



**Nursing Care Quality Assurance Commission (NCQAC)
Regular Meeting Agenda
November 13, 2015
CenterPoint Meeting Center
Kent, WA**

Commission Members:

Margaret E. Kelly, LPN, Chair
Donna Poole MSN, ARNP, PMHCNS-BC, Vice-Chair
Jeannie Eylar, MSN, RN
Charlotte Foster, BSN, MHA, RN
Lois Hoell, MS, MBA, RN
Suellyn M. Masek, MSN, RN, CNOR
Helen Myrick, Public Member
Tiffany Randich, LPN
Tracy Rude, LPN
Laurie Soine PhD, ARNP
Teri Trillo, MSN, RN, CNE

Excused:

Mary Baroni, PhD, RN
Stephen Henderson, JD, MA, Public Member
Gene Pingle, BSN-BC, CEN, RN
Cass Tang, PMP, Public Member, Secretary/Treasurer

Assistant Attorney General:

Gail Yu, Assistant Attorney General

Staff:

Paula R. Meyer, MSN, RN, FRE, Executive Director
Kathy Anderson, Management Analyst
Chris Archuleta, Administrative Assistant
Bobbi Allison, Administrative Assistant
Debbie Carlson, MSN, RN, Associate Director, Nursing Practice
Teresa Corrado, LPN, Licensing Manager
Mary Dale, Discipline Manager
Karl Hoehn, Legal Manager
Mindy Schaffner, PhD, MSN-CNS, RN, Associate Director, Nursing Education
Catherine Woodard, Associate Director, Discipline
Garr Nielsen, Chief Investigator
John Furman, PhD, MSN, CIC, COHN-S, Director, Washington Health Professional Services

If you have questions regarding the agenda, please call the NCQAC office at 360-236-4713. Items may be taken out of order. If you wish to attend the meeting for a single item, contact our office at the number listed above and request a specific time scheduled for that item. This meeting is accessible to persons with disabilities. Special aids and services can be made available upon advance request. Advance request for special aids and services must be made no later than November 1, 2015. If you need assistance with special needs and services, please leave a message with that request at 1-800-525-0127 or, if calling from outside Washington State, call (360) 236-4052. If you have limited English language expertise, call 360-236-4713 before November 1, 2015. TDD may also be accessed by calling the TDD relay service at 711. If you need assistance due to a speech disability, Speech-to-Speech provides human voicers for people with difficulty being understood. The Washington State Speech to Speech toll free access number is 1-877-833-6341.

This meeting will be digitally recorded to assist in the production of accurate minutes. All recordings are public record. The minutes of this meeting will be posted on our website after they have been approved at the January 8, 2016 NCQAC meeting. For a copy of the actual recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov.

Smoking is prohibited at this meeting.

I. 8:30 AM Opening – Margaret E. Kelly, Chair – DISCUSSION/ACTION

II. Call to Order

A. A. Introductions

B. Order of the Agenda

C. Correspondence

D. Announcements

1. Newsletter circulation and distribution
2. Consent agenda – scrivener’s errors

III. 8:40 AM Consent Agenda – DISCUSSION/ACTION

Consent Agenda items are considered routine and are approved with one single motion (Scrivener’s errors or typos can be reported directly to Chris Archuleta).

A. Approval of Minutes

1. NCQAC Business Meeting, September 11, 2015
2. Advanced Practice Sub-committee
 - a. August 11, 2015 Minutes
 - b. September 16, 2015 Minutes
3. Discipline Sub-committee
 - a. July 28, 2015 Minutes
 - b. August 25, 2015 Minutes
4. Consistent Standards of Practice Sub-committee
 - a. September 1, 2015 Minutes

- b. October 6, 2015 Minutes
- 5. Licensing Sub-committee
 - a. August 28, 2015 Minutes

- B. Out of State Travel Reports
 - 1. NCLEX Conference, September 21, Portland OR
 - a. Rhonda Taylor
 - b. Kathy Moisio
 - 2. Federation of Associations of Regulatory Boards, October 1-4, Denver CO – Sara Kirschenman, Miranda Bayne
 - 3. American Association of Nurse Attorneys Education Conference, October 1-3, Philadelphia PA– Margaret Holm
 - 4. Tri-Regulator Symposium, October 6-7, Arlington VA – Paula Meyer
- C. Uniform Disciplinary Act (UDA) report
- D. October 2015 Letter from the NCSBN President, Shirley Brekken

IV. 8:45 AM - 8:50 AM NCQAC Panel Decisions – DISCUSSION

- A. The NCQAC delegates the authority as provided by law for certain decision to a panel of at least three members. A member of the NCQAC must chair panels. Pro tem members of NCQAC may serve as panel members. The following minutes are provided for information.
 - 1. Nursing Program Approval Panel (NPAP)
 - a. August 6, 2015 Minutes
 - b. August 14, 2015 Minutes
 - c. September 3, 2015 Minutes
 - d. September 17, 2015 Minutes
 - 2. Nursing Assistant - Nursing Program Approval Panel (NA-NPAP)
 - a. August 10, 2015 Minutes
 - b. September 16, 2015 Minutes

V. 8:50 AM – 9:30 AM Chair Report DISCUSSION/ACTION

- A. Strategic Plan: the draft plan will be presented by sub-committee and panel chairs and staff. In July, the NCQAC completed a brainstorm activity to list the objectives to consider on the strategic plan. The plan was sorted and presented to the sub-committees and panels. Staff then further refined the plan to address priorities according to laws, rules, and policies in place. The NCQAC will discuss and consider adopting the strategic plan.
- B. Legislative Panel: The vice chair, Donna Poole, serves as the chair of the panel. The panel meets weekly to review and take positions on legislative bills. Ms. Kelly appoints members to the panel

VI. 9:30 AM – 9:45 AM ED Report - DISCUSSION/ACTION

- A. Performance Measures
 - 1. NCQAC
 - 2. Legal
 - 3. Washington Health Professional Services (WHPS)
- B. Computers
 - 1. Printers and headsets: collect lap tops, how lap tops and printers will be sent to members
 - 2. Staff assistance with Equipment Issues – Procedure H13.01
- C. January meeting – January 7, 1:00 pm GoTo training; on January 16, we will use only DOH email addresses and GoTo meetings. There will be no further State Operator assisted calls.
- D. Draft Procedure B19.01 Recognizing Canadian applications for those who have taken NCLEX RN examination
- E. ORBS and ILRS licensing and discipline data bases
- F. Procedure H04.02 Commission Pay – updated with staff deadlines
- G. 2016 Discipline Hearing Dates
- H. Nurse Licensure and Advanced Practice Compact update – Cass Tang, chair, task force

VII. 9:45 AM – 10:15 AM Sub-committee reports

- A. Advanced Practice – Laurie Soine, chair**
 - 1. Advisory Opinion Request - Acupuncture
- B. Discipline – Gene Pingle, chair**
 - 1. Procedure A24 Approved Evaluators
- C. Licensing – Lois Hoell, chair**
- D. Practice – Charlotte Foster, chair**
 - 1. Washington State Nurses Association-Continuing Education Approval and Recognition Program: NCQAC Educational Activity Provider Unit Approved
 - 2. Prevention and Treatment of Opioid-Related Overdoses:
 - a. Advisory Opinion Draft
 - b. Frequently Asked Questions Draft

10:15 AM – 10:30 AM BREAK

VIII. 10:30 AM – 10:45 AM Nursing Assistant Training Program Approval Panel Procedure E02.04 – Tracy Rude - DISCUSSION/ACTION

The NCQAC reviews and determines if nursing assistant training programs meet criteria defined in WAC 246-841-420, WAC 246-841-470 through WAC 246-841-510, WAC 246-841-545 and WAC 246-841-550.. The NCQAC delegates this responsibility to the Nursing Assistant Training Program Approval Panel (NAPAP). The procedure describing the review and decision making process is revised. The NCQAC will review the procedure and consider adopting the changes.

IX. 10:45 AM – 11:00 AM FBI Criminal Background Checks on all applications – Gail Yu – DISCUSSION/ACTION

The NCQAC requested the secretary of health to begin collecting FBI Criminal Background Checks on all new applications beginning January 1, 2016. Gail Yu, Assistant Attorney General, presents analysis of the request. The NCQAC discusses options available and recommendations for action.

- A. Criminal Background Checks on all applicants letter
- B. RCW 18.130.064
- C. House Bill 2080

X. 11:00 AM – 11:30 AM North Carolina Board of Dentistry v US Supreme Court– Gail Yu – DISCUSSION/ACTION

Ms. Yu presents the North Carolina Board of Dentistry v US Supreme Court case related to their decision to limit teeth whitening services to the practice of dentistry. Ms. Yu presents the case, the US Supreme Court decision and implications for the state of WA. The NCQAC discusses options available and recommendations for action.

- A. FTC Guidance NCDB v. FTC
- B. [NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS v FEDERAL TRADE COMMISSION](#) (Optional Reference)

XI. 11:30 AM – 1:00 PM LUNCH

XII. 12 NOON– 1:00 PM Education

Nursing Education, NPAP, NAPAP – The Practice of Teaching

XIII. 1:00 PM – 1:15 PM Open Microphone

XIV. 1:15 PM – 2:15 PM Substance Use Disorder Task Force – Suellyn Masek, Charlotte Foster, Margaret Kelly, Jeanell Rasmussen – DISCUSSION/ACTION

Dr. Nancy Darbro, expert consultant, presents the draft policies and procedures for the Washington Health Professional Services program. Draft procedures were discussed at the September meeting. The NCQAC disciplinary procedures are presented. Revised procedures for the Washington Health Professional Services programs according to input received at the September meeting will also be

presented. The NCQAC will also discuss and consider opening rules related to the Alternative to Discipline/Compliance Monitoring program.

2:15 PM – 2:30 PM BREAK

**XV. 2:30 PM - 3:15 PM HEARING – Continuing Competency and Retired Active Status; Suicide Assessment, Prevention and Treatment – Margaret Kelly
DISCUSSION/ACTION**

The NCQAC presents and considers rules changes for WAC 246-840-125 and WAC 246-840-202 through 207. The continuing competency audit process is revised to include an exemption for CRNAs, remove self-assessment, and create due process when failing to meet requirements. Changes are made to clarify rule language. The rule also implements legislation requiring suicide prevention training.

**XVI. 3:15 PM – 3:45 PM Education Rules – Mindy Schaffner -
DISCUSSION/ACTION**

Dr. Schaffner presents the draft education rules for discussion by the NCQAC.

- A. Nursing Education Rule OTS-7454 2Draft
- B. Nursing Education Rule OTS-4553 2Draft
- C. Nursing Education Rule OTS-7453 1Draft

**XVII. 3:45 PM – 4:00 PM Request for Lists and Labels – Paula Meyer –
DISCUSSION/ACTION**

The NCQAC considers revisions to Procedure J04.08 to delegate these decisions to a panel of NCQAC members.

- A. AMN Healthcare
- B. Namaste Training
- C. Cambria Health Solutions (Regence BlueShield and Asuris Northwest Health)

XVIII. 4:00 PM – 4:15 PM Evaluation

XIX. 4:15 PM Closing



**Nursing Care Quality Assurance Commission (NCQAC)
Regular Meeting Minutes
September 11, 2015
Crown Plaza Hotel
17338 International Boulevard
Seattle, WA 98188**

Commission Members:

Margaret E. Kelly, LPN, Chair
Donna Poole MSN, ARNP, PMHCNS-BC, Vice-Chair
Cass Tang, PMP, Public Member, Secretary/Treasurer
Mary Baroni, PhD, RN
Jeannie Eylar, MSN, RN
Charlotte Foster, BSN, MHA, RN
Stephen J. Henderson, JD, MA, Public Member
Lois Hoell, MS, MBA, RN
Suellen M. Masek, MSN, RN, CNOR
Helen Myrick, Public Member
Gene Pingle, BSN-BC, CEN, RN
Tiffany Randich, LPN
Tracy Rude, LPN
Laurie Soine PhD, ARNP
Teri Trillo, MSN, RN, CNE

Assistant Attorney General:

Gail Yu, Assistant Attorney General

Staff:

Paula R. Meyer, MSN, RN, FRE, Executive Director
Kathy Anderson, Management Analyst
Debbie Carlson, MSN, RN, Associate Director, Nursing Practice
Teresa Corrado, LPN, Licensing Manager
Mary Dale, Discipline Manager
Bobbi Allison, Administrative Assistant
Karl Hoehn, Legal Manager
Mindy Schaffner, PhD, MSN-CNS, RN, Associate Director, Nursing Education
Catherine Woodard, Associate Director, Discipline
Garr Nielsen, Chief Investigator
John Furman, PhD, MSN, CIC, COHN-S, Director, Washington Health Professional Services

The minutes of this meeting will be posted on our website after the November 13, 2015 NCQAC meeting. The NCQAC digitally records all meetings. For a copy of the recording, please contact the Public Disclosure Records Center (PDRC) at PDRC@doh.wa.gov .

I. Opening – Margaret E. Kelley, LPN, Chair – DISCUSSION/ACTION

II. Call to Order

A. Introductions

B. Order of the Agenda

Agenda item V.E, Nursing Assistant Program Approval Procedure (NAPAP) E02.04 revision was removed from the agenda.

C. Correspondence

D. Announcements

Ms. Meyer announced the hiring of Chris Archuleta as the new Administrative Assistant 4. Mr. Archuleta begins working with the NCQAC on September 16.

Ms. Meyer informed the NCQAC we are using both the NCQAC member home and Department of Health (DOH) email addresses to assure receipt of the information. In January, 2016, we will begin to use only DOH email addresses.

Ms. Meyer announced Suellyn Masek's election to the National Council of State Boards of Nursing's Board of directors as the Area I representative. Tracy Rude was elected to the Leadership Succession Committee.

Ms. Meyer also acknowledged the receipt of the Regulatory Achievement Award from The National Council of State Boards of Nursing. Ms. Meyer presented the award to the NCQAC and acknowledged their contributions.

III. 8:40 AM Consent Agenda – DISCUSSION/ACTION

A. Consent Agenda items are considered routine and are approved with one single motion

B. Approval of Minutes

1. NCQAC Business Meeting, July 9, 10, 2015
2. Advanced Practice Sub-committee, July 15, 2015
3. Discipline Sub-committee, May 26, 2015; June 23, 2015
4. Consistent Standards of Practice Sub-committee, August 4, 2015
5. NCSBN Letter from the President, July 27, 2015
6. Use of Automated Drug Distribution Devices by Nursing Student

Ms. Masek requested removal of the July 10, 2015 Business Meeting Minutes from the consent agenda. Ms. Yu requested removal of the Discipline Sub-Committee June 23, 2015 meeting minutes from the consent agenda.

Motion: by Ms. Tang with a second from Ms. Foster to accept the consent agenda with the removal of the July 10, 2015 Business meeting minutes and the Discipline Sub-Committee June 23, 2015 minutes. **Motion carried.**

Ms. Masek requested corrections to the out of state travel plan:

- Ms. Randich will be attending the NCSBN Mid-year meeting in March and not the Public Policy meeting.

Ms. Tang requested correction to the membership of the Legislative Task Force:

- Remove Helen Myrick and replace with Cass Tang as the public member representative.

Motion: by Ms. Tang, with a second from Dr. Baroni, to accept the minutes with the changes. **Motion carried with three abstentions.**

Mr. Pingle requested revision to the Just Culture section of the Discipline Sub-Committee minutes.

- The Sub-committee asked why the NCQAC could not use the NCSBN tool. The NCQAC must follow existing rules which already include aggravating and mitigating factors.
- The tool could be adopted and used to explain these factors and to articulate in orders the reasons for imposing a particular sanction.
- The tool could also be used with the sanction rules when mentoring a new NCQAC member and for the Early Remediation program.
- The tool should not be placed into policy.

Motion: Ms. Foster moved, with a second by Ms. Eylar to accept the minutes with the changes. **Motion carried.**

IV. 8:45 AM NCQAC Panel Decisions – DISCUSSION

A. The NCQAC delegates the authority as provided by law for certain decisions to a panel of at least three members. A member of the NCQAC must chair panels. Pro tem members of NCQAC may serve as panel members. The following minutes were provided for information.

1. Nursing Program Approval Panel (NPAP), May 21, 2015; June 18, 2015; July 2, 2015; July 16, 2015
2. Nursing Assistant - Nursing Program Approval Panel (NA-NPAP), June 28, 2015; July 13, 2015

V. 8:50 AM – 9:15 AM Chair Report – Margaret Kelley – DISCUSSION/ACTION

A. Expectations of NCQAC members

Ms. Kelley requested an annual review.

Ms. Hoell requested a footer be added to include a date.

B. 2014-2015 NCQAC Annual Evaluation Results

Ms. Kelley reviewed the annual report and mentioned two areas for improvement:

- Communication
- Inclusion of the Pro Tem members.

Ms. Kelley asked the sub-committee chairs to include an agenda item for their meeting to review business meeting actions and to disseminate the information to the pro tem members. Ms. Kelley also gave accolades to the staff for the format and report. This is a huge improvement over the paper copies and that this will be used towards the strategic plan.

C. 2014-2015 Board Pay – trends for 2011-2014

1. Commission Pay by Hours
2. Commission Pay Totals

The NCQAC requested three years of information to compare trends. NCQAC members noted the decrease in total board pay in 2014. Ms. Kelley explained that the work to finish Senate House Bill 1518 report increased the overall hours in 2014 and resulting board pay.

D. Nominations Sub-committee

1. Members for upcoming year

Tracy Rude, Tiffany Randich and Helen Myrick volunteered to be members of the committee. Ms. Kelly appointed Ms. Rude as the Chair.

2. Revision of position description to add recognition of nurses

Ms. Rude requested addition of the position of the Secretary/Treasurer to the list of nominees each year.

Ms. Hoell asked if the nurses in Washington would be nominating nurses for the annual recognition. Ms. Meyer stated the Nominations Committee would bring forth the recommendations for the process.

Motion: by Ms. Tang with a second from Ms. Soine to accept both changes to the job position description by adding the Secretary/Treasurer position and adding the annual recognition process. **Motion Carried.**

E. Computers for NCQAC and pro tem members, report on use and schedule for sub-committee and panels to begin use.

Ms. Kelley reviewed the schedule of sub-committees to begin using the computers. The below dates were committed per the table in the agenda with exception as indicated.

- Case Management Team started using the laptops on July 14.
- NPAP A will begin using them the week of September 14.
- Several Reviewing Commission Members are using the computers for investigations rather than receiving paper copies by postal service.
- NPAP B begins use on October 1.
- NAPAP begins use on September 14.
- Discipline begins use on October 27.
- Licensing begins use in October on the fourth Friday, October 23.
- Consistent Standards of Practice begins use on October 6.
- Advanced Practice begins use on October 21.
- Business Packet will be loaded for the November meeting on October 30.
- The Legislative Panel begins use on November 11.

Ms. Tang would like a procedure to ask for assistance. She would like names, phone numbers and email addresses of staff to contact for assistance. Ms. Kelley asked Ms. Tang to draft the procedure. Ms. Meyer reminded NCQAC members of staff available to help and will provide contact information.

Ms. Soine commented on the time out from Citrix. Ms. Tang offered to help Ms. Soine to extend the time on her computer. Ms. Kelley informed the NCQAC that there will be printers available, if needed by the November 13 business meeting.

