an Executive Director, Assistant Executive Director, a field investigator, a professional licensing supervisor/probation compliance officer, a complaint coordinator, and 3 licensing support staff (examination, endorsement, renewal/reactivation/reinstatement). In addition, the Board contracts with the Office of Attorney General for attorney services.

Although the eight members of the office staff are individually responsible and accountable for their specific assigned duties, the operation of the agency reflects the teamwork needed to facilitate efficient and courteous service to the public. Telephone calls and e-mails are numerous and provide an effective vehicle for immediate response to concerns and/or questions posed by the public, nurse employers and licensees. Further, much information regarding the status of licensees, practice questions, and access to the Law Regulating the Practice of Nursing and Rules and Regulations are available on the Board's website.

The Executive Director is responsible for ensuring that programs administered by the agency meet public protection mandates set by the Legislature. The Executive Director is responsible for the management of the office and its staff, implementation of state policies and procedures and for carrying out Board decisions. Weekly staff meetings are utilized to discuss staff schedules, workloads and concerns to promote and maintain a smooth, harmonious operation.

Board decisions are carried out by the Executive Director. State mandates are executed by the Executive Director or delegated to the Assistant Executive Director or the appropriate support staff. The Commissioner of the Department of Professional and Financial Regulation (PFR) is readily available for consultation, counsel and assistance.

Decisions affecting office operations are made by the professional staff with input from support staff. Communications from the Legislature, Governor, Commissioner and State Agencies are transmitted to the office staff by the Executive Director.

As an affiliate of PFR, the Commissioner serves as the liaison between the Board and the Governor. In addition, the Board submits to the Commissioner its budgetary requirements and its annual report. Requests for out-of-state travel must be approved by the Commissioner.
The staff is highly motivated and dedicated to quality regulation and public service. The Board emphasizes continuing professional development, training and education including through the following agencies:

• National Council of State Boards of Nursing (NCSBN)
• Nurse Licensure Compact (NLC)
• Council on Licensure, Enforcement & Regulation (CLEAR)
• National Association of Drug Diversion Investigators (NADDI)
• Commission on Graduates of Foreign Nursing Schools (CGFNS)

Board Funding Source

The Board is funded entirely through dedicated revenue sources, which consist of a combination of licensing (examination, endorsement, advanced practice) and filing fees paid by the regulated nurses.

The Board contributes to the General Fund through periodic transfers of Other Special Revenue funds.

A. Enabling or Authorizing Law

The Board is authorized through the following sections of Maine law:

32 M.R.S. Chapter 31 "Nurses and Nursing" establishes the Board as well as its powers and duties, including:

- **32 M.R.S. § 2151** establishes the Board and terms of appointment;
- **32 M.R.S. § 2152** establishes the Board composition;
- **32 M.R.S. § 2153-A** establishes the duties and powers of the Board.

32 M.R.S. Chapter 31, Subchapter 2-A enacted the Nurse Licensure Compact.

5 M.R.S. § 12004-A defines occupational and professional licensing boards, their primary responsibilities and powers and defines "public member."

10 M.R.S. § 8001-A establishes that the Board is affiliated with the Department of Professional and Financial Regulation

10 M.R.S. § 8003(5) provides the Board with supplemental authority, including:

§ 8003(5)(A-1) to impose a warning, reprimand or censure; a license suspension of up to 90 days per violation; a license revocation; a civil penalty of up to $1500 per violation; and probation with conditions;
§ 8003(5)(B) to enter into a consent agreement with a licensee/applicant;
§ 8003(5)(C) to require applicants to answer questions, require licensees to complete continuing education, deny a license for non-compliance with a consent agreement or Board order, issue "inactive" licenses, and delegate authority to staff to review and approve applications for licensure;
§ 8003(5)(D) to require the surrender of licenses;
§ 8003(5)(E) to issue letters of guidance or concern.

B. Description of Programs

The Maine State Board of Nursing (The "Board") is composed of six registered professional nurses (RN), one licensed practical nurse (LPN) and two public representatives who are appointed by the Governor to serve for a four-year term and who are directed to administer the law in the interest of the public welfare.

To carry out its mandate, the Board employs an executive director, an assistant executive director and 6 support staff.

Board staff is responsible for all regulatory and administrative functions associated with state regulation of practical, registered and advanced practice nurses. The Board's regulatory functions include: licensing; complaint investigation; approval of nursing education programs; and rulemaking. The Board's primary regulatory functions – licensing, complaint investigation and nursing program approval – are implemented with equal priority by Board staff.

Program Goals: To ensure that regulated individuals in the nursing profession that require a license meet the minimum educational standards, provide safe services to the public and conduct themselves in an ethical manner.

Program Objectives: To license practical, registered professional and advanced practice nurses who meet minimum state requirements, approve nursing education programs, regulate licensee conduct through examination and enforcement of standards of practice and conduct, and imposition of discipline, when warranted.

Regulatory functions:

Licensing:

Four full-time staff are responsible for the licensing of practical, registered and advanced practice nurses. Nurses applying for licensure include U.S. educated and foreign educated individuals. To verify identity and education, Board staff use the NCSBN's Nurse System (NURSYS) Verification Service and Fraudulent Identity Tracking System (FITS). NURSYS obtains and confirms original source information from U.S. nursing schools, as well as from the Commission for Graduates of Foreign Nursing Schools (CGFNS), which verifies the identity, education, and training of foreign educated nurses. The Test of English as a Foreign Language (TOEFL) is used to evaluate the English proficiency of internationally educated nurses whose language of textbooks and instruction were not in English. NURSYS also performs a query of the National Practitioner Data Bank ("NPDB") of all applicants for initial licensure. The NPDB maintains a database of nurses who have had malpractice settlements or adverse action taken by a licensing board or health care entity regarding the individual's license, employment or privileges. Applications with negative information are reviewed by the Assistant Executive Director, who may refer review to the full Board.

A. Licensure by Examination

Objective: To ensure that individuals who are licensed as practical (LPN) and registered (RN) nurses have the minimum basic educational preparation necessary to practice safely.

The administration of a national licensure examination which measures safe and effective practice is the primary mechanism for insuring that only qualified candidates enter into nursing practice in Maine. The Board contracts with the NCSBN to use the National Council Licensure Examination (NCLEX®) for registered and practical nurse licensure. The NCSBN, through its Member Boards, provides computerized adaptive testing (CAT) for the licensure examination. Transmission of candidate information and licensure examination results is done via the web.

B. Licensure by Endorsement:

Objective: To assure the public that nurses licensed elsewhere and seeking licensure in Maine meet the same educational requirements as those nurses licensed by examination in this state.

The Board provides the mechanism by which credentials are evaluated of persons educated and licensed in U.S. jurisdictions and territories, Canada or foreign countries. This process, which is called endorsement, involves a review of educational preparation, as well as verification of appropriate testing mechanisms leading to original licensure through the NURSYS database. Public protection is accomplished by ensuring that only nurses with appropriate preparation, licensed through nationally recognized testing, are permitted to practice nursing in this state.

C. Advanced Practice Licensure:

Objective: To ensure that individuals who are licensed as advanced practice registered nurses (APRN) have the minimum basic educational preparation, and certification necessary to practice safely.

The Board licenses advanced practice registered nurses who are clinical nurse specialists, nurse anesthetists, nurse midwives, and nurse practitioners certified by a national nurse certifying organization. Licensure is based on holding an RN license in Maine or a multistate RN license in a compact state. In addition, the Board approves the registration of clinical supervision of APRN candidates who need the required hours of clinical supervision for licensure.

D. APRN Credential Verification:

Objective: To validate credentials for advanced practice nurses (APRN).

The Board has a mechanism to review standards for validation of credentials for nurses in advanced practice. As of January 1, 1996, certified nurse practitioners, nurse anesthetists, clinical nurse specialists, and certified nurse midwives were recognized in statute as advanced practice registered nurses. Further, certified nurse practitioners and certified nurse midwives

have prescriptive authority inherent in their scope of practice, once licensed by the Board. Certified registered nurse anesthetists have limited prescriptive authority upon licensure.

E. Nurse Licensure Compact

Objective: To increases access to care and maintain public protection at the state level by promoting compliance with the laws governing the practice of nursing in each party state through the mutual recognition of party state licenses.

The Nurse Licensure Compact (NLC), implemented in Maine in January 2018, has been an innovative and effective mechanism to address the emerging changes in the delivery of nursing care that have challenged the traditional state-based model of nursing regulation. For nearly 100 years, the state-based model served the citizens of each state well because nurses lived in and were licensed within the borders of the state where they practiced. The Compact was the mechanism selected to facilitate interstate practice and regulation by binding each participating jurisdiction to the terms of the Compact. It makes it unnecessary for a registered profession nurse (RN) and licensed practical nurse (LPN) to seek licensure in every jurisdiction and gives the Board expanded jurisdictional powers to investigate and take action against a Maine license or a compact privilege to practice in Maine when necessary.

- *Issuance of Licenses.* The NLC allows a nurse to have one license (in his or her state of residency) and to practice in other Compact states (remote states) both physically and electronically. Every nurse holding a Compact license is subject to each state's practice laws and regulations. Under the Compact, a nurse may practice across state lines unless otherwise restricted. In order to join the NLC, each state must pass legislation authorizing the Compact. Board staff determine if an applicant for initial licensure is eligible for a multistate license based on uniform licensure requirements.

- *Discipline of Compact Licenses.* The home state and remote state where a violation occurs have jurisdiction to take licensure action. If the home state takes adverse action against a nurse's multistate license, the nurse will not have a multistate privilege until the license is unencumbered. These mechanisms protect the public by monitoring the practice of nurses until the nurse satisfactorily completes the conditions of the disciplinary order.

- *Information Exchange.* The Compact requires the Board to share licensure and disciplinary information through the NURSYS database. The Board staff uploads updates daily.

- *Rules and Regulations.* States entering the Compact also adopt administrative rules and regulations for implementation of the Compact.

- *Administration.* Each Compact state designates a Nurse Licensure Compact Commissioner to facilitate the exchange of information between the states relating to Compact nurse licensure and regulation. On January 19, 2018, the Nurse Licensure Compact Commissioners were organized to protect the public's health and safety by

promoting compliance with the laws governing the practice of nursing in each party state through the mutual recognition of party state licenses. The executive director of the Board is the Compact Administrator for Maine.

Education Program Standards and Approval:

Objective: To ensure that programs of nursing education in the State of Maine that prepare RNs and LPNs for initial entry into nursing practice meet the minimum state and national educational standards.

The educational standards for both the professional (RN) and practical (LPN) nursing programs are based on current nursing practice and patient needs and require national nursing program accreditation. To ensure that the Board's educational standards for nursing programs located in the State of Maine are maintained, the Board conducts survey visits every six years (and more frequently when indicated) to the programs and their affiliated clinical agencies. The Board approves only those programs which meet established criteria. Only graduates of programs approved by the Board or its counterparts in other jurisdictions are eligible for admission to the NCLEX®. In 1983 the standards for both professional and practical nursing faculty were revised to require a higher level of educational preparation. This was the result of a collaborative effort between the Board and representatives from the individual educational programs in nursing throughout the State. In 2019, Chapter 7 of the Board's Rules, the Regulations for Pre-Licensure Nursing Education Programs, was adopted after thorough review and revision by stakeholders and is consistent with current national nursing program accreditation standards.

Currently, Maine has 17 Board-approved educational programs in nursing: 15 to prepare RNs and 2 to prepare LPNs. In addition, the University of Southern Maine, University of Maine, and Husson College, have generic master's degree in nursing programs for individuals who already have a baccalaureate degree in another field. See Attachment B for nursing programs approved by the Board.

Complaint Investigation & Monitoring:

Objective: To balance the need to safeguard the due process rights of licensees who may be the subject of a complaint against the public's right to know about unethical or unsafe conduct of licensees and receive notification of the disposition of complaints.

Three full-time staff (Executive Director, Investigator, Complaint Coordinator), with the advice and counsel of two (2) half-time assistant attorneys general, are responsible for the investigation of complaints filed with or initiated by the Board. The complaint investigative process is based upon the one employed by the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation, and is designed to balance the need to safeguard the due process rights of licensees who may be the subject of a complaint against the public's right to know about unethical or unsafe conduct of licensees and receive notification of the disposition of complaints. Complaints filed by consumers (patients, patients' relatives) and other entities (mandated reports because of employment or privilege termination

from health care entities; other health care providers; other state or federal agencies) are docketed and processed by Board staff. The Executive Director works in coordination with the Board investigator and assistant attorneys general to conduct investigations and report investigative information to the board agenda committee. The complaint coordinator prepares complaint information for presentation to the board. In addition, questions regarding prior disciplinary actions by other jurisdictions are included on all applications for licensure.

A frequently asked question document regarding the Board's complaint and investigative process is available to the Licensee and all persons who file a complaint, together with an acknowledgement of the complaint. FAQs regarding the Board's complaint and investigative process are also available on the Board's website: https://www.maine.gov/boardofnursing/discipline/faq.html. A copy of those FAQs can be found in Attachment C.

Incoming complaints against licensees are reviewed, investigated and once completed are provided to the Board for review and action at one of its scheduled monthly meetings. Complaint reviews occur during public (open) sessions of the Board by de-identifying the licensee and the patient (unless there is a likelihood that the public would somehow discern the identity of the patient or nurse due to the circumstances). When necessary, and pursuant to the advice of the Board's assistant attorneys general, the Board may go into executive session to review a complaint. Under such circumstances, the nurse and their attorneys may be present for the Board's executive session review.

Following review, the Board has the authority to take any of the following actions regarding a complaint:

- Dismiss a complaint;
- Issue a letter of concern;
- Invite the licensee and complainant to attend an informal conference;
- Offer the licensee a consent agreement that resolves the complaint;
- Schedule a complaint for an adjudicatory hearing.

Complaints are dismissed when the Board determines there is no violation of a Board statute or rule. The Board issues letters of concern/guidance to educate or reinforce knowledge. The Board invites a licensee to an informal conference when the Board needs more information to make a decision. Informal conferences are required to be conducted in executive session (unless otherwise requested by the licensee) and both the licensee and complainant and their attorneys may be present. The Board enters into consent agreements with the agreement of the licensee and Office of Attorney General to resolve complaint investigations. Executed consent agreements constitute adverse actions that are reportable to the National Practitioner Data Bank and the NCSBN, which provide reports regarding the adverse action to all jurisdictions where the individual is licensed or seeking licensure. The Board holds adjudicatory hearings when unable to resolve a complaint by consent agreement or other means.