Ms. Foster asked if she could forward meeting request to her Administrative Assistant to schedule her appointments. Ms. Yu said that as long as there was nothing else in the body of the email that would be fine.

VI. 9:15 AM – 9:45 AM Budget Report – Cass Tang - DISCUSSION/ACTION

Kathy Anderson assisted in the presentation of the close of the 2015 biennium and the projected 2015-2017 biennial budget.

Ms. Anderson gave updates on the completed 13-15 biennium report and the projected budget for the 15-17 biennium. There will be no budget report at the November meeting. Ms. Anderson and Ms. Tang will present a full report in January.

Ms. Meyer gave an update on the Integrated Licensure and Regulation System (ILRS) Database. Currently, DOH is using the ILRS system for licensing; Health Systems Quality Assurance (HSQA) worked with the vendor to create a discipline side to this database. That discipline functionality is not meeting NCQAC requirements. HSQA suggested working with another vendor to create a system to meet requirements. NCSBN is also working on a licensure and discipline system, Optimal Regulatory Board System (ORBS), for all state boards of nursing. NCSBN provides the licensing/discipline system to member boards at no cost. The business case to use ORBS has a much more attractive ROI and use of public funds versus the cost to use the ILRS system.

HSQA proposes to begin the business requirements gathering process by funding a business analyst and two administrative resources to gather requirements from all agencies under the DOH umbrella and design a financial assessment for a future procurement RFP process.

NCQAC will concurrently investigate implementation of the NCSBN ORBS system.

Ms. Meyer suggested that NCQAC contribute funds to HSQA to perform and participate in requirements gathering to design and build a data interface from ORBS to the new WA State IRLS replacement.

Motion: Ms. Poole with a second from Ms. Masek and Ms. Hoell recommended a one-time \$50,000 contribution in the 15-17 biennium to support HSQA work on the business requirements for new system as it integrates with the ORBS system. **Motion Carried.**

VII. 9:45 AM - 10:30 Executive Director Report – Paula Meyer – DISCUSSION/ACTION

A. Performance Measures Report

1. HSQA Performance Measures

The NCQAC exceeded the targets on performance measures. Ms. Meyer announced the Dr. Mary Sue Gorski will be the new member of the NCSBN's Commitment to Ongoing Regulatory Excellence (CORE) committee. Ms. Meyer completed four years on the committee and NCQAC recognizes her dedication and contribution.

2. Washington Health Professional Services Performance Measures, baseline measures – Dr. John Furman

Dr. Furman presented new performance measures for the Washington Health Professional Services.

NCQAC requested more detail about employment information.

NCQAC inquired about drug test durations concurrent with nurse requesting medical review, retest, and removal from practice.

3. Legal Services Performance Measures, baseline measures – Karl Hoehn

Mr. Hoehn presented new performance measures for the Legal Services Unit.

NCQAC requested addition of the following data statistics:

- How many new cases per attorney are started each month?
- What are the number of summary suspensions and timelines?
- How many attorneys are being reported in data sets provided?

B. Data and Quality Assurance at the NCQAC – Dr. Mary Sue Gorski

NCQAC initiated a task force to review existing NCQAC data provisions for research projects. Task force members are Lois Hoell, Lauri Soine, Mary Baroni and Jeannie Eylar. Dr. Gorski will be staff for the task force. Dr. Baroni will chair the task force.

Motion: Made by Helen Myrick with a second by Suellyn Masek to initiate a task force to work on research projects outlined by the NCQAC and use existing data sources. **Motion carried.**

C. Out-of-State Nursing Education Programs Annual Report - Dr. Mary Sue Gorski

Dr. Gorski presented reports on students enrolled in Nursing Education Programs across the state.

D. Medical Assistant Definition Rule Change: Request from NCQAC to file the Code Reviser (CR) 103. NCQAC used the CR-105 expedited rule process to revise WAC 246-841-535(2). The proposed rule definition incorporates, by reference or without material change, another Department of Health rule. The CR 105 process eliminates the need for a public

hearing. On March 13, 2015, NCQAC approved and staff filed the CR 105. The code reviser's office then published the CR 105. The announcement allowed 45 days for the public to send written comments to the NCQAC. NCQAC did not receive any public comments. Therefore, the NCQAC proceeds directly to adopt the final rule as published by the code reviser. A CR103 will be filed.

Ms. Meyer reviewed the rule process and explained the change to the rule.

Motion: Ms. Rude, with a second from the Nursing Assistant Program Approval Panel, moved to adopt the rule and file the CR103 with the Code Revisers office: WAC 246-841-535(2) revised to read Medical Assistant Certified under Chapter 18-88A RCW means a person who holds a current certification from one of the certifying organizations in WAC 246-827-0200(2). **Motion Carried.**

10:30 AM – 10:45 AM BREAK

VIII. 10:45 AM – 11:30 AM Sub-committee Report – DISCUSSION/ACTION

A. Advanced Practice – Laurie Soine, Chair

1. Advanced Practice Strategic Plan Goals and Objectives

Ms. Poole reported on the Advanced Practice portion of the strategic plan.

2. Health Care Authority-Applied Behavior Analysis Rule Revision

Ms. Poole reported on the rule change by the Health Care Authority. The Health Care Authority moved quickly and resolved the issue of identifying ARNPs as midlevel practitioners in the rule.

B. Consistent Standards of Practice – Charlotte Foster, Chair

1. Consistent Standards of Practice Strategic Plan Goals and Objectives

Ms. Foster reported on the strategic plan for the Consistent Standards of Practice sub-committee.

C. Discipline – Gene Pingle, Chair

1. Just Culture Principles

Mr. Pingle gave an update, this is not a rule just a suggestion to use as a guide when reviewing cases. The sub-committee is bringing this forward as a tool for the Sanction Standards.

2. Procedure A34 Early Remediation (ER) Program revision

Motion: Mr. Pingle explained that when the program was developed, nurses would enter the program when NCQAC received an initial complaint. The case was placed in the investigation phase until the nurse completed an action plan, with a timeline of 170 days. Staff found many nurses currently in the ER program are offered the program after full investigation. With the additional time used by the Reviewing Commission Member (RCM) and then legal review places these cases well beyond timelines allowed. The changes made to the procedure include, adding a section addressing ER cases referred at Case Disposition, closing the discipline case after entry to the non-disciplinary track and some edits and clarifications. Mr. Pingle moved, with a second from the Discipline Sub-Committee, to adopt the revisions in Procedure A34.05 Early Remediation Program. **Motion Carried.**

3. Strategic plan goals

Mr. Pingle reported on the strategic plan for the Discipline Sub-Committee.

D. Licensing – Lois Hoell, Chair

1. Update on Continuing Competency Rules

Ms. Hoell provided an update on the Continuing Competency Rules. The sub-committee anticipates the hearing to be held at the November meeting.

2. Update on Retired Active Rules

Ms. Hoell provided an update on the Retired Active Rules. The sub-committee anticipates the hearing to be held at the November meeting.

3. Strategic plan goals

Ms. Hoell gave an update on the Licensing Sub-Committee strategic plan.

IX. Education Strategic Plan – Tracy Rude, Chair NAPAP; Teri Trillo, Chair NPAP-B; Dr. Mary Baroni, Chair NPAP-A

Ms. Rude along with the other panel members, Ms. Trillo and Dr. Baroni, gave the update to the Education strategic plan.

X. 11:30 AM – 1:00 PM Lunch

XI. 12:00 PM – 1:00 PM Education Session

Washington Compact Administrators Panel

Compact administrators in Washington present their experiences working with an interstate compact and being a member of an interstate compact NCQAC. Jeff Litwak, the Columbia River Gorge Commission and Dawn Bailey, Juvenile Offenders Compact, presented on their experience as compact administrators. Mr. Litwak is a professor of compact law with Lewis and Clark College.

XII. 1:00 PM Open Microphone

A. Open microphone is for public presentation of issues to the NCQAC. If the public has issues regarding disciplinary cases, please call 360-236-4713.

Dr. Fujio MacPherson requested an Interpretive Statement or Advisory Opinion to support Acupuncture being recognized as being within the scope of practice for ARNPs.

XIII. 1:15 PM – 3:00 PM Substance Use Disorder Task Force – Suellyn Masek, Margaret Kelley, Charlotte Foster, Jeanell Rasmussen, Dr. Nancy Darbro - DISCUSSION/ACTION

RCW 18.130.160, RCW 18.130.175, and WACs 246-840-750 through 246-840-780 describe the NCQAC's regulations on nurses and substance use and abuse. Dr. Nancy Darbro, expert consultant, advised the members of the task force. The members of the task force presented recommendations for approval of the Washington Health Professional Services program.

Ms. Masek gave an introduction to the Washington Health Professional Services (WHPS) program and their policies and procedures. Ms. Masek introduced Dr. Darbro and her work with the task force. Dr. Darbro reviewed the draft NCQAC procedures for the WHPS program. NCQAC members recommended changes to the draft procedures. The updated procedures with the recommendations from the NCQAC will be available at the November meeting.

3:00 PM – 3:15 PM BREAK

XIV. 3:15 PM – 3:45 PM Nurse Licensure Compact and Advanced Practice Compact task force - Cass Tang, Donna Poole, Suellyn Masek, Tracy Rude, Helen Myrick, Jeannie Eylar - DISCUSSION/ACTION

Ms. Tang updated NCQAC on the recent meeting with representatives from the Washington State Nurses Association and Service Employees International Union/1199. One of the outcomes of this meeting is to meet on a regular basis to understand mutual needs and priorities. Based on provided recommendations from NCQAC and any nursing-related groups, NCQAC will send a survey to the nursing community to gather information on the changing work environment, their needs, and how NCQAC can assist. The NCQAC is planning the second meeting with WSNA and SEIU to continue dialogue on issues that are of importance to nurses and the public.

XV. 3:45 PM – 4:15 PM Request for Lists and Labels – Paula Meyer – DISCUSSION/ACTION

A. Annual review of recognized professional associations and educational organizations

At every September business meeting, the NCQAC reviews the list of recognized entities and revises the list as necessary.

B. Requests

The NCQAC reviewed the updated list.

Motion: Dr. Baroni, with a second from Mr. Pingle, moved to adopt the updated list of Professional Associations and Educational Organizations recognized by the NCQAC as meeting the criteria in Procedure J04.01.

Motion Carried.

XVI. 4:15 PM Meeting Evaluation

Ms. Meyer asked the NCQAC their preference in meeting location. The NCQAC members voted between the Kent Center Point Conference Center and the Crowne Plaza Hotel. The November NCQAC meeting will be held at the Kent Center Point Conference Center. NCQAC decided to have their meetings for January, March, and May of 2016 at the Crowne Plaza Hotel in SeaTac. The January meeting will begin at 1:00 PM on January 7 for computer training and continue with an all-day regular meeting on January 8.

PROS	CONS
Computers	Cold Room
Facility	Table Space
Food	Agenda on Screen

Good Meeting	Phone Portion
Hotel	Problem with Mics
Lunch Presentation	Skylight
Location	Traffic Noise
Techies helping with computers one-on-one	Meeting Room
NCSBN Award	Remotely driving the projector
Staff	
The good work of the Chair	
The work that Bobbi did for her first meeting	
Wi-Fi	

XVII. 3:38 PM Closing

DRAFT



Nursing Care Quality Assurance Commission (NCQAC)
Advanced Practice Sub-committee Minutes
August 11, 2015 7:00 PM to 8:00 PM
Town Center 2, Room 140
111 Israel Rd SE, Tumwater, WA 98501

Committee Members Present: Donna Poole, MSN, ARNP, PMHCNS-BC
 Dan Simonson, CRNA, MHPA
 Heather Schoonover, MN, RN, PHCNS-BC
Absent: Laurie Soine, PhD, ARNP, Chair
Absent: Heather Bradford, CNM, ARNP, FACNM

Staff: Willie O. Hunt, WHNP-BC, ARNP, MS, Advanced Practice Advisor
 Jean Wheat, Nurse Practice Administrative Assistant

I.	7:00 PM Opening – Donna Poole, Vice Chair, in place of Laurie Soine
II.	<p>Call to Order</p> <ul style="list-style-type: none"> • The public disclosure statement was read. • Introductions made. • Announcements – <ul style="list-style-type: none"> ○ Willie Hunt reviewed and discussed the recent article in the Seattle Times on August 9, 2015 titled “As number of insured increases, nurse practitioners play new role”. She provided information on the ARNP role and function in Washington State to Lisa Stiffler, writer for the Seattle Times article. ○ Jean Wheat informed the Sub-committee that we will no longer allow the public to call in. They are more than welcome to show up to the meetings, but can no longer call in as the Attorney General for the Nursing Commission says we do not want to be showing any favoritism. ○ Jean Wheat recommended to the Sub-committee they think about using GoTo Webinar again. The Sub-committee wants to wait until the September meeting to discuss with Laurie Soine. ○ Jean Wheat informed the Sub-committee that after September all documents will be place in the X drive in their personal folders. For those that do not have new laptops, the Nursing Commission will come up with a way to get the documents to them. <p style="text-align: center;">NCQAC Business Meeting November 13, 2015</p>
III.	Health Care Authority Rule Revision¹ Draft: WAC 182-531-A-0800 Applied

	<p>Behavior Analysis (ABA) Provider Requirements</p> <ul style="list-style-type: none"> • Willie Hunt discussed the Health Care Authority’s external review of their Behavior Analysis proposed rulemaking CR-102 in regard to WAC 182-531A-0700 delivery of applied behavior analysis services and provider requirements. The Nursing Care Quality Assurance Commission provided edits to reflect the independent practice of Advanced Registered Nurse Practitioners. The commission has noted that Advanced Registered Nurse Practitioners (ARNPs) are independent providers and do not require physician oversight or supervision. Also, Psychiatric, Pediatric and FNPs are involved in the spectrum of Autism Care. <p>In addition, the Nursing Commission takes issue with the use of the term “Midlevel Practitioner” and its reference “who has been trained by and works under the tutelage of a specialist (MD, PhD, Psychologist.” The HCA declined the changes that NCQAC recommended so the following actions will be taken:</p> <ul style="list-style-type: none"> ○ Meeting with Lin Payton who is the ABA program manager for HCA. She is the lead on this rule and is currently on vacation and due to return August 20, 2015. ○ Engage AANP and Louise Kaplan, PhD to address this outdated and limited draft rule. ○ Encourage all interested parties to attend the public hearing on September 8, 2015 at 10am at the HCA. The address is Health Care Authority, 626 8th Ave SE, Olympia, WA 98501. ○ Place this item on the NCQAC Business meeting agenda on September 11, 2015. <ul style="list-style-type: none"> • Dan Simonson made a motion to recommend to the Nursing Commission the section in WAC 182-531-A-0800 to eliminate the term “Mid-Level Provider.” Sub-committee would recommend the language be changed to “Non-Physician Provider.” • Sub-committee is recommending that the language in the rule be updated, as it is out of date. Sub-committee is also requesting to see the Federal rules. • Sub-committee agreed to use any and all available resources to get the language changed to reflect ARNP current scope of practice as outlined in the WACS.
IV.	<p>2015-2017 Strategic Plan Draft – Advanced Nursing Practice</p> <ul style="list-style-type: none"> • Sub-committee discussed the strategic plan. The objectives of the Nursing Commission are to align ARNP Nursing laws and rules with the NCSBN Consensus Model. The first objective reviewed and discussed was to change the legal designation for all ARNPs to APRNs (Advanced Practice Registered Nurse). A project plan was presented to have 90 day periods in which to move this goal forward with an evaluation and review at the end of each 90 day period to assess progress toward this goal. • The second and more challenging objective is to attain implementation of the APRN Nurse Compact to align with the APRN Consensus Model. This will be done in small steps and involve multiple areas of input and expertise to move forward. • The ARNP Subcommittee supports and approves of the Strategic Plan as outlined.
V.	<p>Agenda Items for the Next Sub-Committee meeting</p> <ul style="list-style-type: none"> • Sanction Guidelines • Update on ABA Applied Analysis – and outcome • Update on the September 11, 2015 NCQAC business meeting – Laurie and Donna • Review of CNS Preceptor Evaluation of Core Competencies Draft
VI.	<p>Adjourned – 7:35 PM</p> <p style="text-align: center;">NCQAC Business Meeting November 13, 2015</p>



Nursing Care Quality Assurance Commission (NCQAC)
Advanced Practice Sub-committee Minutes
September 16, 2015 7:00 PM to 8:00 PM
Town Center 2, Room 140
111 Israel Rd SE, Tumwater, WA 98501

Committee Members Present: Laurie Soine, PhD, ARNP, **Chair**
 Dan Simonson, CRNA, MHPA
 Heather Bradford, CNM, ARNP, FACNM
 Heather Schoonover, MN, RN, PHCNS-BC
Absent: Donna Poole, MSN, ARNP, PMHCNS-BC

Public Attendees: Melissa Johnson, Lobbyist, WSNA
 Leslie Emerick, Lobbyist, AAPPN
 Mary Moller, Associate Professor, Pacific Lutheran University

Staff: Willie O. Hunt, WHNP-BC, ARNP, MS, Advanced Practice Advisor
 Jean Wheat, Nurse Practice Administrative Assistant

I.	7:00 PM Opening – Laurie Soine, Chair
II.	Call to Order <ul style="list-style-type: none"> • The public disclosure statement was read. • Introductions made. Laurie Soine welcomed aboard Heather Bradford and Heather Schoonover. • Announcements – None. • Review of August 11, 2015 special meeting minutes of the Advanced Practice Sub-committee were recommended to the Nursing Commission for approval.
III.	Review/Update of September 11, 2015 NCQAC Business Meeting <ul style="list-style-type: none"> • Laurie Soine provided highlights from the NCQAC Business Meeting. • Laurie Soine announced the Nursing Care Quality Assurance Commission was awarded the NCSBN Regulatory Achievement Award in Chicago back in August 2015. • Laurie Soine spoke about the lunch Education Session on the RN and APRN Compact. Paula Meyer had invited a law professor to come in from Lewis and Clark to speak about the history of Compacts in the United States. Laurie Soine provided the link: http://www.doh.wa.gov/Portals/1/Documents/Mtgs/2015/AG-NCQAC.pdf, if interested to look at the presentation. (They are book marked IX.1 and IX.2).

IV.	<p>Update on Health Care Authority Rule Revision Draft: WAC 182-531-A 0800 – Applied Behavior Analysis (ABA) Provider Requirement</p> <ul style="list-style-type: none"> Willie Hunt discussed the rule on Applied Behavior Analysis which was heard on September 8, 2015 at the Health Care Authority’s Public Health Department. All changes and edits to the WACs were accepted and approved. Willie Hunt thanked HCA, AANP, Louise Kaplan PhD, Leslie Emerick, and ARNP subcommittee members in helping to create a law which reflects the independent practice of ARNPs. The Advanced Practice Sub-committee does not require any further action at this time.
V.	<p>ARNP Sanction Guidelines</p> <ul style="list-style-type: none"> Laurie Soine gave a little history on the ARNP Sanction Guidelines. The guidelines were adopted by the Commission at the March 2011 meeting. The Sub-committee made recommendations to change a few items in the document. Laurie Soine proposed language be added to include continuing education from PACE. She also recommended that PACE be removed as a clinical assessment option for ARNPs. No motion, minor edits will be made by Willie Hunt who will submit for final approval.
VI.	<p>Advanced Practice Registered Nurse (ARNP) Supervised Practice Requirements</p> <ul style="list-style-type: none"> The CNS work group has been working on making this a standard document for use in documenting clinical hours for ARNP applicants who cannot demonstrate that they meet the 250 practice requirement per WAC 246-840-360. This revised document will include CNS-ARNPs if the CNS inclusion rule is passed. After a brief period of review and comments it was decided that the CNS work group will continue to meet to work on this draft.
VII.	<p>ARNP Licensing Exemption Request</p> <ul style="list-style-type: none"> None
VIII.	<p>Review resumes for the Expert Witness Panel</p> <ul style="list-style-type: none"> None
IX.	<p>Agenda Items for the Next Sub-Committee meeting on October 21, 2015</p> <ul style="list-style-type: none"> Compact discussion/update – Donna Poole Seclusion and Restraint Update - All
X.	<p>Open microphone</p> <ul style="list-style-type: none"> Leslie Emerick – Special thank you to Willie Hunt for her assistance on the Authority Rule Revision Draft: WAC 182-531-A 0800 – Applied Behavior Analysis (ABA) Provider Requirement.
XI.	<p>Adjourned – 7:45 PM</p>



**Nursing Care Quality Assurance Commission (NCQAC)
Discipline Sub-committee Minutes
July 28, 2015 3:30 pm to 5:30 pm
Town Center 2, Room 112
111 Israel Rd SE, Tumwater, WA 98501**

Committee Members: Gene Pingle, BSN-BC, CEN, RN, Chair
Jeannie Eylar, MSN, RN – Excused
Lois Hoell, MS, MBA, RN - Excused
Suellyn Masek, MSN, RN, CNOR - Excused
Tracy Rude, LPN
Cass Tang, PMP, Public Member

Staff: Mary Dale, Discipline Manager
Catherine Woodard, Associate Director of Discipline
Karl Hoehn, Supervising Staff Attorney
Shari Kincy, Administrative Assistant - Excused
Debbie Carlson, Practice Manager, ad hoc

I. 3:30 pm Opening — Gene Pingle, Chair

- Call to order – digital recording announcement
- Roll call

II. June Minutes – Gene

Consensus was to add the June minutes to the NCQAC agenda for approval.

III. Nurse Licensure Compact – Cass

Cass gave an update from the NLC task group. A meeting was held on July 27 to discuss concerns from WSNA and SEU 1199 on the NLC. Concerns were listed, and explained by the members attending. They want to focus on higher priority concerns, not the NLC. Staff described issues that could be resolved by the compact and clarified some misperceptions. All agreed it was an excellent first step, and beginning of a collaborative relationship. Additional meetings will be scheduled. The commission will conduct a survey of nurses, and WSNA and 1199 will provide input.

IV. Investigation Report – Catherine

Catherine reviewed the quarterly update from investigations. Investigations completed within timelines was at 73%, slightly below the target. Catherine was asked to separate “theft” from the “other” category of cases.

V. Discipline Strategic Plan – Mary

The subcommittee reviewed the suggestions from the July 9 workshop, and the CORE Effective Practices (agenda item VIII).

DECISION: Three goals for the subcommittee are:

- Data collection for licensees who are disciplined.
- SIM: Train the trainer (from education topics).
- Ensure probation does not start until the nurse has returned to nursing practice.

Mary will add these goals to the form for the September NCQAC meeting.

VI. Just Culture – Mary

Mary presented the final document with edits per the June discussion.

DECISION: Mary will add the date and identifying information into the document.

This chart will be shared with the commission at the September commission meeting.

VII. Performance Measures – Tracy

Third quarter, FY2015. Tracy noted the measures were presented at the last commission meeting.

VIII. CORE Effective Practices – Mary

Mary presented a chart outlining the CORE effective practices. Of twenty six practices, only five are not used in Washington. The subcommittee did not agree with four of the practices for Washington, and the fifth will be added to the Discipline Strategic Plan.

DECISION: Add “Ensure probation does not run until a nurse has returned to nursing practice” to the Discipline Strategic Plan.

IX. Draft Language for Evaluative Data – Margaret/Tracy

Template language for STIDs and orders were discussed. An example from a STID that explained exactly what was required for the report was included in the packet. The evaluative data should be used for both written reports and for educational course reviews. This would not be a policy or procedure, but a tool to be included in the mentor manual.

DECISION: Karl, Tracy, and Adena Nolet (compliance officer) will put together a document for the August subcommittee meeting.

X. Non-payment of fines/cost recovery by licensees – Gene/Karl

The subcommittee discussed the amount of fines/cost recovery received in a year, and compared to the amount sent to collections.

DECISION: The subcommittee will take this off their work plan and not consider the issue further.

XI. Early Remediation Program – Gene/Karl

The changes to procedure A34 Early Remediation Program were reviewed.

DECISION: The procedure will be on the September commission meeting agenda for adoption. Mary will write the motion.

XII. Procedure A24 Approval of Evaluators in Nurse Discipline Cases - Karl

Karl reviewed the issue and information received from Donna Poole, ARNP member. Donna also made proposed changes to this procedure.

DECISION: Karl will bring a recommendation to the August meeting.

XIII. Background Checks – Lois/Catherine

Recent news articles say that some conviction information is not submitted to the Washington State Patrol (WSP). The commission gets their conviction data from WSP, so there is concern we may be missing information. This issue is not in our control.

DECISION: Ask the Nurse Consultants to discuss this in their presentations. Gene will write a newsletter article. Karl will send references to Gene; Mary will get the due date for the newsletter.

XIV. Refresher Course Following Suspension – Gene

Deferred to August meeting.

XV. Work Plan – Gene

XVI. Closing 5:32 p.m.

DRAFT



**Nursing Care Quality Assurance Commission (NCQAC)
Discipline Sub-committee Minutes
August 25, 2015 3:30 pm to 5:30 pm
Conference Call
111 Israel Rd SE, Tumwater, WA 98501**

Committee Members: Gene Pingle, BSN-BC, CEN, RN, Chair
Jeannie Eylar, MSN, RN (excused)
Lois Hoell, MS, MBA, RN
Suellyn Masek, MSN, RN, CNOR (Absent)
Tracy Rude, LPN
Cass Tang, PMP, Public Member (Absent)

Staff: Mary Dale, Discipline Manager
Catherine Woodard, Associate Director of Discipline
Karl Hoehn, Legal Manager
Shari Kincy, Administrative Assistant (Excused)
Debbie Carlson, Practice Manager, ad hoc

I. 3:30 pm Opening — Gene Pingle, Chair

- Call to order – digital recording announcement
- Roll call

II. July Minutes – Gene

The July minutes were reviewed.

DECISION: Consensus was to add the July minutes to the November NCQAC agenda for approval.

III. Nurse Licensure Compact – Tracy

There was no new information from the task group.

IV. Performance Measures – Tracy

The performance measures from the fourth quarter, FY2015, show an improvement over the third quarter. This was expected, as transitions in the organization were completed.

V. Draft Language for Evaluative Data – Tracy

Template language for STIDs and orders requiring educational courses was reviewed. The draft language states specifically what is to be included in course summaries when educational courses are required.

Language was also drafted to address licensees who have orders that include employment terms, but the nurse is not employed. Currently, over one third of nurses with this requirement are not employed, and may complete their probation without ever working under the restrictions. This template language would ensure probation is not complete without employment.

DECISION: Karl will discuss the draft language with Gail Yu, AAG. This will be presented at the November NCQAC meeting. Lois will send edits to Karl.

VI. Procedure A24 Approval of Evaluators in Nurse Discipline Cases - Karl

Changes to the procedure were discussed.

DECISION: The final document will be reviewed at the September subcommittee meeting, then added to the November NCQAC meeting for adoption.

VII. Refresher Course Following Suspension – Gene

It was determined we would have to have a legislative change to require this. The topic has been dropped.

VIII. Discipline Strategic Plan – Mary

The subcommittee reviewed the draft goals and objectives. This document will be on the September NCQAC agenda for discussion. For goal D1, it was suggested we get a graduate student to address this as a research project. Goal D2 may need to be addressed in conjunction with education, as many schools are using them. We may need to contract with the schools, or require nurses with orders for practice evaluation, to use them. There are some out-of-state programs for practice issues, but they are expensive. Another concern is what happens if the nurse fails the simulator testing.

ACTION: Discuss this possibility with CNEWS; get information from NCSBN, Discipline Knowledge Network and contact states directly. Lois will send the video on simulation to the subcommittee members.

IX. CMT Review – Mary

Mary presented the fiscal year 2015 statistics for Case Management. The number of complaints received remains consistent, but less cases were opened for investigation. This year 33% were opened; last year 42% were opened.

X. Work Plan – Gene

XI. Closing 4:42 p.m.



**Nursing Care Quality Assurance Commission (NCQAC)
Consistent Standards of Practice Sub-committee Minutes
September 1, 2015 12:00 PM to 1:00 PM**

Committee Members: Charlotte Foster, BSN, MHA, RN, **Chair**
Tracy Rude, LPN
Laura Yockey, RN, Pro Tem
Tiffany Randich, LPN
Helen E. Myrick, Public Member

Staff: Deborah Carlson, MSN, RN, Associate Director - Nursing Practice
Jean Wheat, Nursing Practice Administrative Assistant

I. 12:05 PM Opening – Charlotte Foster, Chair

- Call to order and roll call

Attendees: Charlotte Foster, Tracy Rude, Laura Yockey, Tiffany Randich, Helen Myrick, Deborah Carlson

- Introductions.

II. Nursing Scope of Practice for Prevention and Treatment of Opioid-Related Overdoses

- Advisory Opinion Draft.
- Frequently Asked Questions Draft.
 - Review and discussion of draft documents. Debbie Carlson is in process of getting additional stakeholder input especially from those that have already implemented these programs. Decision made to have a final draft of the advisory opinion and frequently asked questions based on stakeholder feedback for review by the Sub-committee at the Consistent Standards of Practice Sub-committee meeting October 6, 2015.

III. Camp Nursing Issue

- Review and discussion of the advisory opinion recommendations to have a written authorization from the health care provider along with parent authorization for the camp nurse to give medications. Discussion included feedback that stated it may be somewhat confusing as to what is considered a “valid order”. Decision made not to make any recommended changes at this time; instructed staff to contact camp nurses and/or camp organizations for guidelines. Debbie Carlson will contact the parent and provide an update of the decision.

IV. Closing

- Meeting adjourned at 12:36 p.m.



**Nursing Care Quality Assurance Commission (NCQAC)
Consistent Standards of Practice Sub-committee Minutes
October 6, 2015 12:00 PM to 1:00 PM**

Committee Members: Charlotte Foster, BSN, MHA, RN, **Chair**
Tracy Rude, LPN
Laura Yockey, RN, Pro Tem
Tiffany Randich, LPN
Helen E. Myrick, Public Member

Staff: Deborah Carlson, MSN, RN, Associate Director - Nursing Practice
Jean Wheat, Nursing Practice Administrative Assistant

I. 12:00 PM Opening – Charlotte Foster, Chair

- Call to order and roll call; **Note:** Started at 12:09 p.m. - technical difficulties, this required reconnecting some attendees.
- Introductions.

II. Nursing Commission Business Meeting Update

- Deferred until December meeting.

III. Nursing Scope of Practice for Prevention and Treatment of Opioid-Related Overdoses

- Advisory Opinion Draft.
- Frequently Asked Questions Draft.
 - After discussion and opportunity for comments, the members agreed to send the Advisory Opinion and Frequently Asked Questions drafts to the Advanced Practice Sub-committee (APSC) in October for their input and comments. This step will delay including this in the Nursing Commission business meeting for November because of packet deadlines. Debbie Carlson informed the Sub-committee members that the Washington State Department of Health has some activities related to ESHB 1671 (Opioid Overdose Legislation) with a communication plan and model protocol in development. The Sub-committee granted permission to add resources if they are finalized prior to commission approval. The drafts will be brought back to the Consistent Standards of Practice Sub-committee if the Advanced Practice Sub-committee recommends significant changes. If there are no significant changes to the documents, the Consistent Standards of Practice Sub-committee recommends including on the January Nursing Commission business meeting agenda.

IV. Closing

- Announcements:
 - The Washington State Nursing Care Quality Assurance Commission received the National Council State Boards of Nursing Regulatory Achievement Award in August 2015.
 - The Nursing Commission received approval from the Washington State Nurses Association (WSNA) Continuing Education Approval and Recognition Program as an Educational Activity Provider Unit. This allows the Provider Unit to issue formal continuing nursing education hours through WSNA.
- Meeting adjourned at 1:00 p.m.

DRAFT



**Nursing Care Quality Assurance Commission (NCQAC)
Licensing Subcommittee Draft Minutes
August 28th, 2015
111 Israel Rd SE, Room 115
Tumwater, WA**

- Committee Members:** Lois Hoell, MS, MBA, RN, Chair
Margaret E Kelly, LPN, Commission Chair
Jeannie Eylar, MSN, RN
- Staff:** Teresa Corrado, LPN, Licensing Manager
Thomas Bolender, Continuing Competency Auditor
Becky Cebula, Continuing Competency Auditor
Shari Kincy, Administrative Assistant
Linda Patterson, BSN, RN, Nursing Practice Consultant
Sara Kirschenman, Staff Attorney
- Absent:** Stephen Henderson, JD, MA
Sally Watkins, RN, Franciscan Health System
- Public Present:** Karen Greenwalt, RN, Parish Nurse

I. 9:30 AM Opening - Lois Hoell, MS, MBA, RN, Sub-committee Chair

- Roll call
 - Completed
- Called to order at 9:35 AM

II. Minutes

- May
 - Approved
- June
 - Approved

III. Discuss Strategic Plan

- Line item number 1 – Have license available for download.
 - Teresa suggested this be removed from the plan. It goes against policies already in place. Paper license is available for a fee.
 - Committee agreed to remove
- Line item number 2 – Take ownership (licensing, discipline) of all nurse aides.
 - Jeannie mentioned this was added to the strategic plan, but it is an extremely complicated process. It is a long reaching goal and other subcommittees have removed it from their plan.
 - Committee agreed to remove.

- Line item number 3 – Ability to track individual nursing education level across state. Minimum data set implementation? Better data collection at time of renewal, e.g. education level, practice area, etc.
 - The National Council of State Boards of Nursing has a minimum data set survey on their website.
 - Teresa and Dr. Mindy Schaffner are working to get links put on our website to steer nurses to take the survey. Hopefully, it will be completed within the next several weeks.
- Line item number 4 – Bring MA’s under the nursing WAC/RCWs
 - The committee members felt this is the same situation as line item 2, which requires a lot of work and coordination. Recommended to remove for the plan.
 - Committee agreed to remove.
- Line item number 5 – Closer partnership with education and practice professional organizations, NWONE and CNEWS with annual retreat.
 - The committee felt it is important to have close partnerships, but it is not a licensing issue.
 - Committee agreed to remove.
- Line item number 6 – Create “retired active” category for ARNPs.
- Teresa said WAC 246-12-120 gives the Commission the ability to do so and it would only take a rule update.
 - Teresa said the Commission would either need to work with each certifying body to determine what their requirements for renewal are, or for each ARNP to determine if they can meet the requirements while being able to work no more than 90 days per year.
 - Margaret asked that the ARNP subcommittee be consulted on the issue.
- Line item number 7 – License renewal every 2 years – LPN, RN and ARNP (and continuing competency audit cycle).
 - Teresa said the commission does have the authority to make the change.
 - It is not as easy as just changing the dates as it will affect the Commission’s annual budget, HEAL-WA and the Washington Center for Nursing. In addition, the competency rules would also have to be changed to reflect a 2 year cycle.
- Line item number 8 – FBI background checks for all new licenses and in 5 years, FBI BGC of all nurses.
 - Teresa mentioned this is already underway.
 - It was brought to the legislature this year, but was unsuccessful.
 - The plan is to re-submit the legislation again.
- Line item number 9 – Implement Enhanced Compact.
 - There was discussion on whether this should be on licensing’s plan.
 - Teresa said it is a higher level goal a Commission task force. NCSBN will be helping financially in support of this effort.
 - Committee agreed it should be kept on the plan
- Line item number 10 – WA nursing jurisprudence exam with relicensing.
 - Teresa said NCSBN is currently working with nursing boards to create a jurisprudence exam.
 - The learning management system (LMS) used by DOH may be able to (((accommodate this through our website.
- Licensing will keep working on this

IV. Rules

- 177-15 Audits
 - Teresa discussed how she, the attorney general's office and Karl Hoehn have come to the conclusion that by not letting a person who fails a 177-15 audit renew, they are not being given due process.
 - They came up with a plan to refer a person over to discipline when the nurse doesn't meet the requirements of the audit.
 - Teresa will email everyone a clean copy of the updated draft rules
- Reactivation applications
 - Teresa talked about giving applicants who have been working in another state the ability to prove 531 practice hours and 45 hours of continuing education instead of entering into the 177-15 agreement. The applicant would be required to provide proof of having met the standards.

V. Audit Progress

- Tom went over graphs
 - Tom talked about the number of random and late audits becoming more consistent from last year.
 - Tom went over graphs showing the number of Retired Active and Inactive licenses are starting to plateau. He thought it will stay stable until 2017 when another large number of nurses will be audited.

VI. Meeting Dates & Time

- Lois suggested we change the meeting day to the fourth Friday of the month to accommodate Margaret's schedule.
 - The committee agreed to the change effective in Sept.
 - The time will remain 9:30A to 11:30A.

VII. Agenda Update

- Margaret asked for an agenda item to be added to the subcommittee meeting taking place after the Commission business meetings. It will be about a 5 minutes review of anything brought up at the meeting relating to Licensing.
- All were in agreement.

VIII. Closing

- Meeting adjourned 10:42 a.m.

**NCSBN
NCLEX Conference
September 21, 2015, Portland, Oregon
Rhonda Taylor**

PURPOSE: The annual NCLEX conference is an opportunity for the NCSBN staff and members to inform and engage an audience of nursing educators, regulators, and vendors regarding the NCLEX exam. I was one of the presenters. I spoke about the new tool for assessing clinical judgement in working with newly licensed nurses and nursing students. I also spoke about using the NCSBN/Mountain Measurement Program Reports. Lastly, I participated on a panel for Q and A as well as FAQ's.

OUTCOME: This day long workshop was sold out with a waiting list. The evaluations from participants were very positive. Many who had attended last year said it was even better this year.

RECOMMENDATION: I highly recommend this workshop to all educators and regulators of nursing.

**National Council of State Boards of Nursing (NCSBN)
NCLEX® 2015
September 21, 2015, Portland Marriott Downtown Waterfront, Portland, Oregon
Kathy Moisio**

PURPOSE:

For NCSBN, the purpose of this educational conference was to present NCLEX® program information and updates and respond to participant questions regarding the NCLEX®. Key experts responsible for developing and administering the NCLEX® presented program information.

For NCQAC, the purpose of having a staff member from the Education Unit attend the conference was for the staff member to (1) learn as much as possible about the NCLEX® for application in work related to nursing education programs; and (2) share conference information with commission members, commission staff, and nursing education programs.