The Board, with the approval of the Attorney General, contracts with a hearing officer to provide it with legal counsel and regulate the course of adjudicatory hearings. The hearing

officer assists the Board by conducting pre-hearing conferences to identify/clarify issues, identify potential witnesses, and review potential exhibits. The hearing officer administers oaths to witnesses, rules on evidentiary objections, and prepares a draft decision and order for the Board to review based upon the findings made by the Board. Decisions issued by the Board are appealable to District or Superior Court. All finalized adverse actions (consent agreements, license surrenders, decisions) are posted on the Board's website. The adverse action is linked to the licensee and may be accessed when using the Board's "Find a licensee in our database" feature:
https://www.pfr.maine.gov/ALMSOnline/ALMSQuery/SearchIndividual.aspx?Board=1310.

During FY 2019 (July 1, 2018 – June 30, 2019) board staff reported activity in 548 docketed cases. During the same time, 371 new complaints were opened, and 366 were closed. Of the cases closed during the period, 87 were resolved through voluntary consent agreements; 91 were dismissed for lack of jurisdiction or lack of evidence of a violation; 12 were resolved by board decision and order; and 179 were resolved with a letter of concern. The balance represents license application denials and shared resolutions.

Compliance Monitoring: Licensee compliance with board orders and voluntary consent agreements is monitored and coordinated by the Probation Compliance Officer to ensure that licensees who are the subject of board discipline comply with limitations and conditions on their practices. Failure of licensees to comply can result in additional discipline.

In FY 2019, the Board entered into the following mutual agreements:

- 47 nurses placed on probation and working using their nursing licenses
- 32 nurses on probation but not working in the nursing field
- 37 of the above 79 nurses are in an active monitoring program

Rulemaking:

Objective: To set standards for licensing, practice, and nursing education programs.

The Board is authorized to set standards for licensing and practice and to adopt rules. The rules adopted by the Board are routine technical rules. During the previous 4 years, the Board has endeavored to enact – whenever possible – joint rules with other licensing boards regarding the same subject area. The Board's rules include:

- Chapter 3 - General Requirements Relating to Licensure
- Chapter 4 - Disciplinary Action and Violations of Law
- Chapter 5 - Regulations Relating to Training Programs and Delegation by Registered Professional Nurses of Selected Nursing Tasks to Certified Nursing Assistants
- Chapter 6 - Regulations Relating to Coordination and Oversight of Patient Care Services by Unlicensed Health Care Assistive Personnel
- Chapter 7 - Regulations for Approval of Prelicensure Nursing Education Programs
- Chapter 8 - Regulations Relating to Advanced Practice Registered Nursing

- Chapter 9 - Advisory Rulings
- Chapter 10 - Administration of Intravenous Therapy by Licensed Nurses
- Chapter 21 - Use of Controlled Substances for Treatment of Pain (joint rule with Board of Licensure in Medicine, Board of Osteopathic Licensure)

The Board's assistant executive director in consultation with the Board's executive director and assistant attorneys general coordinate proposed rule updates for the Board to ensure adherence to rulemaking requirements set forth in the Maine Administrative Procedure Act. Rule updates may be based upon new or emerging issues (e.g. collaborative drug therapy, office-based opioid treatment) or changes to national nursing standards.

The Board is currently undertaking five rulemaking initiatives:

- Chapter 1, Collaborative Drug Therapy Management, joint rule endeavor with the Board of Pharmacy. The purpose of this rule is to establish safe and effective collaborative practice agreements, treatment protocols, and documentation and reporting requirements between a pharmacist and a nurse practitioner.

- Chapter 5, Regulations Relating to Training Programs and Delegation by Registered Professional Nurses of Selected Nursing Tasks to Certified Nursing Assistants. Proposed changes to this chapter include updating regulations relating to training programs and delegation of selected nursing tasks. Specifically, it reduces the number of hours of the Certified Nursing Assistant (CNA) Prescribed Curriculum to coincide with changes in the CNA curriculum, provides for more flexibility with additional CNA skills training quantifies the meaning of the ability to read and write English, and clarifies what recently graduated means in the section for certified nursing assistants from out of state. In addition, it provides the individual with a shorter nurse's aide generalist course and allows for more flexibility for the facility in training the individual with additional skills as needed.

- Chapter 10, Regulations Relating to Administration of Intravenous Therapy by Licensed Nurses. Proposed changes to this chapter include clarifying and updating standards of current practice in intravenous therapy. These changes will reduce the barriers for facilities to utilize licensed practical nurses (LPNs) to provide intravenous therapy by allowing facilities to train licensed practical nurses in intravenous therapy skills specifically related to the needs of the facility. Presently they must wait to utilize out of state and in-state licensed practical nurses until the licensed practical nurses complete the entire certification process (which includes skills that may never be used in the specific facility).

- Chapter 12, Office Based Opioid Treatment (joint rule making endeavor with the Board of Licensure in Medicine and Board of Osteopathic Licensure). This proposed rule would establish minimum standards for providing office based opioid treatment.

- Chapter 21, Use of Controlled Substances for Treatment of Pain (joint rule making endeavor with Board Licensure in Medicine and Board of Osteopathic Licensure, and

Board of Podiatric Medicine). This proposed update would include exemptions for certain categories of patients, including those in hospice care.

Financial Management of Dedicated Revenue:

Objective: To ensure operation of an agency which utilizes human and fiscal resources efficiently and effectively.

The Board's executive director, in coordination with the service center (DAFS), is responsible for the financial management of the Board, including preparation of the biennial budget information based on historical data specific to each program; monitoring incoming dedicated revenue from license fees; analyzing trends in revenue streams and recommending fee adjustments to the Board. Fee adjustments are made through the APA rulemaking process.

Public Accessibility:

Objective: To ensure timely and efficient dissemination of information to nurses and the public.

The Board website is a multi-purpose public information tool that not only allows licensees to serve themselves by submitting initial license applications and renewing their licenses, but it also allows licensees, employers and the public to check the license status of a professional, obtain disciplinary information about a licensee, and download relevant statutes and rules. Public licensing information can be accessed online at www.maine.gov/boardofnursing/licensing/index.html. Recently, the licensing process has been streamlined. An applicant whose application is approved receives an e-mail notification that the license has been activated in the Agency Licensing Management System (ALMS). The licensee may then print the license, thus avoiding any delay traditionally associated with the printing and mailing of a license. In addition, licensees are notified by email 60 days prior to the expiration of their licenses that they are due to renew their licenses, which may be accomplished online. In coordination with InformMe and utilizing data evaluating most frequently accessed information, the Board website was completely redesigned in FY 2017.

The Board recently voted to participate in the Board of Licensure in Medicine's electronic newsletter, which is emailed to all licensees three times a year and posted on its website. This endeavor will allow the Board to provide updates to licensees regarding new laws (mandated reporting, use of PMP, opioid prescribing, etc.); proposed and newly adopted rules; changes to Board membership, leadership or staff; upcoming continuing education courses; licensee notification requirements; nursing issues such as Alzheimer's Disease and Suicide Prevention; and adverse licensing and disciplinary actions. In addition, the endeavor will allow for providing information of mutual concern to both physicians and nurses.

Public Accountability:

Objective: To raise awareness of employees about the proper use of Social Security Numbers and personal information; to prevent the indiscriminate release of such personal information;

and to establish a procedure to assure that public and Freedom of Access Act (FOAA) requests are made and responded to in accordance with the law.

The FOAA (1 M.R.S. §§401-414) ensures that, with limited exceptions, all licensing board meetings are open to the public and that deliberations of boards are a matter of public record. The Board's secretary associate responds to FOAA requests from members of the public and the media. A recently enacted law required the Board to adopt a new protocol for processing requests under the FOAA. A copy of the new protocol can be found in Attachment D.

Program Assessment

Each of the Board's key regulatory functions continues to be needed. Inherent in the practice of professional or practical nursing is the complete faith and trust by the patient in the competency of those who lawfully hold themselves out as nurses. Patients under the care of a nurse are generally vulnerable by virtue of illness or injury and the dependent nature of the nurse-patient relationship. Persons who are especially vulnerable include the elderly, children, the mentally ill, sedated and anesthetized patients, patients whose mental or cognitive ability is compromised, and patients who are disabled and immobilized. The specific public benefit derived from this agency is the assurance that persons who purport to practice nursing are, in fact, qualified to do so. Thus, the citizen population, as well as employers of nurses, can trust that safe and effective care is being rendered. Moreover, it is the reasonable expectation of other health care professionals that their nursing colleagues are qualified to provide competent care.

The Board, in keeping with its mission to protect public health, safety, and welfare, has assured that individuals who are licensed as practical, registered or advanced practice nurses have the minimum professional character and basic educational preparation necessary to practice safely. The Board has accomplished this mission by verifying that those who are licensed are qualified by virtue of their competency and professional character. The Board continually monitors compliance with legal requirements to assure continued competency and has taken action to limit, restrict, or revoke the authority to practice nursing if the licensee has posed a danger to the public. The Board investigates complaints in a timely manner, enforces the laws relating to the practice of nursing, and ensures that individuals who are proven to have violated the Nurse Practice Act or the Board's Rules receive appropriate discipline.

The Board promotes standards of safe nursing practice by interpreting the laws and rules related to nursing practice for nurses, employers, and educators. The Board participates in nursing practice forums with nursing organizations and other state agencies to establish nursing performance guidelines so that employers and consumers can make informed decisions regarding the performance of nursing services. Such collaboration on policy issues and education for nurses, employers and consumers of nursing care enhances patient safety prospectively rather than complete reliance on a complaint-driven system in which actual harm has already occurred.

As the foundation for safe nursing practice, the Board's regulation of nursing education has ensured the establishment and oversight of educational preparation needed for RN and LPN

entry into practice. The Board has accomplished this function through the development and monitoring of standards for pre-licensure programs and the review and approval of new nursing programs/extension sites/campuses. With programs competing for a limited number of qualified faculty and eligible clinical sites necessary for appropriate learning experiences, the Board continues to assess nursing education programs to assure compliance with nursing education standards; provide consultation and guidance to program directors, faculty, and administration; and collects and analyzes educational data useful in long range planning for nursing education. In addition, the Board monitors NCLEX first-time test taker pass rates to ensure programs meet the 80% pass rate standard. A copy of program pass rates are available on the Board's website and are updated on a quarterly basis: https://www.maine.gov/boardofnursing/education/nclex-pass-rates.html. A copy of the 2016-2018 NCLEX pass rates (3-year average) are available in Attachment E.

Since 2014, the Board has approved four (4) new nursing programs, each undergoing a consistent review process to ensure the education program and resources were adequate to produce safe, competent graduates. At the same time, one (1) nursing program closed related to Board action, due to poor performance. The Board conducted site visits to four educational programs in nursing for the purpose of determining compliance with the Board's standards for nursing programs. Surveys are conducted by one or two Board Members and the Executive Director. A written report of the site visit, including the recommendations to the program, is submitted to the Board with a recommendation for approval or non-approval of the program. If continuing approval is granted, the director of the program is sent a signed Certificate of Approval and a copy of the site visit report and recommendations. Since 2015, the Board has approved eight (8) Waivers of Site Visits to programs based on approval of program self-evaluation reports.

As a component in the assurance of Maine nursing education program's adherence to sound educational principles, nursing accreditation is valued by the Board. Fourteen of the professional programs currently hold national nursing accreditation and one is in process of obtaining candidacy. The two LPN programs are also in process of obtaining candidacy for national accreditation.

In 2017, Maine adopted the enhanced Nurse Licensure Compact (NLC) (32 M.R.S., Chapter 31, Subchapter 2-A) which became effective on January 19, 2018. Today, 34 states have joined the compact. The NLC has served to facilitate the states' responsibilities to protect the public's health and safety and to facilitate the exchange of information between party states in the areas of nurse regulation, investigation, and adverse action. Participation in the NLC has served to promote compliance with the laws governing the practice of nursing in each jurisdiction. The NLC provides for safeguards in place to ensure that nurse licensees are providing safe, competent nursing care to the citizens of Maine.

The interstate recognition of a license has increased nurse mobility and facilitated delivery of health care by allowing for innovative communication practices such as telenursing. The nurse practices nursing virtually by interacting with a client at a remote site and electronically receiving data and information regarding the client's health status data; initiating and transmitting therapeutic interventions and regimens; and monitoring and recording the client's response and nursing care outcomes. Additionally, the Compact promotes the public health

and safety by encouraging cooperative efforts among the party states in nurse licensing and regulation. As more state legislatures enact the Nurse Licensure Compact, the nation will move closer to allowing a nurse to have one home state license that confers a privilege to practice nationwide.

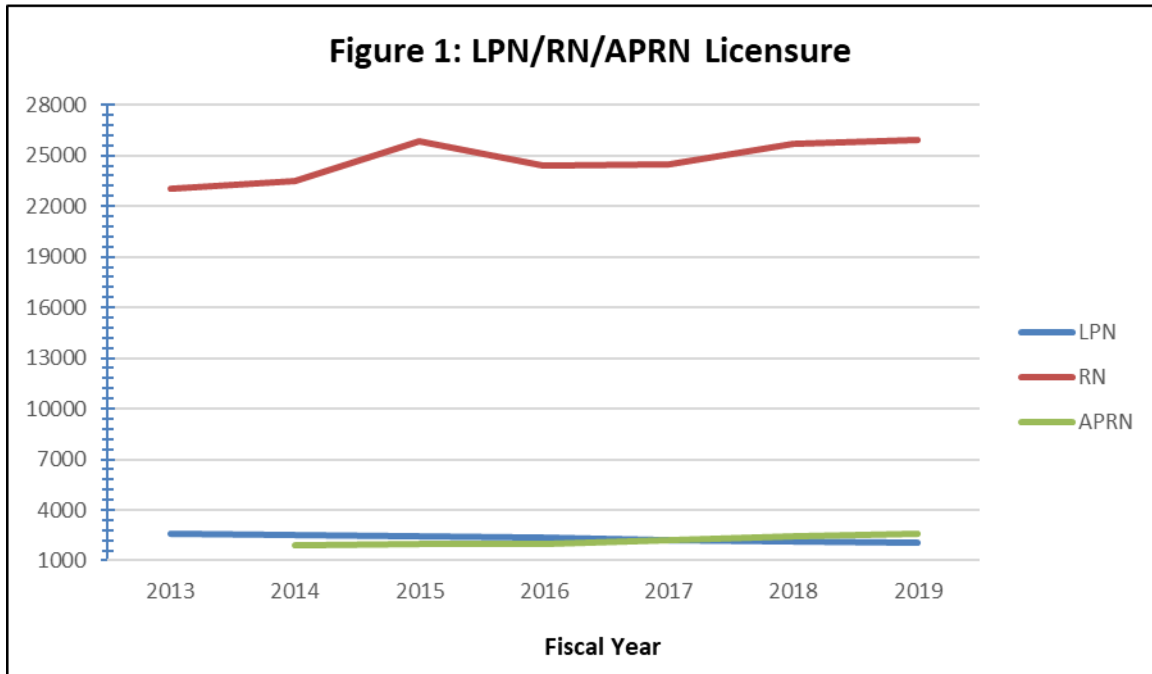
Pursuant to 32 M.R.S. § 2105-A(5), the Board is authorized to establish Protocols for a program for nurses in recovery from substance abuse. Pursuant to 24 M.R.S. § 2502(4-A), the Medical Professionals Health Program (MPHP) developed a program to encourage the identification and rehabilitation of medical professionals, including nurses, impaired by alcohol, substance abuse, ill health, or other debilitating factors. MPHP is the only entity in Maine known to have developed such a program which satisfies the applicable statutory requirements.