OUTCOME:

The conference provided education on the following topics:

- Processes to assure that the NCLEX® is fair, comprehensive, reflecting current practice at the entry level, and legally defensible:
 - ✓ Development: Involves conducting a practice analysis, building basic and detailed test plans, writing test items, and implementing a multi-layered review process (content, bias, style, regulatory, and final reviews)
 - ✓ Maintenance: Includes quarterly pool rotation, item review prior to pool deployment, and assuring content currency with the ability to remove items from the pool when an immediate change in practice warrants
 - ✓ Measurement: Includes steps to assure that the NCLEX® is measuring what it intends to measure (for example, readability testing, statistical testing and analysis of items as pre-test items before use in scoring, and computerized adaptive testing [CAT] to target each test-taker's ability level)

- An introduction to “logit,” the unit of measure used to report the relative difference between the candidate's ability estimate and item difficulty.

- An overview of NCLEX[®] administration which involves participation from NCSBN, Pearson Vue, and Boards of Nursing (BONs) and key steps and processes that must occur before, during, and after testing. The presentation addressed everything from applying for eligibility to take the exam and registration requirements to rules and procedures that apply during the test to how results are scored and released to test-takers.

- An NCLEX[®] Question and Answer Period that included the following highlights:
 - ✓ NCSBN does survey textbooks that are being used by schools. On average, the textbooks are written at a higher reading level (Lexile score) than the NCLEX[®]
 - ✓ BONs approve test accommodations, which vary across states. NCSBN may reject or offer another alternative if accommodations change the test
 - ✓ The new passing standard for 2016 will be made public in mid-December
 - ✓ There is no revision for 2016 in how Bloom’s taxonomy will be applied
 - ✓ Calculation questions that involve “rounding,” clearly indicate the rounding cut point test-takers should use
 - ✓ The test includes generic names for drugs, not brand names

- A Cognitive Model on Nursing Decision-Making explored cognitive psychology theories on decision-making processes and how they relate to nurses’ clinical decision-making. The presentation highlighted the characteristics of the entry-level nurse with regards to decision-making and provided a framework that is useful in educational and clinical settings.

- How Education Programs Can Use NCLEX[®] Program Reports. The presentation discussed the timing of report distribution and four key sub-reports:
 - ✓ Summary Overview Report
 - ✓ Test Plan Report
 - ✓ Content Dimension Report
 - ✓ Test Duration/Test Plan Performance Report

The reports allow education programs to analyze how their graduates compare with graduates from similar programs regionally and nationally and across

different dimensions of the test; they can be used to guide curriculum updates and revisions.

- An Overview of the Practice Analysis Process, which occurs in 3-year cycles to assure test currency regarding practice at the entry level of nursing. The presentation discussed the Practice Analysis process in detail and reviewed highlights of the 2011-2014 analysis, comparing it to the previous analysis. Findings revealed stability between the analyses overall, so the test plan remains unchanged for 2016.

RECOMMENDATION:

- Commission members and supporting staff who are interested in more detail can access all conference Powerpoints at: <https://www.ncsbn.org/7103.htm>
- When communicating with schools and other interested parties, staff from the Education Unit can provide key information from the conference, the link to the conference slides, and the link to view the detailed test plan in December 2015 (no release date specified): <https://www.ncsbn.org/1287.htm>

Federation of Associations of Regulatory Boards (FARB)
2015 Regulatory Law Seminar
October 1-4, 2015 Denver, CO
Sara Kirschenman and Miranda Bayne

PURPOSE:

The FARB Regulatory Law Seminar provides an in-depth analysis of current legal issues impacting regulatory boards. It's unique in its focus on jurisprudence across jurisdictions and the opportunity it provides to address attorneys representing regulatory boards through the U.S.

OUTCOME:

We received valuable information on legal trends affecting professional licensing boards nationwide and new approaches to emerging challenges. The conference also thoroughly examined the potential impact of the *North Carolina State Board of Dental Examiners v. FTC* U.S. Supreme Court case on regulatory board decision-making.

In the *NC* case, the U.S. Supreme Court ruled that the NC Board of Dental Examiners violated federal antitrust laws by preventing non-dentists from providing teeth whitening services in competition with dentists. The NC Board is completely independent with no state agency oversight and is controlled by dentists, which presents a problem from an antitrust perspective. There was much useful discussion at the conference about how to protect regulatory boards from similar claims. This case represents a sea change in how much independent power certain boards can claim. Nevertheless, we left feeling that NCQAC is well protected from these concerns given its current position with DOH as an umbrella agency, and given the Secretary's jurisdiction over unlicensed practice. Updates on case law and new legislative approaches from around the nation also gave good perspective, and ideas on some innovative approaches to the ongoing challenges faced by regulatory boards.

We left the conference confident that the Department of Health and NCQAC are ahead of many other states in terms of our regulatory structure and disciplinary best practices. We did gain valuable insights into potential pitfalls to avoid in our regulatory and disciplinary practice.

We also networked with attorneys for other nursing boards (and NCSBN). These connections are valuable as we review our practices and seek input from other states.

RECOMMENDATION:

This is a valuable conference, and we recommend sending staff to attend next year.

**The American Academy of Nurse Attorneys
34th Annual Meeting and Educational Conference
September 30- October 4, 2015
Philadelphia, PA
Margaret C. Holm**

The purpose of the annual conference is to promote The American Association of Nurse Attorneys mission. The mission provides resources, education and leadership to its members and the healthcare and legal communities.

The Association promotes the profession of nurse attorney, provides educational programs to its members and the public. The association strives to enhance communication, collaboration and leadership among its members and serves as a resource.

This year's topics included the following:

Political Action: Blue Print for Action on Behalf of Nurses

Regulatory and Policy Curriculum for Baccalaureate Nursing Students

Just Culture: Second Victimization and Clinician Support: An Educational/Awareness Program

Information regarding the Institute of Safe Medicines Practices – The Expert Witness

The Changing World of Health Care

Tele Health and Risk Management

Exploring Federal and State Regulatory Approaches to Achieve Patient Safety through Safe Nursing Staffing

Professional Licensure issues and the Collective Bargaining Agreement.

I learned a great deal from the conference regarding the utilization of the nurse attorney in a variety of settings. The collaborative atmosphere promoted concepts of professionalism in the nursing field. I learned various regulatory structures that promote public safety in relation to the field of nursing. An exchange of ideas was helpful in the “Just Culture” and application in Alternatives to Discipline.

The Conference was helpful as I was able to reach out to other nurse attorneys working in the regulatory and education arena. The program broadened my perspective and I believe will enhance my work for the Nursing Commission.

I hope to attend again if the program's agenda is tailored to the regulation of the profession.

**Federation of State Medical Boards (FSMB)
National Association of Boards of Pharmacy (NABP)
National Council of State Boards of Nursing (NCSBN)
The Tri-Regulator Symposium
October 6-7, 2015 Arlington VA
Paula R. Meyer, MSN, RN, FRE**

PURPOSE: The FSMB, NABP and NCSBN host this meeting and present topics impacting all three health profession regulatory bodies. This year's symposium topics centered on team based care and the unique challenges this presents for regulatory bodies. Dr. Leonard Marcus presented on Swarm philosophy. Dr. Marcus was the facilitator for the NCSBN's executive officers and assisted in the revision of the Nurse Licensure and Advanced Practice Compacts. Other sessions included ethical communications and the North Carolina Board of Dentistry Supreme Court decision related to restraint of trade.

OUTCOME: The presentation on regulation of team based practice models presented new information. In practice settings, and education, team based models are currently being introduced and appear to be working for improved patient care. Dr. Teddie Potter, PhD, RN, University of Minnesota, stated there must be a culture where teams thrive and this depends on management. Dr. Potter gave several examples of separated professions: break rooms, cafeterias. Dr. Potter emphasized the sharing of responsibility by the team and no blame. Dr. Potter also emphasized the need to invest time to build the models - - and this is a wise investment in the end. Susan Ksiazek, RPh, stated that teams need to focus on 'power with' rather than 'power over' the members of the team. Team members need to share and be partners in the care and outcomes. Dr. Ksiazek stated:

1. All members on the team are accountable for the outcome
2. All members on the team must trust each other and respect each other
3. Communication among team members is critical and there cannot be an authority gradient: the youngest or least senior of the team afraid to speak up
4. Managing differences of opinion

Professional regulatory boards need to work together on scope of practice issues and joint discipline.

RECOMMENDATION: In Washington, within the Department of Health, we have several examples of work among boards and commissions:

1. Chronic non-cancer pain management rules
2. The Advanced Practice Rules that lifted the collaborative agreements required a joint rule making process with the Nursing Commission, the Medical Commission, the Board of Osteopathic Medicine and Surgeons and the Board of Pharmacy
3. Discipline cases are shared when the professional has more than one license: licensed midwife and naturopath.

I recommend at least one member of the Nursing Commission or executive director continue to attend this conference.



***HEALTH
PROFESSIONS
DISCIPLINE AND
REGULATORY
ACTIVITIES***

2013-15

***Uniform
Disciplinary Act
Biennial Report***



***Health Systems
Quality Assurance
Division***

October 2015



***HEALTH
PROFESSIONS
DISCIPLINE AND
REGULATORY
ACTIVITIES***

2013-15

***Uniform
Disciplinary Act
Biennial Report***

***For more information or additional
copies of this report contact:***

***Office of Health Professions and Facilities
P.O. Box 47860
Olympia, WA 98504-7860
360-236-4996
FAX 360-753-0657***

***For general assistance call:
Customer Service Center
(360) 236-4700***

***John Wiesman, DrPH, MPH
Secretary of Health***



DRAFT

Contents

Introductory Summary	6
Health Systems Quality Assurance Division	6
2013-15 Biennium: Disciplinary Activity and Trends	7
Complaints and Discipline	7
Case Disposition	7
Common Violations of the Law	8
Unlicensed Practice	9
Criminal Background Checks	10
Notices of Decision	11
2013-15 Uniform Disciplinary Act Report	12
Complaint Investigation, Closure, and Case Resolution	12
Percentage of Investigations Completed	15
Cite and Fine Authority	18
Sexual Misconduct Cases	18
Complaints Closed Prior to Disciplinary Action	19
Percentage of Complaints Closed	21
Complaint Resolutions after Adjudicative Proceedings	24
Percentage of Disciplinary Actions	27
Unlicensed Practice Closures and Resolutions	30
Uniform Disciplinary Act Violations	33
Frequent Violations	33
Sanctions Imposed	33
Sanctions Schedule	34
Case Appeals Activity	37
Alternatives to Discipline	38
Case Distribution to Investigators and Staff Attorneys	38
Biennial Comparison	39
Complaints Received	39
Investigations	40
Complaint Closures before Adjudicative Proceedings	40
Complaint Closures after Adjudicative Proceedings	41

Criminal Background Checks	42
Board and Commission Supplemental Reports	46
Reviewing the Disciplinary Graphs	46
Chiropractic Quality Assurance Commission.....	Error! Bookmark not defined.
Dental Quality Assurance Commission	49
Board of Denturists	53
Board of Hearing and Speech	55
Board of Massage	57
Medical Quality Assurance Commission	59
Nursing Care Quality Assurance Commission	64
Board of Nursing Home Administrators.....	66
Board of Occupational Therapy Practice	68
Board of Optometry.....	70
Board of Osteopathic Medicine and Surgery.....	72
Pharmacy Quality Assurance Commission.....	75
Board of Physical Therapy.....	79
Podiatric Medical Board.....	81
Examining Board of Psychology	83
Veterinary Board of Governors.....	85
Appendices.....	87
Appendix A: Definitions.....	88
Appendix B: Licensee Counts by Profession.....	90
Appendix C: Alternative Programs – Chemically Impaired Practitioners.....	93
Appendix D: Distribution of Staff Attorney Workload	95
Appendix E: Distribution of Investigator Workload.....	99

UDA Figures

Figure 1: HSQA Disciplinary Process Flow	8
Figure 2: Complaints and Discipline to Total Healthcare Providers	12
Figure 3: Summary of Case Dispositions and End of Biennium Open Cases	29
Figure 4: Fiscal Years 2013-15 Sanctions Breakdown.....	34
Figure 5: New Complaints Received, 2005-07 to 2013-15 Biennia.....	39
Figure 6: Investigations Completed, 2005-07 to 2013-15 Biennia.....	40
Figure 7: Complaint Closures before Adjudicative Proceedings, 2005-07 to 2013-15 Biennia ..	40
Figure 8: Complaint Closures after Adjudicative Proceedings, 2005-07 to 2013-15 Biennia	41

UDA Tables

Table 1: Secretary and Board/Commission Authority.....	6
Table 2: Most Common Disciplinary Violations.....	8
Table 3: Unlicensed Practice Disciplinary Activity.....	9
Table 4: HSQA Background Check Activity.....	10
Table 5: Investigation Activity by Profession	13
Table 6: Board and Commission Professions - Percentage of Investigations Completed.....	15
Table 7: Secretary Professions - Percentage of Investigations Completed.....	17
Table 8: Complaints Closed Prior to Disciplinary Action	20
Table 9: Board and Commission Complaints Closed Prior to Adjudicative Proceedings.....	22
Table 10: Secretary Professions Complaints Closed Prior to Adjudicative Proceedings.....	23
Table 11: Complaints Resolved after Adjudicative Proceedings	25
Table 12: Board and Commission Professions Complaints Resolved after Adjudicative Proceedings	27
Table 13: Secretary Professions Complaints Resolved after Adjudicative Proceedings	28
Table 14: Unlicensed Practice Closures and Resolutions.....	31
Table 15: Sanctions Imposed by Profession	35
Table 16: Summary of Case Appeals Activity	37
Table 17: HSQA Background Check Activity Summary	42
Table 18: Criminal Background Reports	43

Introductory Summary

Health Systems Quality Assurance Division

The Health Systems Quality Assurance Division (HSQA) of the Department of Health regulates approximately 400,000 health care providers in 83 professions¹.

The department directly regulates 46 health professions. Thirty-seven professions are regulated by 17 boards and commissions². The department works closely with most of these boards and commissions to credential health professionals, investigate complaints, and to take disciplinary action. One board, the Board of Massage, has split authority with the department.³

**Table 1: Secretary and Board/Commission Authority
2013-15 Biennium**

Regulatory Authority	Licensure	Discipline
Secretary of Health	46	48
Boards/Commissions	37	35
Total	83	83

The department also supports the work of the health profession boards and commissions to develop rules and standards of practice that regulate the professions. In addition, it assists the boards and commissions in monitoring healthcare providers' compliance with sanctions.

This report describes regulatory activities for all professions subject to the Uniform Disciplinary Act, including emergency medical services professions. The four emergency services professions are emergency medical technician, first responder, intermediate life support technician, and paramedic.

¹ This count of healthcare professions includes dietitians and nutritionists as a single profession.

² Under 2013 House Bill 1518, the Medical Quality Assurance Commission and Nursing Care Quality Assurance Commission were granted greater authority for most of their credentialing, investigation and discipline functions. The department continues to provide some administrative support to these commissions. HB 1518 also authorized the Chiropractic Quality Assurance Commission to undertake a five-year pilot with similar provisions.

³ While the department has licensing and disciplinary authority for massage practitioners, the Board of Massage has responsibility for evaluating and approving schools and programs of massage, overseeing examinations for massage licensure, establishing continuing education requirements, and determining which other states have substantially equivalent requirements to those of the state of Washington. The board and the department share rulemaking authority for the profession.

The Washington Emergency Medical Services and Trauma Care Steering Committee advises the department about EMS and trauma care needs in the state. The committee reviews the regional medical services and trauma care plans and recommends changes. They also review proposed rules and recommend modifications in rules for EMS and trauma care.⁴

2013-15 Biennium: Disciplinary Activity and Trends

Complaints and Discipline

Most disciplinary activity starts with a complaint from the public, practitioners, facilities, or insurance companies. The department may also open complaints based on media accounts or information from law enforcement. During the last biennium, 19,348 complaints were filed against healthcare providers and 3,911 remained open from fiscal year 2013, representing about five percent of the 427,751 healthcare providers in Washington. Of these complaints, 2,434, or 10 percent, resulted in disciplinary sanctions. In total, less than 1 percent of all regulated health professionals were disciplined during the biennium.

Case Disposition

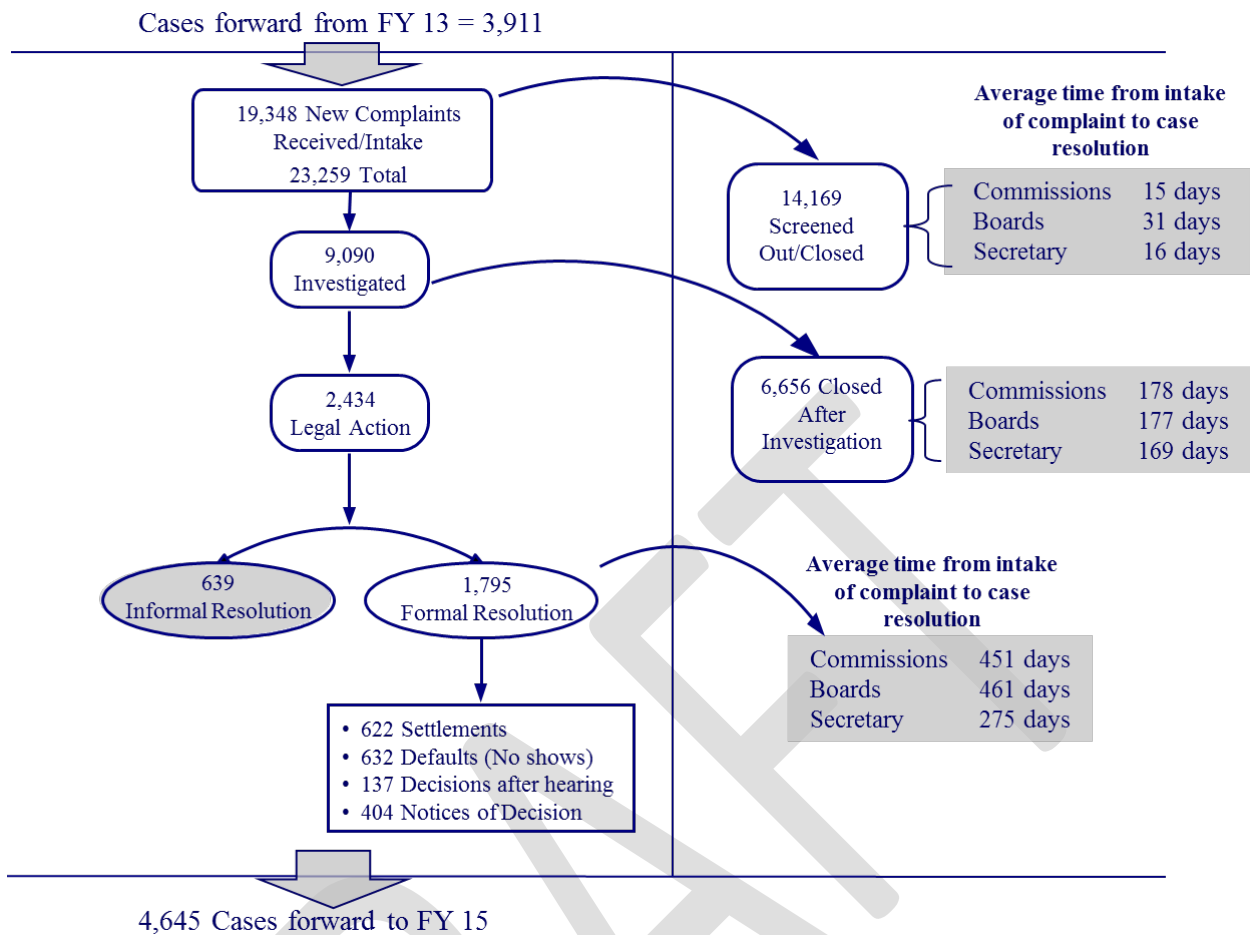
Complaints are resolved when closed without disciplinary action, or after informal or formal disciplinary action is taken. Investigative files and disciplinary documents are public records. Since July 1998, all actions against healthcare provider credentials are available on the Internet⁵. Tables 11, 12, and 13 in the body of the report detail the closure types before and after adjudication. These are broken down by profession and type of disciplining authority (board, commission, or secretary).