The Board of Nursing has a contract with MPHP to assist nurses challenged with substance use, mental health, and behavioral issues. MPHP provides confidential monitoring, support, treatment resources, advocacy, education, and outreach. Information about MPHP is posted on the Board's website and provided to various nursing associations and organizations. The Board strives to inform nurses, hospitals, and other employers that MPHP welcomes those who are voluntarily seeking assistance before licensing is impacted, as well as those who have been referred or mandated by the Board to participate with MPHP in order to maintain or regain licensure.

Evidence of Program Effectiveness

The Board finds it to be a model of an effective and efficient regulatory body. The Board is responsible for licensing, regulating, and monitoring the status of approximately 26,000 licensed registered professional nurses (RNs), 2,000 licensed practical nurses (LPNs) and 2020 advanced practice registered nurses (APRNs). Board approved pre-licensure nursing education programs include 15 nursing education programs for registered nurses and 2 programs for licensed practical nurses. The Board investigates over 400 active complaints on nurses each year and received approximately 22,000 telephone calls in FY 2019 alone. In FY 2019, the Board accomplished this function with approximately 8 full time employees and a budget of approximately 1.1 million dollars. Staff turnover for FY 2019 was 0 percent.

Nurses renew their licenses biennially, and in FY 2019 the Board renewed over 10,852 RNs', 804 LPNs' and 1032 APRNs' licenses. Ninety two percent of the RNs renewed online, while 90% of LPNs renewed online. Almost 850 new RN licenses and 7 new LPN licenses were issued by examination to new graduates. Almost 2,000 new licenses were issued to RNs/LPNs/APRNs through endorsement. The Board has seen a steady increase in the number of new RN and APRN licenses issued (Figure 1).



The Complaint Investigation and Monitoring program has continued to successfully implement strategies designed to address the threat of growing workload and backlog. Beginning in FY 2015, the percentage of investigations more than 36 months old was at 40%. To address this growing backlog without affecting overall disciplinary policies, the Board instituted a Board Agenda Committee to focus on reducing the backlog. The percentage of cases more than 36 months old has dropped to approximately 2 percent from FYS 2015-2019.

Table 1: Age of Open Cases

Months	FY15	FY16	FY17	FY18	FY19
<6	15%	44%	53%	62%	52%
6-11	12%	12%	20%	15%	28%
12-17	9%	14%	10%	14%	12%
18-23	12%	5%	3%	4%	4%
24-35	12%	3%	4%	2%	2%
>36	40%	22%	10%	3%	2%
Total Cases	562	559	651	695	548
Average Days to Close	483	327	249	261	177

During FY 19 (July 1, 2018 – June 30, 2019) board staff reported activity in 548 docketed cases. During the same time, 371 new complaints were opened, and 366 were closed. Of the cases closed during the period, 87 were resolved through voluntary consent agreements; 91 were dismissed for lack of jurisdiction or lack of evidence of a violation; 12 were resolved by board decision and order; and 179 were resolved with a letter of concern. The balance represents license application denials and shared resolutions.

The Nurse Licensure Compact (NLC) has affected nurses, the public, and employers of nurses in the State of Maine. It has permitted greater mobility of practitioners to Maine and therefore, greater access to care for the public. The NLC has allowed expert nursing care to be delivered in rural and underserved areas. This program has permitted employers to hire nurses on a temporary basis, as needed. The NLC has allowed employers in rural areas to arrange expert nursing care by telecommunications to address such issues as mental health therapeutic services, intensive care monitoring of patients, and remote monitoring of patients after discharge from an urban hospital. Employers in Maine have been able to employ nurses with multistate licenses in other Compact states without the need for those nurses to apply for a new license in Maine resulting in expedited priority services that might not have otherwise been available.

Additionally, upon enactment of the NLC, the statutory mandate to obtain FBI fingerprint criminal background checks (CBC) for all applicant's for multi-state licensure was implemented. With the inclusion of required CBC's for applicants for initial licensure, over 4,500 CBCs have been reviewed by the Board since January 19, 2018.

In a 2018 survey of Compact states conducted by NCSBN, 100% of Boards of Nursing indicated there were advantages of being a member of the NLC, 68% indicated there were not any disadvantages of being a member of the NLC, while 32% indicated there were some disadvantages. In the same survey, of nurses who indicated they were aware of the NLC, and indicated they held a Compact license, 52% indicated the Compact license had been beneficial, 28% indicated it had not been beneficial, and 20% had no opinion. Nurse respondents who indicated they were aware of the NLC, and indicated they held a Compact license, were asked if they had practiced in another state/jurisdiction under their Compact license in the past 24 months; 17% indicated they had. Among Maine respondents with a Compact license, 24% indicated that they had spent time communicating with a patient located outside of their state of residence/licensure within the past 24 months. Of employer respondents, 65% indicated there have been advantages of the NLC for their organization, 24% indicated no advantages.

Nursing education programs in the State of Maine are considered in compliance if their approval status does not reflect a Warning or Conditional Approval. Programs are required to develop a Self-Study Report when they have an NCLEX examination pass rate below 80% for the first time to determine factors that may have impacted the pass rate and corrective measures to improve the pass rate. Since 2013, only one approved program was required to submit a Self-Study Report.

The Board is committed to performance measurement and quality improvement and, for several years, has participated in a two-year cycle collection and analysis of data related to nursing regulation through the National Council of State Boards of Nursing Commitment to Ongoing Regulatory Excellence program (CORE). The CORE is a comparative performance measurement and benchmarking process for state boards of nursing. The CORE process incorporates surveys of boards of nursing, as well as three external stakeholder groups including nurses, employers of nurses and nursing educational programs. The Board uses the data to compare performance to other like boards of nursing and determine areas for

improvement. In the most recent CORE report, the Board ranked above average in 25 areas and ranked at the national level in all others. Some examples of above average comparison in the Board's service areas were: effectiveness of the disciplinary process in protecting the public; responsiveness of the Board to changes in practice; time to process licensure and renewal applications; nurse's perceptions regarding the Board's telephone system; and innovation in on-line services.

C. Organizational Structure

The Board is affiliated with the Department of Professional and Financial Regulation and is composed of 9 members appointed by the Governor. The Board leadership consists of a Chair and a Secretary, each of whom are elected by the Board annually.

The Board employs 8 full-time staff, including an executive director who is responsible for administering the program. The Board staff is organized into two major sections: licensing and complaint investigations. An organizational chart can be found in Attachment F.

D. Repealed, P.L. 2013 c. 307

E. Financial Summary

The Maine State Board of Nursing's financial summary is found in Attachment G.

F. Repealed, P.L. 2013 c. 307

G. Areas of Coordination with Other State and Federal Agencies

The State Board of Nursing maintains close working relationships with many state and federal agencies, sharing overlapping authority and/or enforcement responsibility.

Office of the Governor and Department of the Secretary of State
The Board shares a common database with the Governor's Office and the Secretary of State's (SOS) Office containing board member information. The Board coordinates with the SOS regarding all rulemaking initiatives.

The Board coordinates with State Archives and complies with state retention policies and destroys records accordingly. Further, all documents discarded by Board staff are shredded.

Department of Professional and Financial Regulation
The Board is affiliated with the Department of Professional and Financial Regulation (PFR), and works closely with the Commissioner regarding financial issues, leadership development training, and joint rulemaking with Boards within PFR.

The Office of the Attorney General

The Attorney General's Office provides legal counsel to the Board and Board staff through mutual agreement.

Maine Department of Labor

Board staff works collaboratively with the Department of Labor to ensure that military personnel and veterans who seek a professional license receive credit for their military training and experience. In 2017, the 128th Legislature passed a H.P. 921 - L.D. 1327 allowing veterans with nursing service in the medical corps of any branch of the armed forces of the United States to be evaluated for eligibility to sit for the NCLEX-PN exam based on experience. Board staff collaborates at statewide job and career fairs to assist military veterans in obtaining state licenses by documenting valuable military training and experience.

Department of Education

The Board coordinates efforts with the Department of Education, through the educational consultant for health occupations, in matters pertaining to the administration of Certified Nursing Assistant programs.

Department of Health and Human Services

The Board obtains information from or exchanges information with various agencies within the Maine Department of Health and Human Services, including the Maine CDC, Medical Marijuana Program, Prescription Monitoring Program, and the Division of Licensing & Regulatory Services, Medical Facilities Unit. In accordance with 19-A M.R.S. §2201, the Board has revoked nursing licenses when required to do so for failure to pay support obligations. The Commissioner of DHHS notifies the Board in writing when such action is necessary.

The Board has worked closely with the Certified Nurse Assistant (CNA) Registry to update the CNA and Certified Nurse Medication assistant (CNM) curriculum.

Department of Public Safety and U.S. Department of Justice

Board staff coordinates with the Office and the State Bureau of Identification (SBI) within the Department of Public Safety and the U.S. Department of Justice as it relates to the identification and background checks of applicants for initial licensure and multistate licensure.

Maine Board of Licensure in Medicine, Board of Osteopathic Licensure, Board of Pharmacy and Board of Podiatry

The Board works closely with these four boards on matters of common interest, including proposing and adopting joint rules regarding prescribing of controlled drugs. In addition, the boards regularly refer complaints and/or investigative information to one another when indicated.

Maine Health Data Organization

The Board works closely with the Maine Health Data Organization (MHDO), creating "minimum data set" questions for nurses on applications for licensure and renewal, and sharing that data with MHDO and other organizations concerned with identifying the number, specialty, location, and practice of nurses in Maine.

U.S. Drug Enforcement Administration

The Board shares/exchanges investigatory information and adverse actions with the United States Department of Justice and Drug Enforcement Administration.

The United States Veterans Administration

The Board shares/exchanges information with the United States Veterans Administration regarding ongoing and completed complaint investigations involving Maine-licensed nurses working at VA hospitals.

Other State Nursing Licensing Boards/Commissions

The Board is a member of the National Council of State Boards of Nursing ("NCSBN"), a nonprofit organization that supports nursing licensing boards in the United States and its territories. The Board regularly coordinates with nursing licensing boards of other jurisdictions where a licensee under investigation may also have a license to practice nursing.

H. Constituencies

The Board serves the public at large, including more than 30,000 licensees, as well as applicants for licensure and patients seeking information about the Board's complaint process. Additionally, the Board works with a number of professional associations at the state and national level, including:

- National Council of State Boards of Nursing
- Commission for Graduates of Foreign Nursing Schools
- NCSBN Credentials Verification Service
- Nurse Licensure Compact Commission
- International Association of Nurse Regulatory Agencies
- American Nurses Association – Maine Chapter
- Maine State Nurses Association
- Maine Nurse Practitioners Association
- Maine Association of Nurse Anesthetists
- Maine Association of Certified Nurse-Midwives
- Organization of Maine Nurse Leaders (OMNE)
- Maine Nursing Education Collaborative (MeNEC)
- Medical Professionals Health Program

I. Alternative Delivery Systems

The Board has actively pursued alternative delivery systems to carry out its mission. As the Board comes to rely more heavily on information technology, the Board will continue to move in the direction of paperless systems. In coordination with InforME and the National Council of State Boards of Nursing, the Board has made use of information technology to assist the public and Board staff. In the past eight years, this cooperative effort has resulted in the addition of online initial licensing, online license renewal services, many downloadable forms, online licensee search features, and elimination of issuing paper licenses. This has saved Board staff resources, postage, and paper, and has increased customer satisfaction.

By January 2020, the Board will require by policy that all applications for licensure be accessed via the website and that staff will use online methods to process, approve and store agency documents. This will eliminate the need for handling volumes of paper applications and preparing them for electronic storage. Moving those saved resources to other areas has allowed the Board to decrease the number of days to issue a license.

The Board is in the process of developing a process to receive consumer complaints electronically through its online presence. The Board's website provides access to the Nurse Practice Act and the rules adopted by the Board. It also offers extensive information and resources to the Board's constituencies. Additionally, the Board posts its enforcement actions on its website.

<u>NURSYS</u>: The Board is an active participant in the NCSBN's National Licensing and Disciplinary Data Bank (NURSYS). This information is updated daily by NCSBN and is available to member boards at any time. Verification of Maine licensure became possible through NURSYS on July 29, 2002.

<u>National Practitioner Data Bank (NPDB):</u> The NPDB is a repository for information regarding adverse actions taken against health care professionals, including nurses. The Board is required by federal law to report adverse actions it takes with regard to nurses to the NPDB. Like many other state nursing boards, the Board has appointed NCSBN to be its agent in reporting all adverse actions to the NPDB. The basis for this decision was that the information was already being reported to NCSBN who serves as the agent for numerous other states in forwarding the data to the federal level.

J. Emerging Issues

There are several emerging issues that may affect the Board and its constituencies:

<u>Unlicensed Assistive Personnel</u>

In 1995 the legislature adopted the following language into law to address the role of the registered professional nurse (RN) working with unlicensed assistive personnel (other than the certified nursing assistants):

32 M.R.S. §2102(2)(H): Coordination and oversight of patient care services provided by unlicensed health care assistive personnel. Nothing in this paragraph prohibits a nurse in the exercise of professional judgment from refusing to provide such coordination and oversight in any care setting. The board shall adopt, pursuant to Title 5, chapter 375, subchapter II-A, major substantive rules for the application of this paragraph to nursing practice. [1995, c. 670, Pt. C, §6 (NEW); 1995, c. 670, Pt. D, §5 (AFF).]