Disciplinary actions totaled 2,434 in 2013-2015. About 26 percent of the disciplinary actions were resolved with informal dispositions. Formal resolutions included 26 percent with agreed orders, 26 percent with default orders, and 6 percent with final orders after hearings. The remaining actions involved notices of decision on applications. (See page 11)

The following flow chart maps the disciplinary process, with average length of time from complaint intake through resolution.

⁴ The secretary of health appoints members to the committee as of July 1, 2011. Until then, the governor appointed members.

⁵ Credential records are available through the department's "Provider Credential Search". The URL is: <https://fortress.wa.gov/doh/providercredentialsearch/>.



**Figure 1: HSQA Disciplinary Process Flow
2013-15 Biennium**

Common Violations of the Law

The Uniform Disciplinary Act (UDA) regulates healthcare providers. The disciplining authorities decide whether the healthcare professional has committed unprofessional conduct, whether he or she can continue to practice with reasonable skill and safety, and under what conditions, if any. If practitioners commit crimes not already known to law enforcement, the department may notify the appropriate jurisdiction. UDA violations fell into these five frequently reported categories:

**Table 2: Most Common Disciplinary Violations
2013-15 Biennium**

Type	Percent of Complaints*
Violation of any state or federal statute or administrative rule ⁶	36%
Incompetence, negligence, or malpractice ⁷	25%

⁶ RCW 18.130.180(7)

⁷ RCW 18.130.180(4)

Conviction of a gross misdemeanor or felony relating to the practice of a healthcare profession ⁸	18%
Suspension, revocation, or restriction in another jurisdiction ⁹	18%
Personal drug or alcohol abuse ¹⁰	16%

* Percentage totals exceed 100% due to complaints recorded with multiple violations

Table 15: Sanctions Imposed by Profession contains more information about the frequency of violations and the sanctions imposed, by type and by profession.

Average Legal and Investigative Caseloads

RCW 18.130.310 requires that this report will “summarize the distribution of the number of cases assigned to each attorney and investigator for each profession.” The law further requires that identities of staff attorneys and investigators be kept anonymous. Appendix D: Distribution of Staff Attorney Workload and Appendix E: Distribution of Investigator Workload detail, by health profession identify the average number of cases assigned and worked by the division’s staff attorneys and investigators for the 2013-15 biennium.

Unlicensed Practice

When healthcare that can only be provided by a licensed professional is provided by an unlicensed person, it is called “unlicensed practice.” The secretary is responsible for investigating allegations of unlicensed practice. The Office of Investigation and Inspection manages these complaints. If unlicensed practice is found, the department can issue a cease-and-desist order.

A cease-and-desist order requires the person to stop the unlicensed activity and may impose a fine. Continued unlicensed practice may result in court enforcement of the cease-and-desist order or criminal prosecution. Due to limited resources, the department focuses on those cases alleging the highest potential risk to the public.

There were 1,222 unlicensed practice complaints during the 2013-2015 biennium, an increase of 947 complaints (350 percent) from the 2011-2013 biennium. The complete breakdown is summarized below.

**Table 3: Unlicensed Practice Disciplinary Activity
2013-15 Biennium**

Total Complaints	1,222
Closed No Action Taken Before Investigation	521
Closed No Action Taken After Investigation	403
Cease-and-Desist Order Issued	84
Total Closed	1,008

Table 14: Unlicensed Practice Closures and Resolutions offers a more detailed listing of unlicensed practice by type of profession.

⁸ RCW 18.130.180(17)

⁹ RCW 18.130.180(5)

¹⁰ RCW 18.130.180(6) and (23)

Criminal Background Checks

RCW 18.130.064 allows the department to conduct a criminal history background check on all new applicants and current license holders. The purpose of the statute is to ensure patient safety by identifying those who may not be qualified to practice.

The department opened 701 investigations during the 2013-15 biennium on applicants based on criminal conviction information. Of these applicants, 73 percent disclosed the conviction on the application. Table 18 contains additional details about each profession.

Table 4: HSQA Background Check Activity

Total Applicants	143,435
Applicants with criminal history ¹¹	3,075
Cases opened on applicants with criminal history	701
Applicants who disclosed (% of cases)	513 (73%)
Applicants not disclosing (% of cases)	188 (27%)

Also, as part of this background check process, all new applicants are checked against the National Practitioner Data Bank (NPDB)¹². This resource includes information about actions in other states, including some criminal convictions, to help determine the need for further review.

In addition, since 2009 the department now requires federal fingerprint checks for certain applicants and licensees. The checks are processed through the FBI's Criminal Justice Information Services (CJIS) division. The department focuses on applicants coming from outside of Washington or certain applicants with a criminal history in Washington. During the 2013-15 biennium, the department fingerprint checks resulted in 3,075 reports.

¹¹ A total of 3,075 reports were received, but these reports may contain information unrelated to the application, such as prior applications for concealed weapons permits.

Notices of Decision

Historically, discipline included complaints opened because of an issue found on a license application. Legislation in 2008 changed the process for responding to application issues. For purposes of comparing disciplinary action statistics across biennia, the department has continued to include application cases in our complaint figures.

Common issues with applications include discipline in another state where the applicant is already licensed or problems arising from a background check. Prior to 2008, the disciplinary process would have been to conduct a full investigation, issue a statement of charges, then issue a final or agreed order. Currently, the department would issue a notice of decision indicating that the pending application is denied or granted with conditions.

DRAFT

2013-15 Uniform Disciplinary Act Report

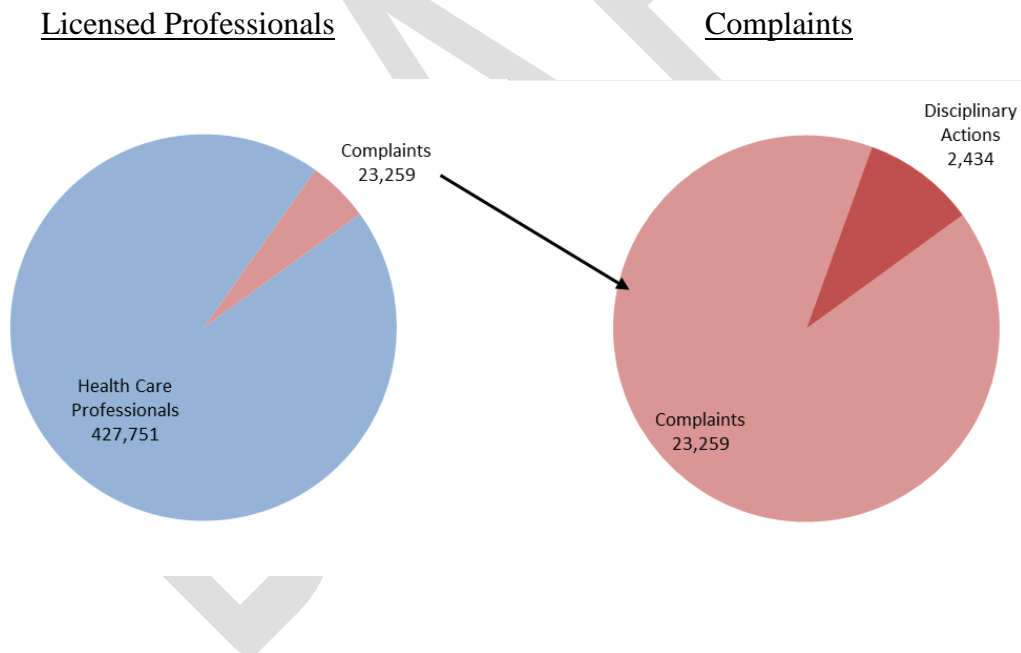
Complaint Investigation, Closure, and Case Resolution

The Uniform Disciplinary Act (UDA), chapter 18.130 RCW, provides standardized processes for discipline of practitioners. It serves as the statutory framework for the regulation of healthcare providers in Washington. This section of the report contains quantitative data on investigations, case closures, and case resolutions involving healthcare providers during the 2013-2015 biennium.

Investigation

The vast majority of healthcare providers never have a complaint filed against them. About five percent of healthcare providers had a complaint against them in the 2013-15 biennium. Of the 23,259 complaints processed during the biennium, about 10 percent, or 2,434, resulted in discipline. When considering all healthcare providers (427,751), less than one percent were disciplined.

**Figure 2: Complaints and Discipline to Total Healthcare Providers
2013-15 Biennium**



During the biennium, HSQA received a total of 19,348 complaints against credentialed healthcare providers and people alleged to be practicing illegally without a license. Included in this total are instances where individual providers received multiple complaints. These new complaints are in addition to 3,911 open complaints carried over from the previous fiscal year. These 23,259 complaints led to over 9,090 investigations.

**Table 5: Investigation Activity by Profession
2013-15 Biennium**

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Investigations Completed	Unlicensed Practice Investigations	Total Investigations
Advanced Emergency Medical Technician	1	4	5	4	0	4
Advanced Registered Nurse Practitioner	76	332	408	134	0	134
Animal Massage Practitioner	1	4	5	0	4	4
Athletic Trainer	2	13	15	4	4	8
Audiologist	1	10	11	0	0	0
Cardiovascular Invasive Specialist	0	1	1	0	0	0
Chemical Dependency Professional	109	316	425	191	6	197
Chemical Dependency Professional Trainee	58	216	274	96	2	98
Chiropractic X-Ray Technician	1	6	7	0	0	0
Chiropractor	150	331	481	217	3	220
Counselor, Agency Affiliated	61	237	298	120	4	124
Counselor, Certified	17	56	73	23	8	31
Counselor, Certified Advisor	1	4	5	1	1	2
Dental Anesthesia Assistant	0	0	0	0	0	0
Dental Assistant	46	126	172	61	13	74
Dental Hygienist	15	54	69	10	5	15
Dentist	178	995	1,173	508	17	525
Denturist	27	55	82	39	0	39
Dietitian/Nutritionist	1	9	10	2	3	5
Dispensing Optician	3	22	25	5	10	15
Dispensing Optician Apprentice	0	2	2	1	0	1
East Asian Medicine Practitioner	15	197	212	23	7	30
Emergency Medical Responder	0	1	1	1	0	1
Emergency Medical Technician	27	110	137	68	0	68
Expanded Function Dental Auxiliary	0	0	0	0	0	0
Genetic Counselor	0	1	1	0	1	1
Health Care Assistant	13	28	41	31	3	34
Hearing Instrument Fitter/Dispenser	4	0	4	3	0	3
Home Care Aide	53	421	474	103	44	147
Humane Society	0	0	0	1	0	1
Hypnotherapist	6	13	19	8	2	10
Licensed Practical Nurse	96	622	718	190	2	192
Marriage and Family Therapist	17	55	72	30	5	35
Marriage and Family Therapist Associate	7	18	25	17	0	17
Massage Practitioner	245	1,144	1,389	279	603	882

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Investigations Completed	Unlicensed Practice Investigations	Total Investigations
Medical Assistant	119	476	595	132	78	210
Mental Health Counselor	66	281	347	151	14	165
Mental Health Counselor Associate	14	55	69	27	2	29
Midwife	18	37	55	26	6	32
Naturopathic Physician	86	114	200	97	13	110
Nursing Assistant	597	5,043	5,640	1,562	54	1,616
Nursing Home Administrator	25	216	241	64	0	64
Nursing Pool Operator	0	3	3	0	0	0
Nursing Technician	0	0	0	0	0	0
Occupational Therapist	21	42	63	21	0	21
Occupational Therapy Assistant	5	33	38	8	0	8
Ocularist	0	0	0	0	0	0
Optometrist	9	57	66	21	5	26
Orthoist/Prosthetist	2	11	13	6	0	6
Osteopathic Physician	76	245	321	135	0	135
Osteopathic Physician Assistant	0	11	11	5	0	5
Paramedic	24	36	60	36	0	36
Pharmacies and Other Pharmaceutical Firms	69	274	343	108	29	137
Pharmacist	142	432	574	266	2	268
Pharmacist Intern	2	11	13	4	0	4
Pharmacy Assistant	38	124	162	61	1	62
Pharmacy Technician	55	106	161	66	3	69
Physical Therapist	27	131	158	54	3	57
Physical Therapist Assistant	12	50	62	17	3	20
Physician	594	2,886	3,480	1,586	44	1,630
Physician Assistant	49	179	228	107	0	107
Podiatric Physician	23	58	81	31	0	31
Psychologist	59	180	239	92	13	105
Radiological Technologist	1	27	28	17	0	17
Radiologist Assistant	0	0	0	0	0	0
Recreational Therapist	0	1	1	0	0	0
Reflexologist	3	18	21	4	9	13
Registered Nurse	408	2,230	2,638	841	13	854
Respiratory Care Practitioner	3	40	43	16	1	17
Retired Volunteer Medical Worker	0	0	0	0	0	0
Sex Offender Treatment Provider	10	29	39	20	0	20
Social Worker Advanced	3	21	24	2	6	8

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Investigations Completed	Unlicensed Practice Investigations	Total Investigations
Social Worker Associate Advanced	1	1	2	1	0	1
Social Worker Associate Independent	12	45	57	27	2	29
Social Worker Independent Clinical	23	106	129	60	7	67
Speech Language Pathologist	2	21	23	3	1	4
Surgical Technologist	7	29	36	19	2	21
Veterinarian	54	227	281	108	27	135
Veterinary Medication Clerk	4	6	10	2	1	3
Veterinary Technician	7	25	32	9	6	15
X-Ray Technician	10	28	38	16	0	16
Totals	3,911	19,348	23,259	7,998	1,092	9,090

Percentage of Investigations Completed

The following tables compare investigations completed to the number of complaints received. The column titled 'Percentage of B/C (Secretary) Investigations to Complaints' shows investigations completed as a percentage of complaints received by the same profession. For example, 33 percent (134) of the 408 total complaints received for Advanced Registered Nurse Practitioners were investigated.

The column titled 'Percentage of B/C (Secretary) Investigations' compares the total number of investigations completed for a profession to the total number of investigations completed for all professions with like disciplinary authority. For example, completed physician investigations made up 28 percent (1,630) of the 5,767 board and commission investigations completed. In the secretary profession investigations completed, nursing assistant investigations represented 52 percent (1,616) of the 3,119 completed secretary profession investigations.

Table 6: Board and Commission Professions - Percentage of Investigations Completed 2013-15 Biennium

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Investigations Completed	Unlicensed Practice Investigations	Total Investigations	% of BC Investigations to Complaints	% of BC Investigations Completed
Advanced Registered Nurse Practitioner	76	332	408	134	0	134	33%	2%
Audiologist	1	10	11	0	0	0	0%	0%
Chiropractic X-Ray Technician	1	6	7	0	0	0	0%	0%
Chiropractor	150	331	481	217	3	220	46%	4%
Dental Assistant	46	126	172	61	13	74	43%	1%
Dentist	178	995	1,173	508	17	525	45%	9%
Denturist	27	55	82	39	0	39	48%	1%
Hearing Instrument Fitter/Dispenser	4	0	4	3	0	3	75%	0%

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Investigations Completed	Unlicensed Practice Investigations	Total Investigations	% of BC Investigations to Complaints	% of BC Investigations Completed
Licensed Practical Nurse	96	622	718	190	2	192	27%	3%
Massage Practitioner	245	1,144	1,389	279	603	882	63%	15%
Naturopathic Physician	86	114	200	97	13	110	55%	2%
Nursing Home Administrator	25	216	241	64	0	64	27%	1%
Occupational Therapist	21	42	63	21	0	21	33%	0%
Occupational Therapy Assistant	5	33	38	8	0	8	21%	0%
Optometrist	9	57	66	21	5	26	39%	0%
Osteopathic Physician	76	245	321	135	0	135	42%	2%
Osteopathic Physician Assistant	0	11	11	5	0	5	45%	0%
Pharmacies and Other Pharmaceutical Firms	69	274	343	108	29	137	40%	2%
Pharmacist	142	432	574	266	2	268	47%	5%
Pharmacist Intern	2	11	13	4	0	4	31%	0%
Pharmacy Assistant	38	124	162	61	1	62	38%	1%
Pharmacy Technician	55	106	161	66	3	69	43%	1%
Physical Therapist	27	131	158	54	3	57	36%	1%
Physical Therapist Assistant	12	50	62	17	3	20	32%	0%
Physician	594	2,886	3,480	1,586	44	1,630	47%	27%
Physician Assistant	49	179	228	107	0	107	47%	2%
Podiatric Physician	23	58	81	31	0	31	38%	1%
Psychologist	59	180	239	92	13	105	44%	2%
Registered Nurse	408	2,230	2,638	841	13	854	32%	14%
Speech Language Pathologist	2	21	23	3	1	4	17%	0%
Veterinarian	54	227	281	108	27	135	48%	2%
Veterinary Medication Clerk	4	6	10	2	1	3	30%	0%
Veterinary Technician	7	25	32	9	6	15	47%	0%
Totals	2,496	11,017	13,513	5,041	774	5,815	43%	

**Table 7: Secretary Professions - Percentage of Investigations Completed
2013-15 Biennium**

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Investigations Completed	Unlicensed Practice Investigations	Total Investigations	% of Secretary Investigations to Complaints	% of Secretary Investigations Completed
Advanced Emergency Medical Technician	1	4	5	4	0	4	80%	0%
Animal Massage Practitioner	1	4	5	0	4	4	80%	0%
Athletic Trainer	2	13	15	4	4	8	53%	0%
Cardiovascular Invasive Specialist	0	1	1	0	0	0	0%	0%
Chemical Dependency Professional	109	316	425	191	6	197	46%	6%
Chemical Dependency Professional Trainee	58	216	274	96	2	98	36%	3%
Counselor, Agency Affiliated	61	237	298	120	4	124	42%	4%
Counselor, Certified	17	56	73	23	8	31	42%	1%
Counselor, Certified Advisor	1	4	5	1	1	2	40%	0%
Dental Hygienist	15	54	69	10	5	15	22%	0%
Dietitian/Nutritionist	1	9	10	2	3	5	50%	0%
Dispensing Optician	3	22	25	5	10	15	60%	0%
Dispensing Optician Apprentice	0	2	2	1	0	1	50%	0%
East Asian Medicine Practitioner	15	197	212	23	7	30	14%	1%
Emergency Medical Responder	0	1	1	1	0	1	100%	0%
Emergency Medical Technician	27	110	137	68	0	68	50%	2%
Genetic Counselor	0	1	1	0	1	1	100%	0%
Health Care Assistant	13	28	41	31	3	34	83%	1%
Home Care Aide	53	421	474	103	44	147	31%	5%
Hypnotherapist	6	13	19	8	2	10	53%	0%
Marriage and Family Therapist	17	55	72	30	5	35	49%	1%
Marriage and Family Therapist Associate	7	18	25	17	0	17	68%	1%
Medical Assistant	119	476	595	132	78	210	35%	7%
Mental Health Counselor	66	281	347	151	14	165	48%	5%
Mental Health Counselor Associate	14	55	69	27	2	29	42%	1%
Midwife	18	37	55	26	6	32	58%	1%
Nursing Assistant	597	5,043	5,640	1,562	54	1,616	29%	52%
Nursing Pool Operator	0	3	3	0	0	0	0%	0%
Orthoist/Prosthetist	2	11	13	6	0	6	46%	0%
Paramedic	0	11	11	5	0	5	45%	0%
Radiological Technologist	1	27	28	17	0	17	61%	1%
Recreational Therapist	0	1	1	0	0	0	0%	0%
Reflexologist	3	18	21	4	9	13	62%	0%

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Investigations Completed	Unlicensed Practice Investigations	Total Investigations	% of Secretary Investigations to Complaints	% of Secretary Investigations Completed
Respiratory Care Practitioner	3	40	43	16	1	17	40%	1%
Sex Offender Treatment Provider	10	29	39	20	0	20	51%	1%
Social Worker Advanced	3	21	24	2	6	8	33%	0%
Social Worker Associate Advanced	1	1	2	1	0	1	50%	0%
Social Worker Associate Independent	12	45	57	27	2	29	51%	1%
Social Worker Independent Clinical	23	106	129	60	7	67	52%	2%
Surgical Technologist	7	29	36	19	2	21	58%	1%
X-Ray Technician	10	28	38	16	0	16	42%	1%
Totals	1,295	8,040	9,335	2,825	290	3,119	33%	

Board and commission professions accounted for 66 percent of the 9,090 investigations completed during the biennium; secretary authority professions completed the remaining 34 percent. In general, boards and commissions regulate more of the primary care professions whose practitioners can pose a greater risk of harm to patients. This may be reflected in the higher percentage of complaints investigated.