It was evident then to many stakeholders that the use of unlicensed assistive personnel was expanding and there was a need to ensure the registered professional nurse maintained a nursing presence in the coordination of these workers. This statutory change and the rule adopted to address this change, Chapter 6 Coordination and Oversight of Unlicensed Assistive Personnel, created a two-tier level of responsibility for the RN: direct responsibility under delegation for the certified nursing assistant; and indirect responsibility under coordination and oversight for all other unlicensed assistive personnel. The untoward effect of this was the placement of the responsibility of unlicensed assistive personnel with a non-nursing entity. The registered professional nurse could refuse to coordinate and oversee the care provided by unlicensed assistive personnel, but the registered professional nurse did not have the authority to prohibit the provision of services by the unlicensed assistive personnel.

Challenges

The use of unlicensed assistive personnel was in its infancy in 1995. As Bill Gates has stated, "We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten." This statutory change is now twenty-four years old. We are facing a healthcare shortage unlike anything we have seen before. The use of unlicensed assistive personnel has increased dramatically to fill gaps in the provision of healthcare and statutory changes have occurred, and will continue to occur, in response to the increasing demand for health care workers.

Because of the shortage of healthcare providers, healthcare is becoming creative and transformative. Delivery of care models will change and the utilization of licensed health care professionals, because of the lack thereof, will force the use of their skills in an efficient and effective manner directing a pool of licensed and unlicensed providers.

Possible Solutions

From a regulatory perspective, the Board like other licensing Boards will be tasked to address legislative changes involving licensed and unlicensed practice and the role of the registered professional nurse. One proactive approach to change would be to ensure that the registered professional nurse will have the authority to practice at the helm of changes in nursing healthcare delivery models based on his/her substantial specialized judgement and skill and the application of the principles of biological, physical, and social sciences as acquired in a professional nursing program. The registered nurse assesses and delegates nursing tasks to ensure patient safety.

Registered professional nurses (RNs) should have the authority to delegate appropriate

nursing tasks to all unlicensed assistive personnel, thus having the direct responsibility to manage a team no matter what that would look like in the future. The time is right to reduce confusion in a time when change is fluid. Unlike coordination and oversight, delegation is well defined in the National Guidelines for Nursing Delegation jointly adopted by the National Council of State Boards of Nursing and the American Nurses Association. These guidelines became effective on April 29, 2019 and can be accessed at https://www.ncsbn.org/1625.htm. A copy of the guidelines can be found in Attachment H.

Adjudicatory Hearing Process

The Board conducts adjudicatory hearings pursuant to the Maine Administrative Procedure Act.

Challenges

The current process for conducting adjudicatory hearings merits review and consideration of statutory changes for the following reasons:

1. The nurse members of the Board are in active nursing practice with full-time positions providing nursing care. The Board meets quarterly for 2 full days, and then on additional dates (typically, once a month) when necessary to conduct adjudicatory hearings. Scheduling additional hearing dates for members in active nursing practice and with patients who depend upon them presents a significant challenge. At times, it results in a choice to juggle their schedule, take unpaid time off, or not attend the adjudicatory hearing. Adjudicatory hearings with complex issues, expert witnesses, and pages of exhibits may take several days to complete. Given the Board members' schedules, this may result in a hearing that is scheduled over several months, especially as the law requires 5 members (a majority) to hold an adjudicatory hearing.

2. The Board both investigates and adjudicates complaints filed against nurses. While permitted under existing law, this dual role increases the risk of licensees and their attorneys raising allegations of bias and prejudgment in any subsequent adjudicatory hearing.

3. The Board is represented by two (2) half-time assistant attorneys general who both provide it with legal advice and counsel and prosecute cases in front of the Board during adjudicatory hearings. While permitted under existing law and the unique power of the Office of Attorney General, this dual role increases the risk of licensees and their attorneys raising allegations of bias by the Board in favor of its assigned assistant attorneys general. It is not unusual for an assigned assistant attorney general to provide legal advice and counsel to the Board and then prosecute a case in front of the Board in the same meeting.

Possible Solutions

The following proposed changes are designed to address concerns regarding scheduling and timely completion of adjudicatory hearings as well as allegations of bias and prejudgment and claims of undue influence of the assistant attorneys general.

1. Change the Board's statute to create standing committees with separate authority to investigate and adjudicate. Each committee would have separate and distinct functions with independent authority to take final action. For example, an investigative committee would have authority to investigate complaints, dismiss complaints without merit, offer a consent agreement to resolve a complaint, and refer a complaint to a hearing committee. The hearing committee would have the authority to adjudicate a complaint, including issuing a decision or approving a consent agreement.

2. Change the Board's statute to permit an independent hearing officer to conduct the adjudicatory hearing and prepare a written recommended decision and order for the Board, together with a record of the hearing (transcripts, exhibits, etc.). A number of State agencies already employ this model.

Advanced Practice Registered Nurse (APRN) Scope of Practice:

Challenges

1. Increasing Portability of APRNs (The APRN Compact)

If regulatory requirements differ from state to state, each state border represents an obstacle to portability—potentially preventing access to professionals and access to care. The National Council of State Boards of Nursing (NCSBN) adopted the Consensus Model for APRN scope of practice in 2008. The Consensus Model provides guidance for states to adopt uniformity in the regulation of APRN roles.

Maine has not adopted the full consensus model. Over the years, as statutory language changed, Maine has adopted some elements of the consensus model (bolded below). The last two elements have not been granted to all four categories of advanced practice registered nurses. Certified Nurse Midwives and Certified Clinical Nurse Specialists have independent practice. Nurse Practitioners have independent practice after two years of clinical supervision in a specific specialty area (i.e. family practice). Maine's failure to adopt the full consensus model eliminates its ability to participate in the APRN Compact (as it does in the Multistate LPN/RN Compact), which would facilitate the licensure of APRNs in Maine, could attract more APRNs to Maine, and thereby increase access to care.

On May 4, 2015, the NCSBN member boards approved the APRN Compact, which allows an advanced practice registered nurse to hold one multistate license with a privilege to practice in other Compact states. The APRN Compact will be implemented

when 10 states have enacted the legislation. Maine is not eligible to join this compact without the implementation of the full Consensus Model. Elements of the Consensus Model include:

- **State recognition of each of the four described roles**
- **Title of APRN in one of the four described roles**
- **Licensure as an RN and as an APRN in one of the four described roles**
- **Graduate or post graduate education from an accredited program**
- **Certification at advanced level from an accredited program that is maintained**
- Independent practice
- Independent prescribing

2. Eliminating Barriers to Care by CRNAs

   a. Opt-Out of Facility Reimbursement Requirement

   Certified Registered Nurse Anesthetists were granted limited independent practice in rural hospitals pursuant to LD116, SP187 *An Act Regarding Anesthesia Care in Rural Maine*, effective September 12, 2017. Unfortunately, a barrier exists to the implementation of this law, which would provide needed services in underserved areas. That barrier includes the fact that Maine has not opted out of the facility reimbursement requirement for Medicare and Medicaid Services (CMS).

   In 2001, the Centers for Medicare & Medicaid Services (CMS) changed the federal physician supervision rule for nurse anesthetists to allow state governors to opt out of this facility reimbursement requirement (which applies to hospitals and ambulatory surgical centers) by meeting three criteria:

   1. Consult the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state;
   2. Determine that opting out is consistent with state law; and
   3. Determine that opting out is in the best interests of the state's citizens.

   To date, 17 states have opted out of the federal physician supervision requirement, thus allowing CRNAs to provide vitally needed services in underserved areas.

   b. Limited Prescriptive Authority

   Some Advanced Practice Registered Nurses have full prescriptive authority. Certified nurse practitioners and certified nurse midwives have independent prescriptive authority for schedules II-V. In contrast, Certified Registered Nurse Anesthetists have only limited prescription authority as provided by *An Act Regarding Anesthesia Care in Rural Maine*, effective September 12, 2017.

Examples of how the inconsistencies have affected the work force in Maine are as follows:

1. Psychiatric and Mental Health Clinical Nurse Specialists prescribing in Massachusetts cannot relocate to Maine and continue to prescribe;
2. Certified Registered Nurse Anesthetists that practice independently and prescribe in New Hampshire in pain clinics cannot extend this service in Maine;
3. Certified Nurse Practitioners practicing independently in other states for years and apply for licensure by endorsement to Maine must provide proof they have been supervised for two years or register a supervising relationship. As a result, some nurse practitioners opt not to continue the endorsement process.

Possible Solutions

1. Adopt the full Consensus Model
2. Opt out of the physician supervision requirement for Certified Nurse Anesthetists

K. Information Specifically Requested by Committee

None requested.

L. Comparison of Related Federal Laws and Regulations

Not applicable

M. Collecting, Managing and Using Personal Information

The Board collects personal information in a variety of ways as part of its function in licensing applicants for licensure and investigating complaints. “Personal information" includes but is not limited to addresses, telephone numbers, dates of birth, Social Security numbers, and medical information. The Board staff is aware of the confidentiality of this information and its proper use in fulfilling its operations. Confidential personal information regarding licensees is not posted on the Board’s website. Licensees have the option of providing a work or other contact address and telephone number for posting online. Board staff do not disclose or release Social Security numbers to the public.

The Board staff interacts with other State and federal agencies who may be authorized to have access to personal information. Board staff consult with their assistant attorneys general regarding any questions about releasing or sharing this information. All requests for information under the Maine Freedom of Access Act (FOAA) are reviewed by the Board’s executive director in consultation with the Board’s assistant attorneys general. The secretary associate assembles the requested information, and reviews and redacts/removes confidential personal information from the information including:

- Social Security numbers
- DEA registration numbers
- Dates of birth
- Medical information

- Birth, marriage, divorce documents
- Signatures

The Legislature recently amended the Board's statute to require, with some limited exceptions, notification to any licensee regarding a request for her/his information from the Board pursuant to FOAA. As a result, the Board has amended its protocol for implementing the new law. A copy of that protocol can be found at Attachment D.

The Board's amended protocol is intended to raise awareness among employees about the proper use of Social Security Numbers and personal information; to prevent the indiscriminate release of such personal information; and to establish a procedure to assure that public and FOAA requests are made and responded to in accordance with the law.

N. List of Reports, Applications and Other Paperwork

The Board provides an annual report to the Legislature. Previous annual reports are available at https://www.maine.gov/budget/maine-state-government-annual-report

The Board maintains several applications and forms that are available online for use by its constituents, including:

- Application for Examination and License as a Registered Professional Nurse
- Application for Examination and License as a Licensed Practical Nurse
- Verification of Registered Nurse License
- Verification of Licensed Practical Nurse License
- Application for License as a Registered Professional Nurse by Endorsement
- Application for License as a Registered Professional Nurse by Endorsement (Canada)
- Application for License as a Registered Professional Nurse by Endorsement (Foreign Other Than Canada)
- Application for License as a Licensed Practical Nurse by Endorsement
- Application for Licensed Practical Nurse by Endorsement (Canada)
- Application for Licensed Practical Nurse by Endorsement (Foreign Other Than Canada)
- Application for License as a Certified Nurse Practitioner
- Application for License as a Certified Registered Nurse Anesthetist

- Application for License as a Certified Clinical Nurse Specialist
- Application for License as a Certified Nurse-Midwife
- Application for Renewal as a Registered Professional Nurse
- Application for Renewal as a Licensed Practical Nurse
- Application for Renewal as an Advanced Practice Registered Nurse
- Application for Reinstatement as a Registered Professional Nurse
- Application for Reinstatement as a Licensed Practical Nurse
- Application for Reinstatement as an Advanced Practice Registered Nurse
- Application for Reactivation as a Registered Professional Nurse
- Application for Reactivation as a Licensed Practical Nurse
- Application for Reactivation as an Advanced Practice Registered Nurse
- Application to Add a Specialty to an Existing Nurse Practitioner or Clinical Nurse Specialist License

The forms are available on the Board's website: https://www.maine.gov/board of nursing/.

Applicants and licensees are urged to use the efficient online services available for initial licensing, license renewal, and change of address, phone and email addresses. Licenses may be renewed electronically 24 hours a day, 7 days a week, up to 60 days prior to the license expiration date. A list of licensee figures is found in Attachment I.

O. List of Reports Required by the Legislature

None required.

P. List of Organizational Units and Programs

See Attachment F for the Organizational Chart.

Q. Statutory Provisions Requiring Legislative Review

There are a number of statutes affecting the Board and its processes that merit Legislative review:

1. **10 M.R.S. § 8003(5)** grants the Board the authority to revoke a license but requires any Board revocation to be reviewed in the District Court after a hearing *de novo*. This means that a licensee is afforded two separate evidentiary hearings before his/her license could be revoked. This results in an unnecessary duplication of time, effort and expense. The Board rarely revokes a license, and when it does so the circumstances underlying such revocation are exceptionally grievous. Judicial review of any action by the Board other than license revocation, including the denial of licensure and suspension, occurs in the Superior Court and based upon the record of the proceedings before the Board. The Board recommends that this section of Title 10 be amended to reflect the same standard of review for revocation actions by licensing boards within the Department of Professional and Financial Regulation – Superior Court based upon the agency record. A draft amendment can be found in Attachment J.

2. **24 M.R.S. § 2502** defines "Board" as the Board of Licensure in Medicine, the Board of Dental Practice or the Board of Osteopathic Licensure. The term "Board" should include the State Board of Nursing to ensure that all provisions of the Maine Health Security Act, 24 M.R.S. Chapter 21, appropriately apply to the Board and nurses. A draft amendment can be found in Attachment K.

3. **24 M.R.S. § 2505** mandates that physicians and physician assistants report to the Board of Licensure in Medicine any physician or physician assistant where there is "reasonable knowledge of acts of the physician or physician assistant amounting to gross or repeated medical malpractice, misuse of alcohol, drugs or other substances that may result in the physician's or the physician assistant's performing services in a manner that endangers the health or safety of patients, professional incompetence, unprofessional conduct or sexual misconduct identified by board rule." Physicians and physician assistants who make mandated reports under this law are afforded immunity from civil suit pursuant to 24 M.R.S. § 2511.

   The statute *permits but does not mandate* that other health care providers such as nurses, pharmacists, physical therapists, social workers, psychologists, professional counselors make such a report to the appropriate board. As a result, these other health care professionals are not afforded the immunity under 24 M.R.S. § 2511 for making a permissive report. Amending the statute to mandate reporting by these other health care professionals serves the dual purpose of encouraging reports to the Board and providing immunity from civil suit for so doing. A draft amendment can be found at Attachment L.

4. **24 M.R.S. § 2506** mandates that a healthcare provider or entity provide specific information to the Maine State Board of Nursing (Board) within 60 days of certain events. However, it does not require the healthcare provider or entity to provide all the relevant information associated with that event until requested by the Board. Thus, the statute requires that the Board formally request all relevant information, an unnecessary additional step that delays the Board's investigation as it always requests the additional relevant information. A draft amendment eliminating this extra and unnecessary step can be found at Attachment M.

5. **24 M.R.S. § 2510** currently provides for confidentiality and exceptions to confidentiality of information provided to the Board ("Board" as defined in § 2502) pursuant to 24 M.R.S. §§ 2505 & 2506. It also eliminates the claim of "physician-patient" privilege in complaints filed with those Boards. However, under Maine law the "physician-patient" privilege has been expanded to "health care professional" which includes licensed physicians, licensed physician assistants, and licensed nurse practitioners. (See Rule 503 of the Maine Rules of Evidence). Therefore, this section should be amended to reflect current Maine law and the term "Board" should include the State Board of Nursing. A draft amendment can be found in Attachment N.

6. **32 M.R.S. § 2105-A(1)** identifies the Board's authority to investigate and take action regarding complaints. The Board believes that the statute should be amended to allow the Board to establish separate standing committees for complaint investigation and adjudicatory hearings. Such an amendment would address the following issues identified above in "Emerging Issues":

    - The nurse members of the Board are in active clinical practice with full-time positions providing nursing care. The Board meets quarterly for 2 full days, and then on additional dates (typically, once a month) when necessary to conduct adjudicatory hearings. Scheduling additional hearing dates for members in active nursing practice and with patients who depend upon them presents a significant challenge. At times, it results in a choice to juggle their schedule, take unpaid time off, or not attend the adjudicatory hearing. Adjudicatory hearings with complex issues, expert witnesses, and pages of exhibits may take several days to complete. Given the Board members' schedules, this may result in a hearing that is scheduled over several months, especially as the law requires 5 members (a majority) to hold an adjudicatory hearing.

    - The Board both investigates and adjudicates complaints filed against nurses. While permitted under existing law, this dual role increases the risk of licensees and their attorneys raising allegations of bias and prejudgment in any subsequent adjudicatory hearing.

    - The Board is represented by two (2) half-time assistant attorneys general who both provide it with legal advice and counsel and prosecute cases in front of the Board during adjudicatory hearings. While permitted under existing law and the unique power of the Office of Attorney General, this dual role increases the risk of licensees and their attorneys raising allegations of bias by the Board in favor of its assigned assistant attorneys general. It is not unusual for an assigned assistant attorney general to provide legal advice and counsel to the Board and then prosecute a case in front of the Board in the same meeting.

    A draft amendment updating this section of the Board's statute can be found at Attachment O.

7. **32 M.R.S. Chapter 31** Nurses and Nursing. The Board is committed to submitting statutory changes for review to the 130th Legislature. While the statute has undergone amendments over the years it has not been comprehensively reviewed since 1959.

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Attachment A – Current Board Members

Name	City	Position/Seat	Expiration Date
Valerie J. Fuller, Chair, D.N.P	Falmouth	APRN Member	January 30, 2023
Shannon Gauvin, DHA, MSN, RN	Livermore	Education	August 17, 2021
Kathleen McManus, RN, MSN, CNE	Hebron	Education	April 14, 2019
Ashley Dudley, RN	Warren	Long-Term Care	November 16, 2022
Debra Stetson, LPN	Saco	LPN Member	July 29, 2021
Gail Dudley, RN	Belfast	Nursing Service	January 30, 2019
Peggy L. Soneson, RN	Orrington	Nursing Service	February 13, 2020
Harvey A. Chesley, Jr.	Clinton	Public Member	November 15, 2022
VACANT		Public Member	TBD

Attachment B –Board Approved Nursing Education Programs

Associate Degree

Beal College
Dr. Colleen Koob
Director of Nursing
99 Farm Road
Bangor, ME 04401

Central Maine Community College
Kathleen McManus, RN, MSN, CNE
Chair, Nursing Programs
1250 Turner Street
Auburn, ME 04210

Eastern Maine Community College
Pilar S. Burmeister, MSN, FNP, RN
Dept. Chair, Nursing Programs
354 Hogan Road
Bangor, ME 04401

Kennebec Valley Community College
Marcia Parker, BSN, MS, RN
Interim Nursing Department Chairperson
92 Western Avenue
Fairfield, ME 04937-1367

Maine College of Health Professions (formerly CMMC)
Dr. Lynne Gotjen
Director, College of Nursing
70 Middle Street
Lewiston, ME 04240

Northern Maine Community College
Angela R. Buck, RN, MSN, FNP-C
Department Chair and Simulation Director
Nursing & Allied Health Department
33 Edgemont Drive
Presque Isle, ME 04768

Southern Maine Community College
Michael Nozdrovicky, NP, RN, NEA-BC
Chair, Nursing Programs
2 Fort Road
So. Portland, ME 04106

Baccalaureate Degree

Husson University
Valerie C. Sauda, PhD, MSN, RN-BC, MGSF
Interim Chief Nurse Administrator, School of Nursing
College of Health and Education
1 College Circle
Bangor, ME 04401-2999

Purdue University Global
Jonathan McCarthy, MSN, MBA, RN
Assistant Academic Chair, Maine
Tonia Holian, MSN, BA
Academic Department Chair, Prelicensure Programs
14 Marketplace Drive
Augusta, ME 04330

St. Joseph's College
Anthony McGuire, PhD, CCRN, ACNP-BC, ACNPC, FAHA
Chair, Nursing Department
Department of Nursing
278 Whites Bridge Road
Standish, ME 04084-5263

University of Maine
Kelley Strout, Ph.D., RN
Interim Director, Assistant Professor
210 Dunn Hall
Orono, ME 04469-5724

University of Maine at Augusta
Terry Colby, RN, MSN
Academic Coordinator, Nursing
Lynne King, DNS, RN
Director of Nursing Education
46 University Drive
Augusta, ME 04330-9410

University of Maine at Fort Kent
Erin Soucy, PhD, RN
Director, Division of Nursing
23 University Drive
Fort Kent, ME 04743-1292

University of New England
Jennifer Morton, DNP, MPH, MSN, APRN

Chair, Dept. of Nursing
716 Stevens Avenue
Portland, ME 04103

University of Southern Maine
Brenda Petersen, PhD, MSN, RN, APRN-BC, CPNP-PC
Director, School of Nursing
College of Science, Technology and Health
96 Falmouth Street
P.O. Box 9300
Portland, ME 04104-9300

Licensed Practical Nursing Programs

Maine College of Health Professions
Dr. Lynne Gotjen
Dean of Nursing
70 Middle Street
Lewiston, ME 04240

Leanne Moreira, MSN, RN
Director, LPN Certificate Program
70 Middle Street
Lewiston, ME 04240

Northern Maine Community College
Angela R. Buck, RN, MSN, FNP-C
Department Chair and Simulation Director
Nursing & Allied Health Department
33 Edgemont Drive
Presque Isle, ME 04768

Attachment C: Complaint FAQs

Complaint FAQs

How do I file a complaint against a Nurse?

Please visit the How to File a Complaint page.

Why should I file a complaint against a licensee?

The Board is composed of both nurses and public representatives appointed by the governor. They have a commitment to protecting the health, welfare, and safety of the public by licensing nurses and investigating concerns raised by both the public and other credentialing/licensing agencies. The Board has taken many actions against licensees including both non-disciplinary and disciplinary actions. For a list of disciplinary actions see our adverse actions page (Link to Adverse Actions).

What are the possible results of a complaint?

A complaint may be closed with no action, closed with a Letter of Concern (non-disciplinary), or the Board may order disciplinary action.

What are some examples of disciplinary action?

- Warning
- Censure
- Reprimand
- Civil Penalty
- Education
- Specific conditions of probation
- Suspension
- Loss of License

What are some grounds for disciplining a nurse?

- Alcohol/Substance Abuse
- Conviction of a Crime
- Fraud & deceit in obtaining a license
- Inappropriate Prescribing
- Incompetence or Unprofessional Conduct
- Violation of Law, Rule, or Board Order

Can the Board provide me with monetary assistance?

No. The Board may discipline a licensee for violating its statutes or rules, but it cannot provide money nor order a licensee to pay money to a complainant to pay for any harm that was done.

Does the Board handle Medical Malpractice claims?

No. Boards may discipline a licensee for incompetence but cannot provide money to the complainant to pay for any harm that was done.

Does the Board help with billing disputes?

The Board may discipline a licensee if their billing involves an element of fraud or deceit. However, the Board cannot order reimbursement of monies.

What is the purpose of an in informal conference?

Informal Conferences are held during the complaint process when the Board has questions it feels can best be answered by speaking directly with both the licensee and the complainant. It allows the Board to gather facts not readily available during a paper review. The information gathered is then used to decide how a complaint should be further processed.

What is the purpose of an adjudicatory hearing?

A complaint results in an Adjudicatory Hearing when the Board, following review of all available information, determines that there may be cause for discipline. An Adjudicatory Hearing is a public hearing (some portions may be closed to protect health care information) held and conducted according to the Maine Administrative Procedure Act. If the Board finds the licensee did not commit any violations, the case will be dismissed or resolved with a Letter of Concern. If the Board finds the licensee committed one or more of the violations, it will determine what sanctions to impose.

May I file a complaint on behalf of the patient?

Yes. Anyone may file a complaint. The complaint must be in writing or by email. Either a letter or a complaint form may be used. Forms are available online or by calling 207-287-1146.

May I be present when the Board reviews my complaint?

Yes. You may be present and listen to the Board's discussion, but the law does not permit you to participate in any way. The Board members individually review each complaint prior to the Board meeting, and therefore, discussion of your complaint may be very brief.

Where can I find information on Nurses who have been disciplined?

All finalized adverse actions (consent agreements, license surrenders, decisions) are posted on the Board's website. The adverse action is linked to the licensee and may be accessed when using the Board's "Find a licensee in our database" feature:
https://www.pfr.maine.gov/ALMSOnline/ALMSQuery/SearchIndividual.aspx?Board=1310.

How can I check the licensing status of a Nurse licensed in Maine?

Click here to go to the Main Search. This is where you can search for a Nurse by license or name.

How can I file a complaint against a Hospital or Nursing Home in Maine?

This Board does not regulate Hospitals or Nursing homes, but to file Complaints against Nursing Homes or Hospitals in Maine- please call 1-800-383-2441 or go to the DHHS website.

How can I file a complaint against a Home Health care agency in Maine?

This Board does not regulate Home Health Care Agencies - For Licensing & Certification, questions & complaints - please call 1-800-621-8222 or go to the DHHS website.

What if I have other questions about the Board of Nursing's disciplinary processes that are not answered here?

You can contact the Board's Complaint Coordinator, Jasmine Greenman, at (207) 287-1146.

Attachment D: FOAA Protocol

Freedom of Access Act Request Protocol

Introduction

Effective 09/19/2019 the boards of medicine, osteopathic licensure, and nursing will have to implement the enacted law "An Act to Protect Licensing Information of Medical Professionals" (See attached). The law requires that upon receipt of a request for all or part of the record of an applicant or licensee, the boards shall:

1. Redact information that is not public;
2. Acknowledge receipt of the request and provide a description of the review process, including an explanation that all or part of the record may be withheld if the board finds that disclosure of all or part of the redacted record creates a potential risk to the applicant's/licensee's personal safety or the personal safety of any 3rd party; and
3. Contemporaneously notify the applicant/licensee at the last address on file with the board explaining that:
    a. A request for their information has been made; and
    b. That prior to providing the requested information:
        i. The board will redact non-public information;
        ii. The applicant/licensee may review the redacted information prior to it being provided to the requester;
        iii. The applicant/licensee has 10 business days (excluding weekends and holidays) from the date the board sends the notice to request the opportunity to review the redacted record;
        iv. If the applicant/licensee makes a timely request to review the redacted information, the board shall send a copy of the redacted information to the applicant/licensee for their review;
        v. The applicant/licensee may petition the board to withhold the release of all or part of a record based upon the potential risk to the applicant/licensee's personal safety or the personal safety of any 3rd party if the record is disclosed. The petition must be filed with the board within 10 business days (excluding weekends and holidays) after the board sends the applicant/licensee the redacted record and must include an explanation of the potential safety risks associated with disclosure of the information and a list of items requested to be withheld;

vi. The board shall notify the applicant/licensee of its decision regarding any petition to withhold information within 60 days of receiving the petition; and

vii. If the applicant/licensee disagrees with the board's decision, he/she may file a petition in the Superior Court to enjoin the board from releasing the information.

FOAA Protocol

1. Upon receipt of a FOAA request from anyone other than the applicant/licensee for the record of an applicant/licensee, the board shall send the attached FOAA Acknowledgment Form Letter to the requester and the attached FOAA Informational Form Letter to the applicant/licensee.

2. If a timely request is received from the applicant/licensee to review the redacted information, it will be sent to them for review using the FOAA Request Review Form Letter.

3. If a timely and sufficient (including explanation) petition to withhold information is received from the applicant/licensee, it will be placed on the board agenda for review and action. Following review and action, the board will issue a FOAA Decision.

4. If the board does not receive a timely request to review the redacted record or petition to withhold information, the board will provide the information to the requester. If a petition has been filed with the board, the board will provide the information to the requester 10 business days after the board has notified the applicant/licensee of its decision so long as the board has not been notified that a Superior Court action to enjoin the release of the information has been filed.