Cite and Fine Authority

RCW 18.130.230 gives the secretary, and the boards and commissions, the authority to cite and fine providers for failing to produce requested documents or records. Providers must produce required items within 21 days of a written request from the disciplining authority. The deadline can be extended for good cause. The fine accrues at \$100 per day of non-compliance. The maximum fine is \$5,000.

One important aspect of this law is that it provides a strong incentive to cooperate in investigations, rather than obstruct the process. In the last biennium, just six cases were opened for cite and fine, and four of these licensees were actually assessed a fine. All were fined the maximum amount, \$5,000. One was a dentist, two were naturopathic physicians, and the fourth was an osteopathic physician.

Sexual Misconduct Cases

RCW 18.130.062 requires the secretary to act as sole disciplinary authority for complaints that allege only sexual misconduct. The intent of the law is to encourage prompt action when a provider has engaged in sexual misconduct but there are no issues that involve clinical expertise or standard of care.

The appropriate board or commission reviews each complaint, and retains responsibility for those cases that also involve clinical expertise or standard of care issues. The board and commissions transfer cases that involve only sexual misconduct to the secretary for discipline. During the biennium, 33 cases were referred to the secretary. Of those, six were returned to the referring board or commission when the investigation revealed a clinical or standard of care issue. One additional referral was made for a case that carried over from the previous biennium.

Case Disposition

Complaints are resolved in one of three ways:

- 1) Without any disciplinary action.
- 2) When informal disciplinary action is taken.
- 3) When formal disciplinary action is taken.

Disciplinary actions totaled 2,434 in 2013-2015. About 26 percent of these actions were resolved with informal dispositions. Formal resolution included 26 percent with agreed orders, 26 percent with default orders, and six percent with final orders. The remaining 17 percent involved notices of decision on applications.

Investigative files and disciplinary documents are public records. Since July 1998, all actions against healthcare provider credentials are available on the Internet.¹³

Definitions are available for key disciplinary terms in Appendix A.

Complaints Closed Prior to Disciplinary Action

Many complaints close before issuance of a statement of allegations or a statement of charges. These cases close for a number of reasons, among them:

- The complaint does not rise to a threshold to warrant investigation.
- After the investigation, it's decided to close the complaint due to minimal risk, the evidence is insufficient to support the allegations against a healthcare provider, the evidence disproves the allegations, or the evidence does not support a finding of unprofessional conduct.
- The disciplinary authority does not have jurisdiction.
- The complaint is best resolved with a Notice of Correction notifying the healthcare provider of a minor technical violation. The healthcare provider has a reasonable time period to correct the violation and then to report the corrective action to the disciplinary authority. If the violation is not corrected, disciplinary action may follow.

In addition, occasionally new evidence warrants the withdrawal of a statement of allegations or statement of charges.

The following table provides information by profession for cases closed before disciplinary action. The statistics include closures in unlicensed practice cases.

¹³ Credential records are available through the Department's "Provider Credential Search." The URL is: <https://fortress.wa.gov/doh/providercredentialsearch/>

**Table 8: Complaints Closed Prior to Disciplinary Action
2013-15 Biennium**

Profession	Total Complaints	Closed Prior To Investigation	Closed After Investigation	Closed with Notice of Decision	Charges or Allegations Withdrawn	Total Closed
Advanced Emergency Medical Technician	5	0	3	0	1	4
Advanced Registered Nurse Practitioner	408	202	110	2	4	321
Animal Massage Practitioner	5	1	2	0	0	3
Athletic Trainer	15	6	7	0	0	13
Cardiovascular Invasive Specialist	1	1	0	0	0	1
Chemical Dependency Professional	425	71	144	22	2	240
Chemical Dependency Professional Trainee	274	21	94	72	2	189
Chiropractic X-Ray Technician	7	1	5	0	0	6
Chiropractor	481	69	174	0	15	261
Counselor, Agency Affiliated	298	80	113	16	2	212
Counselor, Certified	73	22	34	6	1	63
Counselor, Certified Advisor	5	1	0	0	0	1
Dental Anesthesia Assistant	0	0	0	0	0	0
Dental Assistant	172	26	71	11	1	109
Dental Hygienist	69	12	36	1	0	49
Dentist	1,173	467	437	2	20	934
Denturist	82	9	34	1	5	49
Dietitian/Nutritionist	10	6	3	0	0	9
Dispensing Optician	25	9	14	0	0	23
Dispensing Optician Apprentice	2	0	2	0	0	2
East Asian Medicine Practitioner	212	57	128	0	1	186
Emergency Medical Responder	1	1	1	0	0	2
Emergency Medical Technician	137	30	65	4	1	100
Expanded Function Dental Auxiliary	0	0	1	0	0	1
Genetic Counselor	1	0	1	0	0	1
Health Care Assistant	41	27	37	1	1	66
Hearing Instrument Fitter/Dispenser	4	4	5	0	0	9
Home Care Aide	474	172	142	31	4	350
Humane Society	0	0	1	0	0	1
Hypnotherapist	19	2	6	0	0	8
Licensed Practical Nurse	718	389	126	9	4	531
Marriage and Family Therapist	72	19	22	0	1	42
Marriage and Family Therapist Associate	25	2	15	0	0	17
Massage Practitioner	1,389	420	460	45	4	930
Medical Assistant	595	136	173	34	5	349
Mental Health Counselor	347	81	136	1	1	219
Mental Health Counselor Associate	69	18	20	1	1	40
Midwife	55	9	22	0	1	32
Naturopathic Physician	200	19	56	1	2	78
Nursing Assistant	5,640	3,214	1,185	73	7	4,491
Nursing Home Administrator	241	136	52	0	0	189

Profession	Total Complaints	Closed Prior To Investigation	Closed After Investigation	Closed with Notice of Decision	Charges or Allegations Withdrawn	Total Closed
Nursing Pool Operator	3	2	1	0	0	3
Nursing Technician	0	0	0	0	0	0
Occupational Therapist	63	11	16	0	1	28
Occupational Therapy Assistant	38	14	9	2	0	25
Ocularist	0	0	0	0	0	0
Optometrist	66	37	23	0	0	60
Orthoist/Prosthetist	13	1	8	0	0	9
Osteopathic Physician	321	100	79	1	4	190
Osteopathic Physician Assistant	11	1	8	0	0	9
Paramedic	60	7	18	0	0	25
Pharmacies and Other Pharmaceutical Firms	343	92	104	0	1	197
Pharmacist	574	146	218	0	0	365
Pharmacist Intern	13	2	3	1	0	6
Pharmacy Assistant	162	31	39	12	0	82
Pharmacy Technician	161	20	42	3	0	65
Physical Therapist	158	57	61	2	2	122
Physical Therapist Assistant	62	15	14	5	0	34
Physician	3,480	1,223	1,384	8	27	2,648
Physician Assistant	228	63	90	2	3	158
Podiatric Physician	81	25	22	0	1	48
Psychologist	239	73	84	5	4	166
Radiological Technologist	28	11	16	0	0	27
Radiologist Assistant	0	0	0	0	0	0
Recreational Therapist	1	1	0	0	0	1
Reflexologist	21	4	9	1	0	14
Registered Nurse	2,638	1,286	589	22	16	1,917
Respiratory Care Practitioner	43	17	11	0	0	28
Retired Volunteer Medical Worker	0	0	0	0	0	0
Sex Offender Treatment Provider	39	6	26	0	0	32
Social Worker Advanced	24	12	7	0	0	19
Social Worker Associate Advanced	2	2	1	0	0	3
Social Worker Associate Independent	57	10	20	1	0	31
Social Worker Independent Clinical	129	42	64	1	2	109
Speech Language Pathologist	23	9	8	1	0	18
Surgical Technologist	36	9	19	0	0	28
Veterinarian	281	103	101	0	0	206
Veterinary Medication Clerk	10	0	1	2	0	3
Veterinary Technician	32	8	11	0	0	19
X-Ray Technician	38	13	10	2	0	25
Totals	23,259	9,193	7,053	404	147	16,851

Percentage of Complaints Closed

During the biennium HSQA closed almost 17,000 cases before legal proceedings. About 58 percent were board and commission cases and 41 percent were secretary profession cases.

The following tables show the cases closed with no disciplinary action, compared to total cases closed with no action and to the number of complaints received. The column titled “Percentage of B/C (or Secretary) Closures” shows the total number of cases closed with no action for that profession compared to the total number of Board/Commission cases closed with no action.

For example, the 934 dentist cases were 11 percent of the 8,625 board and commission cases closed with no action; the 349 medical assistant cases were four percent of the 7,768 secretary profession cases closed with no action.

The column titled “Percentage of B/C (or Secretary) Closures to Complaints” shows the percentage of cases closed with no action compared to the total number of complaints received for that same profession.

Table 9: Board and Commission Complaints Closed Prior to Adjudicative Proceedings 2013-15 Biennium

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Total Closed	% of B/C Closures	% of B/C Closures to Complaints
Advanced Registered Nurse Practitioner	76	332	408	321	4%	79%
Audiologist	1	10	11	0	0%	0%
Chiropractic X-Ray Technician	1	6	7	6	0%	86%
Chiropractor	150	331	481	261	3%	54%
Dental Assistant	46	126	172	109	1%	63%
Dentist	178	995	1,173	934	11%	80%
Denturist	27	55	82	49	1%	60%
Hearing Instrument Fitter/Dispenser	4	0	4	9	0%	225%
Licensed Practical Nurse	96	622	718	531	6%	74%
Naturopathic Physician	86	114	200	78	1%	39%
Nursing Home Administrator	25	216	241	189	2%	78%
Occupational Therapist	21	42	63	28	0%	44%
Occupational Therapy Assistant	5	33	38	25	0%	66%
Optometrist	9	57	66	60	1%	91%
Osteopathic Physician	76	245	321	190	2%	59%
Osteopathic Physician Assistant	0	11	11	9	0%	82%
Pharmacies and Other Pharmaceutical Firms	69	274	343	197	2%	57%
Pharmacist	142	432	574	365	4%	64%
Pharmacist Intern	2	11	13	6	0%	46%
Pharmacy Assistant	38	124	162	82	1%	51%
Pharmacy Technician	55	106	161	65	1%	40%
Physical Therapist	27	131	158	122	1%	77%
Physical Therapist Assistant	12	50	62	34	0%	55%
Physician	594	2,886	3,480	2,648	31%	76%
Physician Assistant	49	179	228	158	2%	69%
Podiatric Physician	23	58	81	48	1%	59%

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Total Closed	% of B/C Closures	% of B/C Closures to Complaints
Psychologist	59	180	239	166	2%	69%
Registered Nurse	408	2,230	2,638	1,917	22%	73%
Speech Language Pathologist	2	21	23	18	0%	78%
Veterinarian	54	227	281	206	2%	73%
Veterinary Medication Clerk	4	6	10	3	0%	30%
Veterinary Technician	7	25	32	19	0%	59%
Totals	2,281	9,877	12,158	8,625		

Table 10: Secretary Professions Complaints Closed Prior to Adjudicative Proceedings 2013-15 Biennium

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Total Closed	% of Secretary Investigation Closures	% of Secretary Investigation Closures to Complaints
Advanced Emergency Medical Technician	1	4	5	4	0%	80%
Animal Massage Practitioner	1	4	5	3	0%	60%
Athletic Trainer	2	13	15	13	0%	87%
Cardiovascular Invasive Specialist	0	1	1	1	0%	100%
Chemical Dependency Professional	109	316	425	240	3%	56%
Chemical Dependency Professional Trainee	58	216	274	189	2%	69%
Counselor, Agency Affiliated	61	237	298	212	3%	71%
Counselor, Certified	17	56	73	63	1%	86%
Counselor, Certified Advisor	1	4	5	1	0%	20%
Dental Hygienist	15	54	69	49	1%	71%
Dietitian/Nutritionist	1	9	10	9	0%	90%
Dispensing Optician	3	22	25	23	0%	92%
Dispensing Optician Apprentice	0	2	2	2	0%	100%
East Asian Medicine Practitioner	15	197	212	186	2%	88%
Emergency Medical Responder	0	1	1	2	0%	200%
Emergency Medical Technician	27	110	137	100	1%	73%
Genetic Counselor	0	1	1	1	0%	100%
Health Care Assistant	13	28	41	66	1%	161%
Home Care Aide	53	421	474	350	5%	74%
Hypnotherapist	6	13	19	8	0%	42%
Massage Practitioner	245	1,144	1,389	930	12%	67%
Marriage and Family Therapist	17	55	72	42	1%	58%
Marriage and Family Therapist Associate	7	18	25	17	0%	68%
Medical Assistant	119	476	595	349	4%	59%
Mental Health Counselor	66	281	347	219	3%	63%
Mental Health Counselor Associate	14	55	69	40	1%	58%
Midwife	18	37	55	0	0%	0%

Profession	Carry Over From FY13	Complaints Received	Total Complaints	Total Closed	% of Secretary Investigation Closures	% of Secretary Investigation Closures to Complaints
Nursing Assistant	597	5,043	5,640	4,491	58%	80%
Nursing Pool Operator	0	3	3	3	0%	100%
Orthoist/Prosthetist	2	11	13	9	0%	69%
Paramedic	24	36	60	25	0%	42%
Radiological Technologist	1	27	28	27	0%	96%
Recreational Therapist	0	1	1	1	0%	100%
Reflexologist	3	18	21	14	0%	67%
Respiratory Care Practitioner	3	40	43	28	0%	65%
Sex Offender Treatment Provider	10	29	39	32	0%	82%
Social Worker Advanced	3	21	24	19	0%	79%
Social Worker Associate Advanced	1	1	2	3	0%	150%
Social Worker Associate Independent	12	45	57	31	0%	54%
Social Worker Independent Clinical	23	106	129	109	1%	84%
Surgical Technologist	7	29	36	28	0%	78%
X-Ray Technician	10	28	38	25	0%	66%
Totals	1,512	9,004	10,516	7,768		

Complaint Resolutions after Adjudicative Proceedings

The type of order issued to the healthcare provider indicates the manner in which the case was resolved. All orders are public records. Orders associated with actions against health care providers' credentials since July 1998 are available on the Internet.

The Legislature amended the Uniform Disciplinary Act in 2001 to permit practitioners to surrender their license in lieu of other sanctions. Surrender of license is used when the practitioner agrees to retire from practice and not to resume practice. The public can be protected through surrender alone, and the circumstances involve a practitioner at the end of his or her effective practice.

Surrender is not used if the practitioner intends to practice in another jurisdiction or if the disciplining authority believes return to practice is reasonably possible.

Stipulation to Informal Disposition: A Stipulation to Informal Disposition (STID) is an informal disciplinary resolution. If the healthcare provider agrees to the STID, he or she does not admit to unprofessional conduct, but does agree to corrective action. STIDs are reported to national data banks, but because they are informal they do not result in a press release.

Agreed Order: The document, formally called a Stipulated Findings of Fact, Conclusions of Law and Agreed Order, is a negotiated settlement between the healthcare provider and representatives of the agency in a formal disciplinary proceeding. It states the substantiated violations of law and the sanctions being placed on the healthcare provider's credential. The healthcare provider agrees to the conditions in the order. The Agreed Order is presented to the disciplinary authority and if approved, becomes final. The order is reported to national data banks and the public through a press release.

Default Orders: A Default Order is issued when the credentialed health care provider was given due notice, but either failed to answer the allegations or failed to participate in the adjudicative process as required by law.

Final Order after Hearing: The document is formally called Findings of Fact, Conclusions of Law and Order. This document is issued after a formal hearing is held. The hearing may be before a health law judge representing the secretary as the initial decision maker, or before a panel of board or commission members as the final decision makers with a health law judge acting as the presiding officer. The document identifies the proven facts, violations of law and the sanctions being placed on the healthcare provider's credential. The healthcare provider has the right to ask for administrative review of an initial order. Final orders are subject to reconsideration of the decision or appeal to a superior court. The order is reported to national data banks and the public through a press release.

Notice of Decision (NOD): A NOD is issued pursuant to RCW 18.130.055 when the disciplining authority decides to deny an application for licensure or grant the license with conditions.