Attachment E: 3-Year Average NCLEX Program Pass Rates (2016-2018)

Maine State Board of Nursing
NCLEX RN First Time Testing Pass Rate
3 Year Average (January 1, 2016 – December 31, 2018)

Registered Nurse (RN)	Type	2016	2017	2018	3 – Year Average 2016-2018
National Pass Rate	All	84.57	87.11	88.29	86.66
Maine Pass Rate	All	84.16	87.66	89.04	86.95

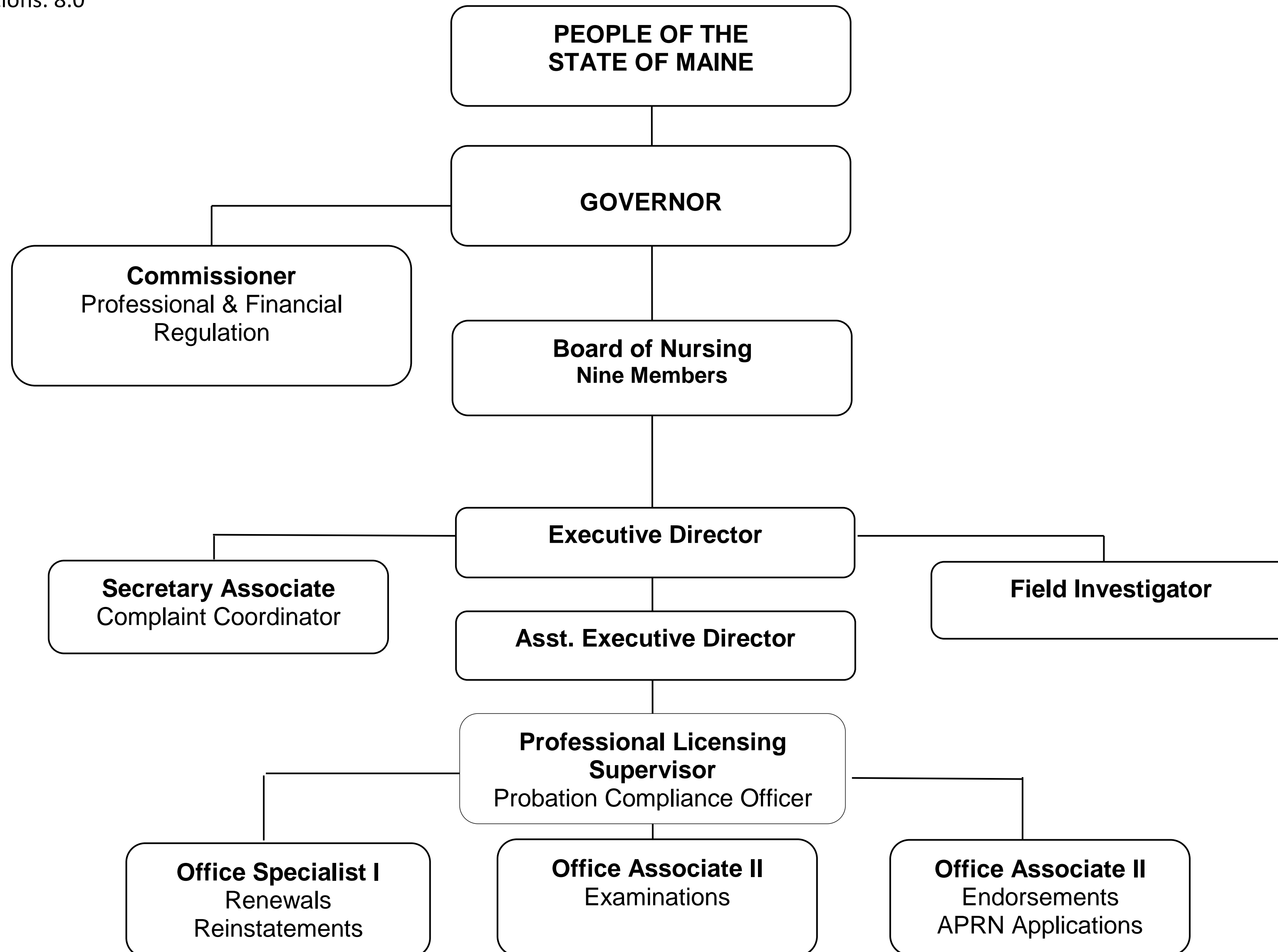
Program – **Bachelor of Science in Nursing (BSN)**

Registered Nurse (RN)	Type	2016	2017	2018	3-Year Average 2016-2018
National BSN Pass Rate	BSN	87.80	90.04	91.57%	89.81
Maine BSN Pass Rate	BSN	81.89	87.59	90.16	86.55
Husson University	BSN	87.27	90.74	79.37	85.80
Purdue University Global	BSN	73.33	77.27	92.31	80.97
St. Joseph's College	BSN	75.00	87.72	100	87.58
University of Maine (Orono)	BSN	74.71	90.28	86.52	83.84
University of Maine at Fort Kent	BSN	83.67	85.54	88.89	86.04
University of Southern Maine	BSN	87.50	88.03	86.00	87.18
University of New England	BSN	91.76	93.55	98.02	94.45

Program – **Associate Degree (AD)**

Registered Nurse (RN)	Type	2016	2017	2018	3-Year Average 2016-2018
National AD Pass Rate	AD	81.68	84.24	85.11	83.67
Maine AD Pass Rate	AD	86.42	87.73	89.81	88.25
Central Maine Community College	AD	91.67	90.91	85.71	89.43
Eastern Maine Community College	AD	79.31	100	100	93.11
Kennebec Valley Community College	AD	87.18	80.56	97.22	88.32
Maine College of Health Professions	AD	87.51	86.27	75.44	83.04
Northern Maine Community College	AD	84.85	80.00	87.50	84.12
Southern Maine Community College	AD	92.59	88.89	92.96	91.48
University of Maine at Augusta	AD	81.82	87.50	N/A	N/A

Attachment F: Organizational Chart



Attachment G: Financial Summary

PROGRAM: **STATE BOARD OF NURSING (0372)**
FUNDING SOURCE: **Dedicated Revenue**

	FISCAL YEAR	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
ALLOCATED	PERSONAL SERVICES	$638,679	$658,037	$534,143	$537,048	$553,197	$585,622	$609,872	$603,001	$604,848	$617,239
	ALL OTHER	$476,079	$486,348	$489,804	$476,421	$477,688	$477,943	$549,955	$561,682	$559,239	$562,249
	TOTAL	**$1,114,758**	**$1,144,385**	**$1,023,947**	**$1,013,469**	**$1,030,885**	**$1,063,565**	**$1,159,827**	**$1,164,683**	**$1,164,087**	**$1,179,488**
EXPENDED											
	PERSONAL SERVICES	$443,581	$532,293	$534,142	$515,389	$530,540	$581,691	$604,631	$551,790	$566,959	$580,412
	ALL OTHER	$438,077	$401,293	$371,181	$342,753	$382,102	$383,096	$457,264	$433,945	$409,395	$438,888
	TOTAL	**$881,658**	**$933,586**	**$905,323**	**$858,142**	**$912,642**	**$964,786**	**$1,061,895**	**$985,735**	**$976,354**	**$1,019,300**

**Allocated includes funds allotted by Financial Order*

National Guidelines for Nursing Delegation

National Council of State Boards of Nursing

In early 2015, the National Council of State Boards of Nursing convened two panels of experts representing education, research, and practice. The goal was to develop national guidelines based on current research and literature to facilitate and standardize the nursing delegation process. These guidelines provide direction for employers, nurse leaders, staff nurses, and delegatees.

Keywords: Delegation, evidence-based, guidelines, nursing assignment, regulation, research

Objectives

- Understand evidence-based, state-of-the-art standards for delegation.
- Explain the differences between assignment and delegation and the responsibilities of the employer, nurse leader, delegating nurse, and delegatee in the process of delegation.

Health care is continuously changing and this includes the roles and responsibilities of licensed health care providers and assistive personnel. The number of licensed nurses (i.e., advanced practice registered nurses [APRNs], registered nurses [RNs], or licensed practical nurse/vocational nurses [LPN/VNs]) may be limited in certain regions and/or institutions. Therefore, care may need to extend beyond the traditional role and assignments of RNs, LPN/VNs, and unlicensed assistive personnel (UAP). When certain aspects of nursing care need to be delegated beyond the traditional role and assignments of a care provider, it is imperative that the delegation process and the state nurse practice act (NPA) be clearly understood so that it is safely and effectively carried out.

The delegation process is multifaceted. It begins with decisions made at the administrative level of the organization and extends to the staff responsible for delegating, overseeing the process, and performing the responsibilities. It involves effective communication, empowering staff to make decisions based on their judgment and support from all levels of the health care setting. The employer/nurse leader, individual licensed nurse, and delegatee all have specific responsibilities within the delegation process. (See Figure 1.) It is crucial to understand that states/jurisdictions have different laws and rules/regulations about delegation, and it is the responsibility of all licensed nurses to know what is permitted in their state NPA, rules/regulations, and policies.

In early 2015, the National Council of State Boards of Nursing (NCSBN) convened two panels of experts representing education, research, and practice to discuss the literature and key issues, and evaluate findings from delegation research funded through NCSBN's Center for Regulatory Excellence Grant Program. The goal was the development of national guidelines to facilitate and standardize the nursing delegation process. They build on previous work by NCSBN and the American Nurses Association, and provide clarification on the responsibilities associated with delegation.

Additionally, these guidelines are meant to address delegation with respect to the various levels of nursing licensure (i.e., APRN, RN, and LPN/VN, where the state NPA allows).

Delegation Versus Assignment

Delegation has been a source of significant debate for many years and includes many philosophical discussions over the differences between assignment and delegation. Much of the literature surrounding nursing delegation has focused on the nursing home setting. The Centers for Medicare & Medicaid Services (CMS) requires nursing homes to employ certified nursing assistants or aides (CNAs) as part of a mechanism to ensure higher standards of care. Through this mechanism, CMS supports federal regulations concerning CNA training and competency, which were established by the Omnibus Budget Reconciliation Act of 1987. These regulations require nursing homes to employ CNAs who complete state-approved CNA programs, outline the fundamental skills that should be included in all CNA programs, and require the CNA to pass a competency evaluation administered and evaluated only by the state or by a state-approved entity and be added to the state registry. The interpretation of these guidelines by the nursing practice community has likely led to some confusion about what activities, skills, or procedures can be delegated to CNAs. The regulations define the minimum curriculum to be included in a CNA program but do not necessarily define all the activities, skills, or procedures that can

FIGURE 1

Delegation Model

be performed by a CNA. It is likely that nursing practice has understood these regulations to mean that CNAs can only perform those activities, skills, or procedures that were learned in the basic state-approved CNA training program. CMS defers to state requirements for what CNAs are allowed to perform (Sheila Blackstock, personal communication, December 7, 2015).

When performing a fundamental skill on the job, the delegatee is considered to be carrying out an assignment. Delegation is allowing a delegatee to perform a specific nursing activity, skill, or procedure that is beyond the delegatee's traditional role and not routinely performed. This applies to licensed nurses as well as UAP.

Regardless of the current role of the delegatee (RN, LPN/VN, or UAP), delegation can be summarized as follows:

- A delegatee is allowed to perform a specific nursing activity, skill, or procedure that is outside the traditional role and basic responsibilities of the delegatee's current job.
- The delegatee has obtained the additional education and training, and validated competence to perform the care/delegated responsibility. The context and processes associated with competency validation will be different for each activity, skill, or procedure being delegated. Competency validation should be specific to the knowledge and skill needed to safely perform the delegated responsibility as well as to the level of practitioner (i.e., RN, LPN/VN, UAP) to whom the activity, skill, or procedure has been delegated.
- The licensed nurse who delegates the "responsibility" maintains overall accountability for the patient. However, the delegatee bears the responsibility for the delegated activity, skill, or procedure.
- The licensed nurse cannot delegate nursing judgment or any activity that will involve nursing judgment or critical decision making.
- Nursing responsibilities are delegated by someone who has the authority to delegate.
- The delegated responsibility is within the delegator's scope of practice.
- When delegating to a licensed nurse, the delegated responsibility must be within the parameters of the delegatee's authorized scope of practice under the NPA.

Regardless of how the state/jurisdiction defines delegation as compared to assignment, appropriate delegation allows for the transition of a responsibility in a safe and consistent manner. The licensed nurse transfers the performance of an activity, skill, or procedure to a delegatee. However, the practice pervasive functions of clinical reasoning, nursing judgment, or critical decision making cannot be delegated.

Delegation should not be confused with assignment. Assignment is defined as follows:

- The routine care, activities, and procedures that are within the authorized scope of practice of the RN or LPN/VN or part of the routine functions of the UAP

- The above are included in the coursework taught in the delegatee's basic educational program.

A licensed nurse is still responsible for ensuring an assignment given to a delegatee is carried out completely and correctly.

An example of assignment is an LPN/VN caring for a diabetic patient. He or she takes vital signs, checks the blood sugar level using a blood glucose meter, monitors input and output, documents the information, and reports data to the RN. This is considered an "assignment" because these functions are taught in the LPN/VN program and are part of the LPN/VN scope of practice.

One exception to these definitions pertains to advanced UAP roles. Skills once believed exclusive to the RN and LPN/VN role are now taught in certain advanced UAP programs. In a basic course, examples of this include:

- Certified medication aides taught to pass out medications
- Certified medical assistants taught to give injections.

Even if taught in a basic education program, when the activity requires a significant level of skill and knowledge, such as administering medications or injections, it is advised that employers/nurse leaders regard these procedures as being delegated and validate competency.

For example, an APRN works with a certified medical assistant (CMA) in a physician's office. The CMA has been taught to give injections in his or her basic coursework and administering injections is part of the CMA role; however, due to the skill and knowledge required and the potential risk to patient safety if not done correctly, the APRN considers injections a delegated responsibility. While additional coursework may not be necessary, competency validation is required. In this scenario, prior to delegating injections, the APRN observes the CMA drawing up medication and administering an injection on different types of patients. Once the APRN is comfortable that the CMA is competent to perform the procedure, it can be routinely delegated to him or her.

Additional Key Definitions

Accountability: "To be answerable to oneself and others for one's own choices, decisions and actions as measured against a standard…" (American Nurses Association, 2015, p. 41)

Delegated Responsibility: A nursing activity, skill, or procedure that is transferred from a licensed nurse to a delegatee.

Delegatee: One who is delegated a nursing responsibility by either an APRN, RN, or LPN/VN (where state NPA allows), is competent to perform it, and verbally accepts the responsibility. A delegatee may be an RN, LPN/VN, or UAP.

Delegator: One who delegates a nursing responsibility. A delegator may be an APRN, RN, or LPN/VN (where state NPA allows).

Licensed Nurse: A licensed nurse includes APRNs, RNs and LPN/VNs. In some states/jurisdictions, LPN/VNs may be allowed to delegate.

UAP: Any unlicensed personnel trained to function in a supportive role, regardless of title, to whom a nursing responsibility may be delegated. This includes but is not limited to CNAs, patient care technicians, CMAs, certified medication aides, and home health aides.

Literature Review

A review of the literature was conducted in CINAHL and MEDLINE to search for current articles published in the United States on nursing delegation from 2010 to September 2015. The published evidence surrounding delegation is limited, although communication or the collaborative relationship between the licensed nurse and the UAP and scope of practice or scope of employment/function (in the case of the UAP) were primary themes of the published literature.

Evidence shows that the better the communication and collaborative relationship between the nurse and the delegatee, the more optimal the outcome of the delegation process (Anthony & Vidal, 2010; Bittner & Gravlin, 2009; Corazzini, Anderson, Mueller, Hunt-McKinney et al., 2013; Damgaard & Young, 2014; Gravlin & Bittner, 2010; Kalisch, 2011; Saccomano & Pinto-Zipp, 2011; Young & Damgaard, 2015). In Gravlin and Bittner's (2010) descriptive, exploratory study, they 1) measured RNs' and nurse assistants' (NAs) reports of missed nursing care and reasons for missed care, 2) identified RNs' and NAs' reports of factors related to successful delegation, and 3) described the nurse managers' reports of missed care. They found that communication between an RN and an NA contributes to effective delegation. Similarly, the literature suggests that a collaborative relationship between the licensed nurse and the UAP influences the effectiveness of delegation and promotes positive patient outcomes (Bittner & Gravlin, 2009; Corazzini, Anderson, Mueller, Hunt-McKinney et al., 2013; Saccomano & Pinto-Zipp, 2011). Bittner and Gravlin (2009) found in their study that nurturing a work relationship based on trust and respect is necessary for effective teamwork and therefore effective delegation.

Additionally, evidence also demonstrates that the UAP's level of competence and knowledge impacts effective delegation (Damgaard & Young, 2014; Gravlin & Bittner, 2010; Young & Damgaard, 2015). Damgaard and Young (2014) and Young and Damgaard (2015) evaluated a nursing care model that included partnering trained UAP at a school with RNs via telehealth technology. The UAP consisted of teachers, school administrators, and administrative assistants who agreed to assist in the management of the children with diabetes. The American Diabetes Association's (ADA) standardized curriculum, *Diabetes Care Tasks at School: What Key Personnel Need to Know* (ADA, 2008), was used to train the UAP. Damgaard and Young found that this model was an effective method of delegating diabetes nursing care tasks to UAP. Although this research supports how

TABLE 1

Five Rights of Delegation

Right task

- The activity falls within the delegatee's job description or is included as part of the established written policies and procedures of the nursing practice setting. The facility needs to ensure the policies and procedures describe the expectations and limits of the activity and provide any necessary competency training.

Right circumstance

- The health condition of the patient must be stable. If the patient's condition changes, the delegatee must communicate this to the licensed nurse, and the licensed nurse must reassess the situation and the appropriateness of the delegation.

Right person

- The licensed nurse along with the employer and the delegatee is responsible for ensuring that the delegatee possesses the appropriate skills and knowledge to perform the activity.

Right directions and communication

- Each delegation situation should be specific to the patient, the licensed nurse, and the delegatee.
- The licensed nurse is expected to communicate specific instructions for the delegated activity to the delegatee; the delegatee, as part of two-way communication, should ask any clarifying questions. This communication includes any data that need to be collected, the method for collecting the data, the time frame for reporting the results to the licensed nurse, and additional information pertinent to the situation.
- The delegatee must understand the terms of the delegation and must agree to accept the delegated activity.
- The licensed nurse should ensure that the delegatee understands that she or he cannot make any decisions or modifications in carrying out the activity without first consulting the licensed nurse.

Right supervision and evaluation

- The licensed nurse is responsible for monitoring the delegated activity, following up with the delegatee at the completion of the activity, and evaluating patient outcomes. The delegatee is responsible for communicating patient information to the licensed nurse during the delegation situation. The licensed nurse should be ready and available to intervene as necessary.
- The licensed nurse should ensure appropriate documentation of the activity is completed.

Source: National Council of State Boards of Nursing. (1995, 1996).

the UAP's level of competence impacts effective delegation, further research may include evaluating the impact of the licensed nurse's competence on effective delegation.

Another prominent theme in the delegation literature involves the effect role confusion has on delegation (Bittner & Gravlin, 2009; Kalisch, 2011). In relation to this, variation exists among states/jurisdictions surrounding scope of practice related to delegation across both the RN and LPN/VN licensure levels (Corazzini et al., 2010; Corazzini et al, 2011; Corazzini, Anderson, Mueller, Hunt-McKinney et al., 2013; Corazzini, Anderson, Mueller, Thorpe, & McConnell, 2013; Mueller, Anderson, McConnell, & Corazzini, 2012; Mueller & Vogelsmeier, 2013). This variation in NPAs and administrative codes promotes confusion among LPN/VNs related to their scope of practice surrounding delegation and supervision (Corazzini, Anderson, Mueller, Thorpe, & McConnell, 2013; Mueller et al., 2012).

At times in the long-term care (LTC) setting, RN and LPN licensure levels are not delineated (Corazzini, Anderson, Mueller, Hunt-McKinney et al., 2013). Corazzini et al. (2010) reported that a lack of RNs in LTC clinical leadership sometimes thrusts LPNs into leadership roles in which they are responsible for delegation that extends beyond their scope of practice. Inadequate staffing mix and lack of staff engagement can subsequently have a negative effect on the RN and LPN collaborative relationship (Corazzini, Anderson, Mueller, Hunt-McKinney et al., 2013).

Variation in scope of practice or scope of employment/function across states has also been identified with the CNA role (McMullen et al., 2015). This same variation was also found with the roles and responsibilities of other UAP (Budden, 2011; Jenkins & Joyner, 2013; Mitty et al., 2010).

Additionally, Jenkins and Joyner (2013) found variation across acute-care hospitals in the Washington, DC, metropolitan area in what activities UAP were allowed to perform, ranging from basic nursing care functions (including personal hygiene) to special skills, which fall outside the traditional UAP duties.

In summary, the evidence demonstrates that successful delegation is influenced by various factors, including effective communication, collaborative work relationship, level of competence and knowledge of the UAP, and role clarity.

Guidelines for Delegation

Purpose: To provide clear direction and standardization of the delegation process, from a system (employer) and patient care perspective, for safe delegation of nursing responsibilities.

Intended Users: Include, but are not limited to: BONs, health care facilities, community-based settings, professional associations, nurse educators, licensed nurses, and UAP.

When using these delegation guidelines, it is important to understand that states/jurisdictions have different laws and rules/regulations about delegation, and it is the responsibility of all licensed nurses to know what is permitted in their state NPA, rules/regulations, and policies.

These guidelines can be applied to:

- APRNs when delegating to RNs, LPN/VNs, and UAP
- RNs when delegating to LPN/VNs and UAP
- LPN/VNs (as allowed by their state/jurisdiction) when delegating to UAP.

These guidelines do not apply to the transfer of responsibility for care of a patient between licensed health care providers (e.g., RN to another RN or LPN/VN to another LPN/VN), which is considered a handoff (Agency for Healthcare Research and Quality, 2015).

Employer/Nurse Leader Responsibilities

1. **The employer must identify a nurse leader responsible for oversight of delegated responsibilities for the facility.** If there is only one licensed nurse within the practice setting, that licensed nurse must be responsible for oversight of delegated responsibilities for the facility.

Rationale: The nurse leader has the ability to assess the needs of the facility, understand the type of knowledge and skill needed to perform a specific nursing responsibility, and be accountable for maintaining a safe environment for patients. He or she is also aware of the knowledge, skill level, and limitations of the licensed nurses and UAP. Additionally, the nurse leader is positioned to develop appropriate staffing models that take into consideration the need for delegation. Therefore, the decision to delegate begins with a thorough assessment by a nurse leader designated by the institution to oversee the process.

2. **The designated nurse leader responsible for delegation, ideally with a committee (consisting of other nurse leaders) formed for the purposes of addressing delegation, must determine which nursing responsibilities may be delegated, to whom, and under what circumstances.** The nurse leader must be aware of the state/jurisdiction's NPA and the laws/rules and regulations that affect the delegation process and ensure all institution policies are in accordance with the law.

Rationale: A systematic approach to the delegation process fosters communication and consistency of the process throughout the facility.

3. **Policies and procedures for delegation must be developed.** The employer/nurse leader must outline specific responsibilities that can be delegated and to whom these responsibilities can be delegated. The policies and procedures should also indicate what may not be delegated. The employer must periodically review the policies and procedures for delegation to ensure they remain consistent with current nursing practice trends and that they are consistent with the state/jurisdiction's NPA (institution/employer policies can be more restrictive, but not less restrictive).

Rationale: Policies and procedures standardize the appropriate method of care and ensure safe practices. Having a policy and procedure specific to delegation and delegated responsibilities eliminates questions from licensed nurses and UAP about what can be delegated and how they should be performed.

4. **The employer/nurse leader must communicate information about delegation to the licensed nurses and UAP and educate them about what responsibilities can be delegated.** This information should include the competencies of delegatees who can safely perform a specific nursing responsibility.

Rationale: Licensed nurses must be aware of the competence level of staff and expectations for delegation (as described within the policies and procedures) in order to make informed decisions on whether or not delegation is appropriate for the given situation. Licensed nurses maintain accountability for the patient. However, the delegatee has responsibility for the delegated activity, skill, or procedure.

5. **All delegatees must demonstrate knowledge and competency on how to perform a delegated responsibility.** Therefore, the employer/nurse leader is responsible for providing access to training and education specific to the delegated responsibilities. This applies to all RNs, LPN/VNs, and UAP who will be delegatees. Competency validation should follow education and competency testing should be kept on file. Competency must be periodically evaluated to ensure continued competency. The con-

text and processes associated with competency validation will be different for each activity, skill, or procedure being delegated. Competency validation should be specific to the knowledge and skill needed to safely perform the delegated responsibility as well as to the level of practitioner (i.e., RN, LPN/VN, UAP) to whom the activity, skill, or procedure has been delegated.

Rationale: This ensures that competency of the delegatee is determined not only at the beginning of the delegation process, but on an ongoing basis, as well.

6. **The nurse leader responsible for delegation, along with other nurse leaders and administrators within the facility, must periodically evaluate the delegation process.** The licensed nurse and/or his or her manager (if applicable) must report any incidences to the nurse leader responsible for delegation. A decision should be made about corrective action, including whether further education and training are needed or whether that individual should not be allowed to perform a specific delegated responsibility.

Rationale: Patient safety should always be the priority for a health care setting. If any compromises in care are noted, immediate action must be taken. Gravlin and Bittner (2010) identified that evaluation of the effectiveness of the delegation process and resolution of any issues is critical to delegation.

7. **The employer/nurse leader must promote a positive culture and work environment for delegation.**

Rationale: A positive culture nurtures effective communication and collaboration in order to create an environment supportive of patient-directed care.

Licensed Nurse Responsibilities

Any decision to delegate a nursing responsibility must be based on the needs of the patient or population, the stability and predictability of the patient's condition, the documented training and competence of the delegatee, and the ability of the licensed nurse to supervise the delegated responsibility and its outcome, with special consideration to the available staff mix and patient acuity. Additionally, the licensed nurse must consider the state/jurisdiction's provisions for delegation and the employer's policies and procedures prior to making a final decision to delegate. Licensed nurses must be aware that delegation is at the nurse's discretion, with consideration of the particular situation. *The licensed nurse maintains accountability for the patient, while the delegatee is responsible for the delegated activity, skill, or procedure.* If, under the circumstances, a nurse does not feel it is appropriate to delegate a certain responsibility to a delegatee, the delegating nurse should perform the activity him/herself.

1. **The licensed nurse must determine when and what to delegate based on the practice setting, the patients' needs and condition, the state/jurisdiction's provisions for delegation, and the employer policies and procedures regarding delegating a specific responsibility.** The licensed nurse must determine the needs of the patient and whether those needs are matched by the knowledge, skills, and abilities of the delegatee and can be performed safely by the delegatee. The licensed nurse cannot delegate any activity that requires clinical reasoning, nursing judgment, or critical decision making. The licensed nurse must ultimately make the final decision whether an activity is appropriate to delegate to the delegatee based on the Five Rights of Delegation (National Council of State Boards of Nursing, 1995, 1996). See Table 1 for the description of the Five Rights of Delegation.

Rationale: The licensed nurse, who is present at the point of care, is in the best position to assess the needs of the patient and what can or cannot be delegated in specific situations.

2. **The licensed nurse must communicate with the delegatee who will be assisting in providing patient care.** This should include reviewing the delegatee's assignment and discussing delegated responsibilities, including information on the patient's condition/stability, any specific information pertaining to a certain patient (e.g., no blood draws in the right arm), and any specific information about the patient's condition that should be communicated back to the licensed nurse by the delegatee.

Rationale: Communication must be a two-way process involving both the licensed nurse delegating the activity and the delegatee being delegated the responsibility. Evidence shows that the better the communication between the nurse and the delegatee, the more optimal the outcome (Corazzini, Anderson, Mueller, Hunt-McKinney et al., 2013). The licensed nurse must provide information about the patient and care requirements. This includes any specific issues related to any delegated responsibilities. These instructions should include any unique patient requirements. The licensed nurse must instruct the delegatee to regularly communicate the status of the patient.

3. **The licensed nurse must be available to the delegatee for guidance and questions, including assisting with the delegated responsibility, if necessary, or performing it him/herself if the patient's condition or other circumstances warrant doing so.**

Rationale: Delegation calls for nursing judgment throughout the process. The final decision to delegate rests in the hands of the licensed nurse as he or she has overall accountability for the patient.

4. **The licensed nurse must follow up with the delegatee and the patient after the delegated responsibility has been completed.**

Rationale: The licensed nurse who delegates the "responsibility" maintains overall accountability for the patient, while the delegatee is responsible for the delegated activity, skill, or procedure.

5. **The licensed nurse must provide feedback information about the delegation process and any issues regarding delegatee competence level to the nurse leader.** Licensed nurses in the facility need to communicate, to the nurse leader responsible for delegation, any issues arising related to delegation and any individual that they identify as not being competent in a specific responsibility or unable to use good judgment and decision making.

Rationale: This will allow the nurse leader responsible for delegation to develop a plan to address the situation.

Delegatee Responsibilities

Everyone is responsible for the well-being of patients. While the nurse is ultimately accountable for the overall care provided to a patient, the delegatee shares the responsibility for the patient and is fully responsible for the delegated activity, skill, or procedure.

1. **The delegatee must accept only the delegated responsibilities that he or she is appropriately trained and educated to perform and feels comfortable doing given the specific circumstances in the health care setting and patient's condition.** The delegatee should confirm acceptance of the responsibility to carry out the delegated activity. If the delegatee does not believe he or she has the appropriate competency to complete the delegated responsibility, then the delegatee should not accept the delegated responsibility. This includes informing the hospital leadership if he or she does not feel he or she has received adequate training to perform the delegated responsibility, is not performing the procedure frequently enough to do it safely, or his or her knowledge and skills need updating.

Rationale: The delegatee shares the responsibility to keep patients safe and this includes only performing activities, skills, or procedures in which he or she is competent and comfortable doing.