**Table 11: Complaints Resolved after Adjudicative Proceedings
2013-15 Biennium**

Profession	Informal Disposition	Agreed Order	Default Order	Final Order	NOD	Total
Advanced Emergency Medical Technician	0	0	0	0	0	0
Advanced Registered Nurse Practitioner	10	24	8	4	2	48
Animal Massage Practitioner	0	1	0	0	0	1
Athletic Trainer	0	0	0	0	0	0
Cardiovascular Invasive Specialist	0	0	0	0	0	0
Chemical Dependency Professional	7	20	12	11	22	72
Chemical Dependency Professional Trainee	5	14	9	12	72	112
Chiropractic X-Ray Technician	0	0	0	0	0	0
Chiropractor	17	16	6	3	0	42
Counselor, Agency Affiliated	6	14	15	3	16	54
Counselor, Certified	1	2	2	0	6	11
Counselor, Certified Advisor	0	0	0	0	0	0
Dental Anesthesia Assistant	0	0	0	0	0	0
Dental Assistant	6	9	5	0	11	31
Dental Hygienist	3	3	0	1	1	8
Dentist	62	30	3	6	2	103
Denturist	6	3	1	1	1	12
Dietitian/Nutritionist	0	0	0	0	0	0
Dispensing Optician	1	0	0	0	0	1
Dispensing Optician Apprentice	0	0	0	0	0	0
East Asian Medicine Practitioner	3	0	0	0	0	3
Emergency Medical Responder	0	0	0	0	0	0
Emergency Medical Technician	5	5	9	0	4	23
Expanded Function Dental Auxiliary	0	0	0	0	0	0

Profession	Informal Disposition	Agreed Order	Default Order	Final Order	NOD	Total
Genetic Counselor	0	0	0	0	0	0
Health Care Assistant	0	0	1	0	1	2
Hearing Instrument Fitter/Dispenser	0	0	0	0	0	0
Home Care Aide	0	3	5	2	31	41
Humane Society	0	0	0	0	0	0
Hypnotherapist	1	1	0	0	0	2
Licensed Practical Nurse	39	26	27	9	9	110
Marriage and Family Therapist	2	2	0	0	0	4
Marriage and Family Therapist Associate	0	4	0	0	0	4
Massage Practitioner	8	30	14	3	45	100
Medical Assistant	18	15	6	1	34	74
Mental Health Counselor	12	11	2	0	1	26
Mental Health Counselor Associate	0	3	1	0	1	5
Midwife	1	6	0	0	0	7
Naturopathic Physician	11	16	2	6	1	36
Nursing Assistant	80	88	304	10	73	555
Nursing Home Administrator	8	0	0	0	0	8
Nursing Pool Operator	0	0	0	0	0	0
Nursing Technician	0	0	0	0	0	0
Occupational Therapist	10	2	0	2	0	14
Occupational Therapy Assistant	2	0	2	0	2	6
Ocularist	0	0	0	0	0	0
Optometrist	2	0	1	0	0	3
Orthoist/Prosthetist	0	0	0	0	0	0
Osteopathic Physician	9	10	3	7	1	30
Osteopathic Physician Assistant	0	0	0	0	0	0
Paramedic	5	6	3	0	0	14
Pharmacies and Other Pharmaceutical Firms	4	4	0	0	0	8
Pharmacist	39	15	0	0	0	54
Pharmacist Intern	0	1	1	0	1	3
Pharmacy Assistant	9	7	10	1	12	39
Pharmacy Technician	12	10	14	1	3	40
Physical Therapist	0	4	0	0	2	6
Physical Therapist Assistant	2	0	2	1	5	10
Physician	75	51	16	14	8	164
Physician Assistant	14	0	2	0	2	18
Podiatric Physician	4	0	0	4	0	8
Psychologist	5	16	4	0	5	30
Radiological Technologist	1	1	1	0	0	3
Radiologist Assistant	0	0	0	0	0	0
Recreational Therapist	1	0	0	0	0	1
Reflexologist	0	0	0	0	1	1
Registered Nurse	108	114	134	21	22	399
Respiratory Care Practitioner	0	4	2	0	0	6

Profession	Informal Disposition	Agreed Order	Default Order	Final Order	NOD	Total
Retired Volunteer Medical Worker	0	0	0	0	0	0
Sex Offender Treatment Provider	1	1	0	0	0	2
Social Worker Advanced	0	0	0	0	0	0
Social Worker Associate Advanced	0	0	0	0	0	0
Social Worker Associate Independent	0	0	0	0	1	1
Social Worker Independent Clinical	7	4	0	0	1	12
Speech Language Pathologist	1	1	0	0	1	3
Surgical Technologist	0	2	2	1	0	5
Veterinarian	14	20	1	11	0	46
Veterinary Medication Clerk	0	0	0	0	2	2
Veterinary Technician	2	0	0	1	0	3
X-Ray Technician	0	3	2	1	2	8
Totals	639	622	632	137	404	2,434

Percentage of Disciplinary Actions

The following tables show the percentage of disciplinary action for each profession compared to all board, and commission or secretary disciplinary actions. For example, the 103 dentist actions were nine percent of the 1,225 board and commission disciplinary actions; the 100 massage practitioner actions were seven percent of the 1,158 secretary-profession disciplinary actions. The tables also show the percentage of disciplinary actions for each profession compared to the same profession's total complaints.

Table 12: Board and Commission Professions Complaints Resolved after Adjudicative Proceedings 2013-15 Biennium

Profession	Carry Over from FY13	Complaints Received	Total Complaints	Total Disciplinary Action	% of B/C Disciplinary Action to Complaints	% of All B/C Disciplinary Action
Advanced Registered Nurse Practitioner	76	332	408	48	12%	4%
Audiologist	1	10	11	0	0%	0%
Chiropractic X-Ray Technician	1	6	7	0	0%	0%
Chiropractor	150	331	481	42	9%	3%
Dental Assistant	46	126	172	31	18%	3%
Dentist	178	995	1,173	103	9%	8%
Denturist	27	55	82	12	15%	1%
Hearing Instrument Fitter/Dispenser	4	0	4	0	0%	0%
Licensed Practical Nurse	96	622	718	110	15%	9%
Naturopathic Physician	86	114	200	36	18%	3%
Nursing Home Administrator	25	216	241	8	3%	1%
Occupational Therapist	21	42	63	14	22%	1%
Occupational Therapy Assistant	5	33	38	6	16%	0%
Optometrist	9	57	66	3	5%	0%

Profession	Carry Over from FY13	Complaints Received	Total Complaints	Total Disciplinary Action	% of B/C Disciplinary Action to Complaints	% of All B/C Disciplinary Action
Osteopathic Physician	76	245	321	30	9%	2%
Osteopathic Physician Assistant	0	11	11	0	0%	0%
Pharmacies and Other Pharmaceutical Firms	69	274	343	8	2%	1%
Pharmacist	142	432	574	54	9%	4%
Pharmacist Intern	2	11	13	3	23%	0%
Pharmacy Assistant	38	124	162	39	24%	3%
Pharmacy Technician	55	106	161	40	25%	3%
Physical Therapist	27	131	158	6	4%	0%
Physical Therapist Assistant	12	50	62	10	16%	1%
Physician	594	2,886	3,480	164	5%	13%
Physician Assistant	49	179	228	18	8%	1%
Podiatric Physician	23	58	81	8	10%	1%
Psychologist	59	180	239	30	13%	2%
Registered Nurse	408	2,230	2,638	399	15%	33%
Speech Language Pathologist	2	21	23	3	13%	0%
Veterinarian	54	227	281	46	16%	4%
Veterinary Medication Clerk	4	6	10	2	20%	0%
Veterinary Technician	7	25	32	3	9%	0%
Totals	2,281	9,877	12,158	1,225		

Table 13: Secretary Professions Complaints Resolved after Adjudicative Proceedings 2013-15 Biennium

Profession	Carry Over from FY13	Complaints Received	Total Complaints	Total Disciplinary Action	% of Secretary Disciplinary Action to Complaints	% of All Secretary Disciplinary Actions
Advanced Emergency Medical Technician	1	4	5	0	0%	0%
Animal Massage Practitioner	1	4	5	1	20%	0%
Athletic Trainer	2	13	15	0	0%	0%
Cardiovascular Invasive Specialist	0	1	1	0	0%	0%
Chemical Dependency Professional	109	316	425	72	17%	6%
Chemical Dependency Professional Trainee	58	216	274	112	41%	10%
Counselor, Agency Affiliated	61	237	298	54	18%	5%
Counselor, Certified	17	56	73	11	15%	1%
Counselor, Certified Advisor	1	4	5	0	0%	0%
Dental Hygienist	15	54	69	8	12%	1%
Dietitian/Nutritionist	1	9	10	0	0%	0%
Dispensing Optician	3	22	25	1	4%	0%
Dispensing Optician Apprentice	0	2	2	0	0%	0%
East Asian Medicine Practitioner	15	197	212	3	1%	0%

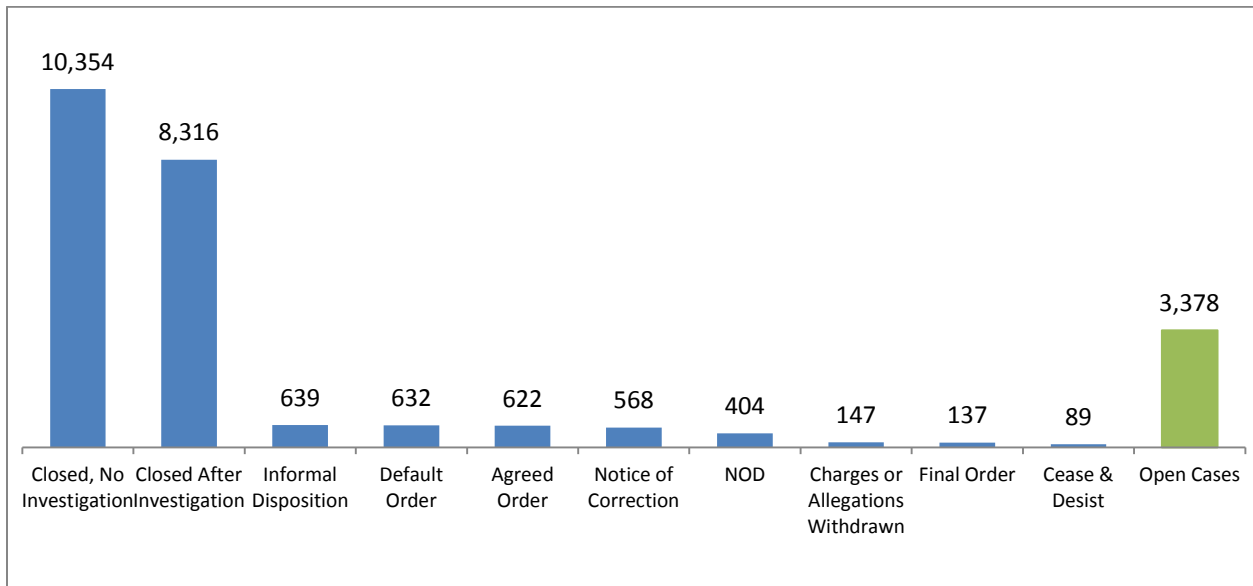
Profession	Carry Over from FY13	Complaints Received	Total Complaints	Total Disciplinary Action	% of Secretary Disciplinary Action to Complaints	% of All Secretary Disciplinary Actions
Emergency Medical Responder	0	1	1	0	0%	0%
Emergency Medical Technician	27	110	137	23	17%	2%
Genetic Counselor	0	1	1	0	0%	0%
Health Care Assistant	13	28	41	2	5%	0%
Home Care Aide	53	421	474	41	9%	4%
Hypnotherapist	6	13	19	2	11%	0%
Massage Practitioner	245	1,144	1,389	100	7%	9%
Marriage and Family Therapist	17	55	72	4	6%	0%
Marriage and Family Therapist Associate	7	18	25	4	16%	0%
Medical Assistant	119	476	595	74	12%	6%
Mental Health Counselor	66	281	347	26	7%	2%
Mental Health Counselor Associate	14	55	69	5	7%	0%
Midwife	18	37	55	7	13%	1%
Nursing Assistant	597	5,043	5,640	555	10%	48%
Nursing Pool Operator	0	3	3	0	0%	0%
Orthoist/Prosthetist	2	11	13	0	0%	0%
Paramedic	24	36	60	14	23%	1%
Radiological Technologist	1	27	28	3	11%	0%
Recreational Therapist	0	1	1	1	100%	0%
Reflexologist	3	18	21	1	5%	0%
Respiratory Care Practitioner	3	40	43	6	14%	1%
Sex Offender Treatment Provider	10	29	39	2	5%	0%
Social Worker Advanced	3	21	24	0	0%	0%
Social Worker Associate Advanced	1	1	2	0	0%	0%
Social Worker Associate Independent	12	45	57	1	2%	0%
Social Worker Independent Clinical	23	106	129	12	9%	1%
Surgical Technologist	7	29	36	5	14%	0%
X-Ray Technician	10	28	38	8	21%	1%
Totals	1,452	8,875	10,327	1,158		

Of the 2,434 disciplinary actions during the 2013-15 biennium, boards and commissions handled 51 percent and the secretary professions 48 percent.

Professions with high rates of disciplinary actions compared to total complaints include, chemical dependency professional trainees with 41 percent, pharmacy technicians with 25 percent, and pharmacy assistants with 24 percent.

Figure 3 displays the distribution of the various complaint outcomes.

Figure 3: Summary of Case Dispositions and End of Biennium Open Cases



Unlicensed Practice Closures and Resolutions

The secretary is responsible for taking action against unlicensed practice. The HSQA Office of Investigation and Inspection manages intake, assessment, and investigation. Unlicensed practice complaints may be closed before or after investigation, or resolved with a Notice of Correction or a Cease-and-Desist Order.

A Notice of Correction notifies the person there will be further action if they continue to infringe on the scope of practice of credentialed healthcare providers. A Cease-and-Desist Order requires the recipient to stop practice and may impose a fine. Continued unlicensed practice may result in court enforcement of the Cease-and-Desist Order or criminal prosecution. HSQA focuses its resources on those cases posing the greatest risk to the public. Table 14 provides a breakdown of actions by profession.

**Table 14: Unlicensed Practice Closures and Resolutions
2013-15 Biennium**

Profession	Carry Over from 2011	Cases Received	Total Cases	Closed Prior to Investigation	Closed after Investigation	Cease & Desist Order Issued	Total Closed
Advanced Emergency Medical Technician	0	0	0	0	0	0	0
Advanced Registered Nurse Practitioner	0	0	0	0	0	0	0
Animal Massage Practitioner	3	4	7	1	2	0	2
Athletic Trainer	0	4	4	1	2	0	2
Audiologist	0	0	0	0	0	0	0
Cardiovascular Invasive Specialist	0	0	0	0	0	0	0
Chemical Dependency Professional	0	6	6	0	3	0	3
Chemical Dependency Professional Trainee	0	2	2	0	2	0	2
Chiropractic X-Ray Technician	1	0	1	0	1	0	1
Chiropractor	0	3	3	3	0	0	0
Counselor, Agency Affiliated	1	4	5	1	2	0	2
Counselor, Certified	6	8	14	7	7	0	7
Counselor, Certified Advisor	0	1	1	0	0	0	0
Dental Anesthesia Assistant	0	0	0	0	0	0	0
Dental Assistant	7	13	20	1	11	3	14
Dental Hygienist	0	5	5	0	2	3	5
Dentist	3	17	20	5	8	1	9
Denturist	1	0	1	0	0	0	0
Dietitian/Nutritionist	1	3	4	2	1	0	1
Dispensing Optician	1	10	11	1	7	1	8
Dispensing Optician Apprentice	0	0	0	0	0	0	0
East Asian Medicine Practitioner	3	7	10	2	10	0	10
Emergency Medical Responder	0	0	0	0	0	0	0
Emergency Medical Technician	4	0	4	0	4	0	4
Expanded Function Dental Auxiliary	0	0	0	0	0	0	0
Genetic Counselor	0	1	1	0	1	0	1
Health Care Assistant	2	3	5	0	3	0	3
Hearing Instrument Fitter/Dispenser	2	0	2	0	1	0	1
Home Care Aide	2	44	46	34	10	0	10
Humane Society	0	0	0	0	0	0	0
Hypnotherapist	0	2	2	1	1	0	1
Licensed Practical Nurse	0	2	2	0	1	0	1
Marriage and Family Therapist	2	5	7	3	4	0	4
Marriage and Family Therapist Associate	1	0	1	0	0	0	0
Massage Practitioner	42	603	645	337	141	61	202
Medical Assistant	0	78	78	15	54	1	55
Mental Health Counselor	0	14	14	7	2	0	2
Mental Health Counselor Associate	0	2	2	1	1	0	1
Midwife	3	6	9	3	4	0	4
Naturopathic Physician	3	13	16	1	4	0	4
Nursing Assistant	3	54	57	41	12	1	13

Profession	Carry Over from 2011	Cases Received	Total Cases	Closed Prior to Investigation	Closed after Investigation	Cease & Desist Order Issued	Total Closed
Nursing Home Administrator	0	0	0	0	0	0	0
Nursing Pool Operator	0	0	0	0	0	0	0
Nursing Technician	0	0	0	0	0	0	0
Occupational Therapist	0	0	0	0	1	0	1
Occupational Therapy Assistant	0	0	0	0	0	0	0
Ocularist	0	0	0	0	0	0	0
Optometrist	2	5	7	2	4	0	4
Orthoist/Prosthetist	0	0	0	0	0	0	0
Osteopathic Physician	0	0	0	0	0	0	0
Osteopathic Physician Assistant	0	0	0	0	0	0	0
Paramedic	0	0	0	0	0	0	0
Pharmacies and Other Pharmaceutical Firms	4	29	33	6	17	2	19
Pharmacist	4	2	6	2	2	3	5
Pharmacist Intern	0	0	0	0	0	0	0
Pharmacy Assistant	1	1	2	1	0	0	0
Pharmacy Technician	0	3	3	1	2	0	2
Physical Therapist	1	3	4	1	3	0	3
Physical Therapist Assistant	1	3	4	0	4	0	4
Physician	14	44	58	11	31	3	34
Physician Assistant	0	0	0	0	0	0	0
Podiatric Physician	0	0	0	0	0	0	0
Psychologist	1	13	14	8	5	0	5
Radiological Technologist	1	0	1	0	1	0	1
Radiologist Assistant	0	0	0	0	0	0	0
Recreational Therapist	0	0	0	0	0	0	0
Reflexologist	0	9	9	2	3	0	3
Registered Nurse	2	13	15	7	3	3	6
Respiratory Care Practitioner	0	1	1	1	0	0	0
Retired Volunteer Medical Worker	0	0	0	0	0	0	0
Sex Offender Treatment Provider	0	0	0	0	0	0	0
Social Worker Advanced	0	6	6	5	1	0	1
Social Worker Associate Advanced	0	0	0	0	0	0	0
Social Worker Associate Independent	0	2	2	0	1	0	1
Social Worker Independent Clinical	1	7	8	2	3	0	3
Speech Language Pathologist	0	1	1	0	0	0	0
Surgical Technologist	0	2	2	0	2	0	2
Veterinarian	5	27	32	4	15	1	16
Veterinary Medication Clerk	0	1	1	0	0	0	0
Veterinary Technician	2	6	8	1	4	1	5
X-Ray Technician	0	0	0	0	0	0	0
Totals	130	1,092	1,222	521	403	84	1,008

Violations and Sanctions

Uniform Disciplinary Act Violations

Section 180 of the Uniform Disciplinary Act (UDA) lists 25 violations considered unprofessional conduct. Healthcare providers cannot be criminally charged by boards, commissions, or the secretary because the UDA is administrative law. However, the ability of credential holders to make a living in the healthcare field may be adversely affected.

The department, or a board or commission, may refer complaints of a criminal nature to law enforcement, which may result in criminal action. Conversely, criminal convictions can result in UDA actions against practitioners' credentials.