2. **The delegatee must maintain competency for the delegated responsibility.**

Rationale: Competency is an ongoing process. Even if properly taught, the delegatee may become less competent if he or she does not frequently perform the procedure. Given that the delegatee shares the responsiblity for the patient, the delegatee also has a responsibility to maintain competency.

3. **The delegatee must communicate with the licensed nurse in charge of the patient.** This includes any questions related to the delegated responsibility and follow-up on any unusual incidents that may have occurred while the delegatee was performing the delegated responsibility, any concerns about a patient's condition, and any other information important to the patient's care.

Rationale: The delegatee is a partner in providing patient care. He or she is interacting with the patient/family and caring for the patient. This information and two-way communication is important for successful delegation and optimal outcomes for the patient.

4. **Once the delegatee verifies acceptance of the delegated responsibility, the delegatee is accountable for carrying out the delegated responsibility correctly and completing timely and accurate documentation per facility policy.** The delegatee cannot delegate to another individual. If the delegatee is unable to complete the responsibility or feels as though he or she needs assistance, the delegatee should inform the licensed nurse immediately so the licensed nurse can assess the situation and provide support. Only the licensed nurse can determine if it is appropriate to delegate the activity to another individual. If at any time the licensed nurse determines he or she needs to perform the delegated responsibility, the delegatee must relinquish responsibility upon request of the licensed nurse.

Rationale: Only a licensed nurse can delegate. In addition, because they are responsible, they need to provide direction, determine who is going to carry out the delegated responsibility, and assist or perform the responsibility him/herself, if he or she deems that appropriate under the given circumstances.

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Expert Panel

The National Council of State Boards of Nursing (NCSBN) wishes to thank the members of the expert panel that developed the National Delegation Guidelines. The members of the panel include:

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After being developed, the guidelines were vetted by the state boards of nursing and national nursing leaders across the United States. They were approved by the NCSBN Board of Directors.

Attachment I: Licensing Figures (Current)

	Active	Not Active	Type Total
CNM	98	64	162
CNP	2,025	621	2,646
CNS	71	113	184
CRNA	486	505	991
LPN	2,019	12,035	14,054
RN	25,921	47,610	73,531
Status Total	**30,620**	**60,948**	**91,568**

Attachment J: Draft Amendment to 10 M.R.S. § 8003(5)

Draft Amendment to 10 M.R.S. § 8003(5) Authority of bureaus, offices, boards or commissions

Amend the last two paragraphs of this section as follows:

Any nonconsensual disciplinary action taken under authority of this subsection may be imposed only after a hearing conforming to the requirements of Title 5, chapter 375, subchapter 4, and~~, except for revocation actions,~~ is subject to judicial review exclusively in the Superior Court in accordance with Title 5, chapter 375, subchapter 7.

~~Any nonconsensual revocation of an occupational or professional license taken under authority of this subsection is subject to, upon appeal within the time frames provided in Title 5, section 11002, subsection 3, de novo judicial review exclusively in District Court. Rules adopted to govern judicial appeals from agency action apply to cases brought under this section.~~

The bureau, office, board or commission shall hold a hearing conforming to the requirements of Title 5, chapter 375, subchapter 4 at the written request of any person who is denied an initial or renewal license without a hearing for any reason other than failure to pay a fee, provided that the request for hearing is received by the office, board or commission within 30 days of the applicant's receipt of written notice of the denial of the application, the reasons for the denial and the applicant's right to request a hearing.

The office, board or commission may subpoena witnesses, records and documents in any adjudicatory hearing it conducts.
Rules adopted to govern judicial appeals from agency action apply to cases brought under this subsection.

In the event of appeal to Superior Court from any form of discipline imposed pursuant to this subsection, including denial or nonrenewal of a license, the office, board or commission may assess the licensed person or entity for the costs of transcribing and reproducing the administrative record.

Attachment K: Draft Amendment to 24 M.R.S. § 2502

§2502. DEFINITIONS

As used in this chapter, unless the context indicates otherwise, the following words shall have the following meanings.

1. **Board.** "Board" means the Board of Licensure in Medicine, the Board of Dental Practice, the State Board of Nursing or the Board of Osteopathic Licensure.

Attachment L: Draft Amendment to 24 M.R.S. § 2505

§2505. COMMITTEE AND OTHER REPORTS

Any professional competence committee within this State and any health care practitioner as defined by this Chapter ~~physician or physician assistant~~ licensed to practice or otherwise lawfully practicing within this State shall, and any other person may, report the relevant facts to the appropriate board relating to the acts of any physician or physician assistant in this State if, in the opinion of the committee, physician, physician assistant or other person, the committee or individual has reasonable knowledge of acts of the physician or physician assistant amounting to gross or repeated medical malpractice, misuse of alcohol, drugs or other substances that may result in the physician's or the physician assistant's performing services in a manner that endangers the health or safety of patients, professional incompetence, unprofessional conduct or sexual misconduct identified by board rule. The failure of any such professional competence committee or any such ~~physician or physician assistant~~ health care practitioner to report as required is a civil violation for which a fine of not more than $1,000 may be adjudged.

Except for specific protocols developed by a board pursuant to Title 32, section 2596-A, 3298 or 18323, a ~~physician or physician assistant~~health care practitioner or committee is not responsible for reporting misuse of alcohol, drugs or other substances or professional incompetence or malpractice as a result of physical or mental infirmity or by the misuse of alcohol, drugs or other substances discovered by the health care practitioner or committee as a result of participation or membership in a professional review committee or with respect to any information acquired concerning misuse of alcohol, drugs or other substances or professional incompetence or malpractice as a result of physical or mental infirmity or by the misuse of alcohol, drugs or other substances, as long as that information is reported to the professional review committee. This section does not prohibit an impaired physician, physician assistant or dentist from seeking alternative forms of treatment.

The confidentiality of reports made to a board under this section is governed by this chapter.

Attachment M: Draft Amendment to 24 M.R.S. § 2506

§2506. PROVIDER, ENTITY AND CARRIER REPORTS

A health care provider or health care entity shall, within 60 days, report in writing to the disciplined practitioner's board or authority the name of any licensed, certified or registered employee or person privileged by the provider or entity whose employment, including employment through a 3rd party, or privileges have been revoked, suspended, limited or terminated or who resigned while under investigation or to avoid investigation for reasons related to clinical competence or unprofessional conduct, together with pertinent information relating to that action. Pertinent information includes: a description of the adverse action; the name of the practitioner involved; the date, the location and a description of the event or events giving rise to the adverse action; ~~and~~ identification of the complainant giving rise to the adverse action;~~.~~ ~~Upon written request, the following information must be released to the board or authority within 20 days of receipt of the request:~~ the names of the patients whose care by the disciplined practitioner gave rise to the adverse action; medical records relating to the event or events giving rise to the adverse action; written statements signed or prepared by any witness or complainant to the event; and related correspondence between the practitioner and the provider or entity. The report must include situations in which employment, including employment through a 3rd party, or privileges have been revoked, suspended, limited or otherwise adversely affected by action of the health care practitioner while the health care practitioner was the subject of a proceeding regarding employment or a disciplinary proceeding, and it also must include situations where employment, including employment through a 3rd party, or privileges have been revoked, suspended, limited or otherwise adversely affected by act of the health care practitioner in return for the health care provider's or health care entity's terminating such proceeding. Any reversal, modification or change of action reported pursuant to this section must be reported immediately to the practitioner's board or authority, together with a brief statement of the reasons for that reversal, modification or change. If the adverse action requiring a report as a result of a reversal, modification or change of action consists of the revocation, suspension or limitation of employment, including employment through a 3rd party, or clinical privileges of a physician, physician assistant or advanced practice registered nurse by a health care provider or health care entity for reasons relating to clinical competence or unprofessional conduct and is taken pursuant to personnel or employment rules or policies, medical staff bylaws or other credentialing and privileging policies, whether or not the practitioner is employed by that health care provider or entity, then the provider or entity shall include in its initial report to the disciplined practitioner's licensing board or authority the names of all patients whose care by the disciplined practitioner gave rise to the adverse action. The failure of any health care provider or health care entity to report as required is a civil violation for which a fine of not more than $5,000 may be adjudged.

Carriers providing managed care plans are subject to the reporting requirements of this section when they take adverse actions against a practitioner's credentials or employment for reasons related to clinical competence or unprofessional conduct that may adversely affect the health or welfare of the patient.

Attachment N: Draft Amendment to 24 M.R.S. §2510

§2510. CONFIDENTIALITY OF INFORMATION

2. **Confidentiality of orders in disciplinary proceedings.** Orders of the board relating to disciplinary action against a ~~physician~~ health care practitioner as defined by this Chapter, including orders or other actions of the board referring or scheduling matters for hearing, shall not be confidential.

5. Health care professional – patient; ~~**Physician-patient;**~~ **proceedings by board.** The health care professional-patient ~~physician-patient~~ privilege shall, as a matter of law, be deemed to have been waived by the patient and shall not prevail in any investigation or proceeding by the board acting within the scope of its authority, provided that the disclosure of any information pursuant to this subsection shall not be deemed a waiver of such privilege in any other proceeding.

6. **Disciplinary action.** Disciplinary action by the board in conformance with its laws and Title 5, Chapter 375, subchapter 4.~~Board of Licensure in Medicine is in accordance with Title 32, chapter 48; disciplinary action by the Board of Osteopathic Licensure is in accordance with Title 32, chapter 36; and disciplinary action by the State Board of Veterinary Medicine is in accordance with Title 32, chapter 71-A.~~

Attachment O: Example of update to 32 M.R.S. § 2105-A(1) Board Complaint Investigation Statute

§. BOARD INVESTIGATORY AND HEARING COMMITTTEES

1. **Investigatory Committees.** The board may establish investigatory committees to review and investigate applications for licensure and complaints.

A. Membership. An investigatory committee shall consist of 5 members as follows:

1. Four nurses who are members of the Board, appointed by the chair of the board, subject to the following:

   a. If the complaint/application for licensure involves an advanced practice registered nurse, then the advanced practice registered nurse member must be one of the four nurses;

2. A public member of the board, appointed by the chair of the board.

B. Duties. The investigatory committees shall:

1. Investigate complaints, review applications for licensure, and take any of the following actions:

   A. **Complaints.**

   1. Dismiss the complaint;

   2. Issue a letter of guidance or concern to the licensee;

   3. Hold an informal conference with the licensee who is the subject of the complaint;

   4. Execute a consent agreement that resolves a complaint or investigation without further proceedings. Consent agreements may be entered into only with the consent of: the applicant, licensee or registrant; the investigatory committee; and the Department of the Attorney General. Any remedy, penalty or fine that is otherwise available by law, even if only in the jurisdiction of the Superior Court, may be achieved by consent agreement, including long-term suspension and permanent revocation of a professional or occupational license. A consent agreement is not subject to review or appeal and may be modified only by a writing executed by all parties to the original consent agreement. A consent agreement is enforceable by an action in Superior Court;

   5. Refer the complaint for a hearing before a hearing committee of the board;

   6. Refer the complaint to the Department of the Attorney General to file an action in the District Court in accordance with Title 4, chapter 5.

   B. License Applications.

1. Grant the application for licensure;

2. Hold an informal conference with the applicant for licensure;

3. Issue a letter of concern;

4. Execute a consent agreement that resolves a pending application;

5. Deny an application for licensure.

C. Prohibition. No member of an investigatory or licensure committee who investigated, reviewed, and took action on a specific complaint or application for licensure shall serve on a hearing committee involving that specific complaint or application for licensure.

D. Quorum. Notwithstanding any other provision of law to the contrary, a majority of the members serving on an investigatory committee or a licensing committee constitutes a quorum.

2. Hearing Committees.

The board may establish hearing committees to adjudicate complaints and applications for licensure and/or re-licensure.

A. Membership. A hearing committee shall consist of 5 members as follows:

1. Four nurses who are members of the board, appointed by the chair of the board;

2. A public member of the Board, appointed by the chair of the Board.

B. Duties. The hearing committees shall conduct adjudicatory hearings in accordance with Title 5, chapter 375, subchapter 4.

1. Complaints. The hearing committees may adjudicate complaints, and take any of the following actions:

A. Dismiss the complaint;

B. Issue a letter of guidance or concern to the licensee;

C. Impose any sanction authorized by Title 10, section 8003, subsection 5;

D. Refer the complaint to the Department of the Attorney General to file an action in the District Court in accordance with Title 4, chapter 5;

E. Execute a consent agreement that resolves a hearing without further proceedings. Consent agreements may be entered into only with the consent of: the applicant, licensee or registrant; the hearing committee; and the Department of the Attorney General. Any remedy, penalty or fine that is otherwise available by law, even if only in the jurisdiction of the Superior Court, may be achieved by consent agreement, including long-term suspension and permanent revocation of a license. A consent agreement is not subject to review or appeal and may be modified only by a writing

executed by all parties to the original consent agreement. A consent agreement is enforceable by an action in Superior Court.

2. License Applications. The hearing committee may adjudicate license applications, and take any of the following actions:

A. Grant the application;

B. Deny the application;

C. Grant the application with probation and conditions;

D. Grant the application and issue a letter of concern;

E. Execute a consent agreement that resolves a hearing without further proceedings. Consent agreements may be entered into only with the consent of: the applicant, licensee or registrant; the hearing committee; and the Department of the Attorney General. Any remedy, penalty or fine that is otherwise available by law, even if only in the jurisdiction of the Superior Court, may be achieved by consent agreement, including long-term restriction or denial of a license or registration. A consent agreement is not subject to review or appeal and may be modified only by a writing executed by all parties to the original consent agreement. A consent agreement is enforceable by an action in Superior Court.

C. Prohibition. No member of an investigatory committee who investigated, reviewed, and took action with respect to a specific complaint and/or license application shall serve on a hearing committee involving that specific complaint or license application.

D. Quorum. Notwithstanding any other provision of law to the contrary, a majority of the members serving on the hearing committee constitutes a quorum.

E. Appeal and Judicial Review.

1. Complaints. Notwithstanding any other provision of law, including Title 10, section 8003, subsection 5, any nonconsensual disciplinary action taken under authority of this subsection, including license revocation, may be imposed only after a hearing conforming to the requirements of Title 5, chapter 375, subchapter 4, and is subject to judicial review exclusively in the Superior Court in accordance with Title 5, chapter 375, subchapter 7.

2. License Applications. Notwithstanding any other provision of law, any nonconsensual licensing action taken under authority of this subsection, including denial of licensure or re-licensure, may be imposed only after affording the individual the opportunity to request a hearing conforming to the requirements of Title 5, chapter 375, subchapter 4, and is subject to judicial review exclusively in the Superior Court in accordance with Title 5, chapter 375, subchapter 7.