Frequent Violations

Of the 25 possible UDA violations, five accounted for 81 percent of the 2,183 violations across all professions. The number of violations exceeds the number of disciplinary actions because violators are often cited for more than one violation.

Violations related to moral turpitude, dishonesty, or corruption, RCW 18.130.180(1), were cited 873 times in sanctions reported to the National Practitioner Data Bank (NPDB), making these violations the most frequently reported violation.

However, violations of RCW 18.130.180(1) frequently are not the only reported issue. In fact, 96 percent were cited in conjunction with other violations.

The most frequently reported issues in these violations, other than moral turpitude, dishonesty, or corruption, during the 2013-15 biennium were:

1. RCW 18.130.180(7): Violation of any state or federal statute or administrative rule, 778 (36 percent).
2. RCW 18.130.180(4): Incompetence, negligence, or malpractice, 556 (25 percent).
3. RCW 18.130.180(17): Conviction of a gross misdemeanor or felony relating to the practice of a healthcare profession, 401 (18 percent).
4. RCW 18.130.180(5): Suspension, revocation, or restriction in another jurisdiction, 386 (18 percent).
5. RCW 18.130.180(6) and (23): Personal drug or alcohol abuse, 352 (16 percent).

Sanctions Imposed

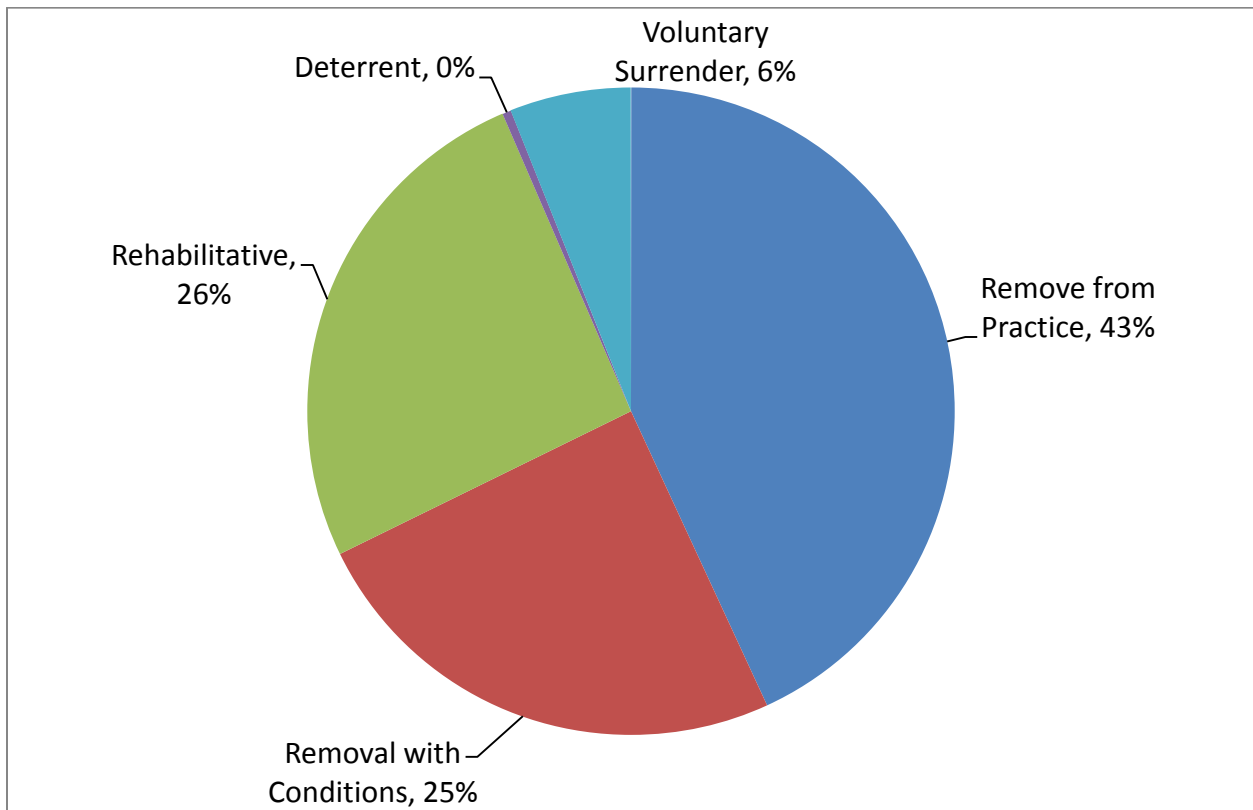
When adverse actions are reported to NPDB, the sanction imposed on the practitioner is also reported. For purposes of this report, sanctions were divided into five categories:

- Removal from practice
- Removal from practice with conditions
- Rehabilitative
- Deterrent
- Surrender of the credential

For definitions of these and other terms, please consult Appendix A.

The disciplinary actions represent cases closed after adjudication. There can be multiple cases against a single practitioner. Reports to the data bank represent reports on individual practitioners, not individual cases.

**Figure 4: Fiscal Years 2013-15 Sanctions Breakdown
2013-15 Biennium**



Sanctions Schedule

In 2006, the department adopted sanctions guidelines for professions where the secretary is the disciplinary authority. The purpose of these guidelines was to promote consistent disciplinary sanctions for similar unprofessional conduct. Each of the 14¹⁴ boards and commissions with disciplinary authority adopted the guidelines later. In 2009, the guidelines were adopted in rule.

Cases sometimes arise that cannot be addressed by the guidelines. To account for these cases, compliance goals were set at 95 percent for secretary professions and 80 percent for board and commission professions. These goals have been consistently met or exceeded on an aggregate basis.

Notes on Table 15

Numbers from Table 15 may not match exactly with the count of disciplinary actions in Tables 11-13. Table 15 is drawn from a different data source than preceding tables, where professions are grouped slightly differently. Additionally, notices of decision are not included in Table 15. Further divergence may occur because Tables 11-13 count cases closed in the last biennium, while Table 15 uses the sanction’s effective date.

¹⁴ At this time, there were fourteen boards and commissions with disciplinary authority.

**Table 15: Sanctions Imposed by Profession
2013-15 Biennium**

Profession	Remove from Practice (Revocation, Indefinite, Inspection)	Removal with Conditions (Suspension for Specific Period)	Rehabilitative (Probation, Limitation, or Restriction)	Deterrent (Reprimand, Fine)	Voluntary Surrender	Total
Advanced Emergency Medical Technician	0	0	0	0	0	0
Advanced Registered Nurse Practitioner	16	10	9	0	1	36
Animal Massage Practitioner	0	0	0	0	0	0
Athletic Trainer	0	0	0	0	0	0
Audiologist	0	0	0	0	0	0
Cardiovascular Invasive Specialist	0	0	0	0	0	0
Chemical Dependency Professional and Trainee	52	11	102	0	1	166
Chiropractic X-Ray Technician	0	0	0	0	0	0
Chiropractor	7	14	6	0	2	29
Counselor, All	26	6	18	0	2	52
Dental Anesthesia Assistant	0	0	0	0	0	0
Dental Assistant	12	5	11	0	1	29
Dental Hygienist	0	3	4	0	0	7
Dentist	11	59	23	0	4	97
Denturist	1	5	3	0	0	9
Dietitian/Nutritionist	0	0	0	0	0	0
Dispensing Optician	0	0	0	0	0	0
Dispensing Optician Apprentice	0	0	0	0	0	0
East Asian Medicine Practitioner	0	3	0	0	0	3
Emergency Medical Responder	0	0	0	0	0	0
Emergency Medical Technician	10	3	3	0	1	17
Expanded Function Dental Auxiliary	0	0	0	0	0	0
Genetic Counselor	0	0	0	0	0	0
Health Care Assistant	0	0	0	0	0	0
Hearing Instrument Fitter and Dispenser	0	0	1	0	0	1
Home Care Aide	14	0	15	0	0	29
Humane Society	0	0	0	0	0	0
Hypnotherapist	0	0	0	0	0	0
Licensed Practical Nurse	42	36	23	1	4	106
Marriage and Family Therapist	0	1	6	0	1	8
Marriage and Family Therapist Associate	0	0	0	0	0	0
Massage Practitioner	23	6	11	1	7	48
Medical Assistant	16	16	39	0	1	72
Mental Health Counselor	8	7	4	0	7	26
Mental Health Counselor Associate	0	0	0	0	0	0
Midwife	2	2	0	0	0	4
Naturopathic Physician	10	9	6	0	2	27
Nursing Assistant	347	69	77	2	11	506

Profession	Remove from Practice (Revocation, Indefinite, Inspection)	Removal with Conditions (Suspension for Specific Period)	Rehabilitative (Probation, Limitation, or Restriction)	Deterrent (Reprimand, Fine)	Voluntary Surrender	Total
Nursing Home Administrator	0	0	0	0	0	0
Nursing Pool Operator	0	0	0	0	0	0
Nursing Technician	0	0	0	0	0	0
Occupational Therapist	1	6	3	0	1	11
Occupational Therapy Assistant	1	1	1	0	1	4
Ocularist	0	0	0	0	0	0
Optometrist	1	2	0	0	0	3
Orthoist/Prosthetist	0	0	0	0	0	0
Osteopathic Physician	5	8	4	1	1	19
Osteopathic Physician Assistant	0	0	0	0	0	0
Paramedic	5	3	4	0	1	13
Pharmacist	7	40	6	0	2	55
Pharmacist Intern	2	0	1	0	0	3
Pharmacy Assistant	15	7	5	0	4	31
Pharmacy Technician	21	9	5	0	4	39
Physical Therapist	1	0	3	0	0	4
Physical Therapist Assistant	2	2	4	0	0	8
Physician	17	55	38	2	17	129
Physician Assistant	1	11	1	0	2	15
Podiatric Physician	1	2	0	0	2	5
Psychologist	4	5	9	0	2	20
Radiological Technologist	4	1	1	0	0	6
Radiologist Assistant	0	0	0	0	0	0
Recreational Therapist	0	0	0	0	1	1
Reflexologist	0	0	0	0	0	0
Registered Nurse	185	82	75	1	36	379
Respiratory Care Practitioner	4	0	1	0	1	6
Retired Volunteer Medical Worker	0	0	0	0	0	0
Sex Offender Treatment Provider	0	0	0	0	1	1
Social Worker, All	2	5	2	1	3	13
Speech Language Pathologist	0	1	2	0	0	3
Surgical Technologist	5	0	0	0	0	5
Veterinarian	0	0	0	0	0	0
Veterinary Medication Clerk	0	0	0	0	0	0
Veterinary Technician	0	0	0	0	0	0
X-Ray Technician	2	0	2	0	0	4
Totals	883	505	528	9	124	2049

Case Appeals Activity

A healthcare professional has the right to appeal a final decision of a disciplinary authority to a court of law. The process involves filing a petition with a county superior court. Depending on the outcome, the healthcare professional can appeal to an appellate court. An appellate court's decision sets precedence for future decisions of the same nature. A healthcare professional may appeal an appellate court's decision to the Washington State Supreme Court, which decides the cases it will accept or decline. The following table lists all case appeals activit in the last biennium.

**Table 16: Summary of Case Appeals Activity
2013-15 Biennium**

Docket Number	Profession	County	Outcome
M2009-347	Physician	King	Denied
M2012-512	Veterinarian	King	Stayed
M2012-1019	Registered Nurse	King	Dismissed
M2012-1072	Registered Nurse	Benton	Denied
M2013-70	Licensed Practical Nurse	Thurston	Affirmed
M2012-519 M2012-520	Registered Nurse/Advanced Registered Nurse Practitioner	Thurston	Pending
M2010-319	Marriage and Family Counselor	Thurston	Dismissed
M2011-711	Physician	Thurston	Pending
M2012-980 M2012-981	Registered Nurse/Advanced Registered Nurse Practitioner	Thurston	Affirmed
M2013-358	Unlicensed Practice	Spokane	Affirmed
M2012-1134	Dentist	King	Reversed
M2012-1261	Physician	Thurston	Pending
M2013-514	Osteopath Physician	Thurston	Denied
M2014-191	Physician	Pierce	Pending
M2010-1451	Podiatrist	Thurston	Pending
M2013-944	Chemical Dependency Provider	Pierce	Remanded
M2013-293	Dentist	King	Pending
M2015-16	Dentist	King	Dismissed
M2014-826	Osteopath Physician	Thurston	Pending

Alternatives to Discipline

The department may refer practitioners to one of three different substance abuse monitoring programs. Two programs work under contracts monitored by department staff. The department operates a third program.

- Washington Physicians Health Program (WPHP) is a contracted program that works with chemically impaired allopathic physicians and physician assistants, dentists, osteopathic physicians and physician assistants, veterinarians, and podiatrists.
- Washington Recovery Assistance Program for Pharmacy (WRAPP) is a contracted program that works with chemically impaired pharmacists and other credentialed pharmacy staff.
- Washington Health Professional Services (WHPS) is a department-run program that works with chemically impaired practitioners in nursing professions.
- Washington Recovery and Monitoring Program (WRAMP) is a department-run program that works with chemically impaired health professionals not served by WPHP, WHPS, or WRAPP.

Disciplining authorities can refer practitioners to a program. They may also require providers to enter the program as a condition of practice or return to practice. Practitioners may also voluntarily participate in one of the programs if they have an active healthcare credential in Washington. The substance abuse monitoring programs must report practitioners to the department if they don't comply with the conditions of a monitoring contract. The disciplining authority may then take disciplinary action. See Appendix C, Alternative Programs – Chemically Impaired Practitioners for more information.

Case Distribution to Investigators and Staff Attorneys

RCW 18.130.310 requires, as part of the UDA Report, a report that will “summarize the distribution of the number of cases assigned to each attorney and investigator for each profession.” The law further requires that identities of staff attorneys and investigators be kept anonymous. Appendices D and E detail, by health professions identified, the average number of cases assigned and worked by the division's staff attorneys and investigators for the 2013-2015 biennium.

These data may invite comparisons of workload and efficiency between professions. However, the resources needed to pursue individual disciplinary cases cannot be typified across professions or even within a profession. Many factors can influence the amount of investigative and legal resources needed for any individual case, including but not limited to the complexity of the profession, whether there are companion cases with other professions, the nature of the complaint, the availability of investigative records and other information and the involvement of other entities such as law enforcement.

This data also may suggest links to other data within this report, such as the rates of closure of complaints or the rates of discipline. Again, it is important to be cautious; some disciplinary cases may require significant investigative and legal work, only to determine there is no basis for

pursuing discipline. By contrast, in certain instances, serious disciplinary action may occur as a result of information (e.g., criminal convictions or actions by other licensing authorities) that requires relatively little new investigative or legal work.

The table in Appendix D shows cases worked by investigators and staff attorneys during the biennium. The information is shown by staff and profession. As you review, please note:

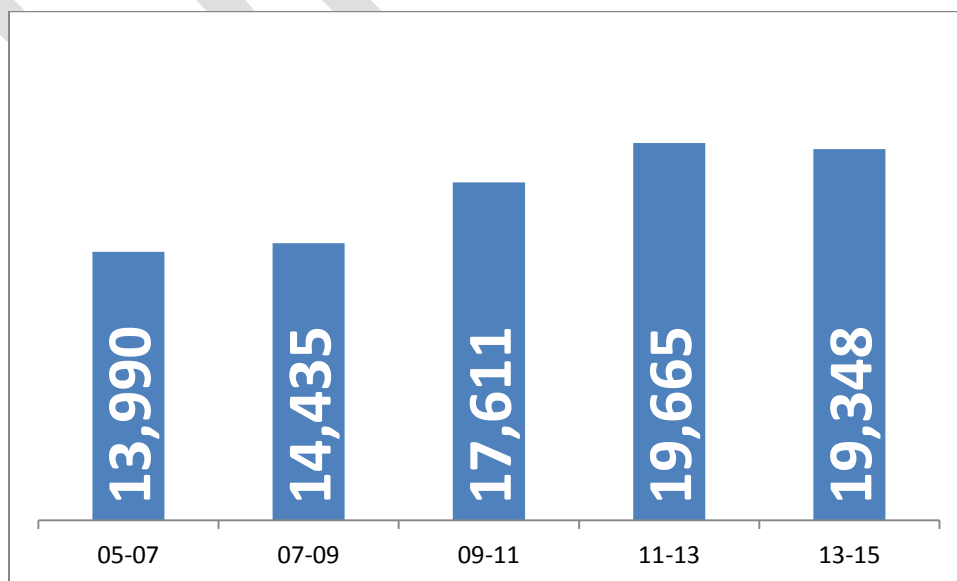
- To preserve anonymity individual staff members are indicated by a number.
- The number of cases shown includes any case worked during the biennium.
- This number of cases shown will be different than the numbers of cases received or closed as it can include cases at any point in the investigative or legal process.
- Not all staff worked for the department through the entire biennium which resulted in varying numbers of cases worked.
- The number of months each staff member worked for the department during the 2013-2015 biennium is indicated in the bottom row of each chart.
- Certain investigators conduct both investigations and inspections for the pharmacy program.
- In some cases, multiple staff may have provided support to the primary investigator or staff attorney.
- Certain staff attorneys work only for the Medical Quality Assurance Commission.

Biennial Comparison

Complaints Received

The number of new complaints received declined 2% from the 2011-13 biennium. This does not include carry-forward complaints from the previous biennium.

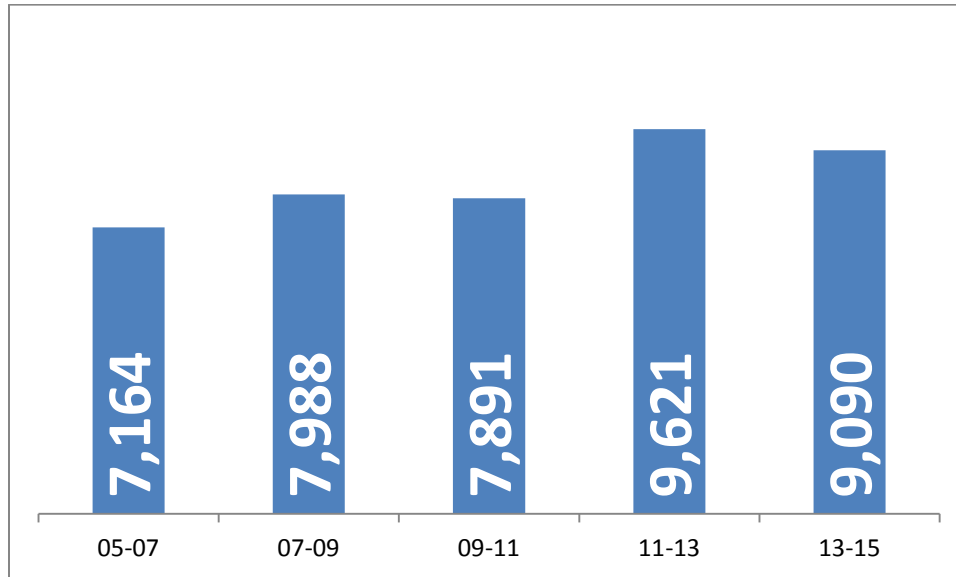
Figure 5: New Complaints Received, 2005-07 to 2013-15 Biennia



Investigations

The number of completed investigations (including unlicensed practice) decreased 6 percent compared to last biennium.

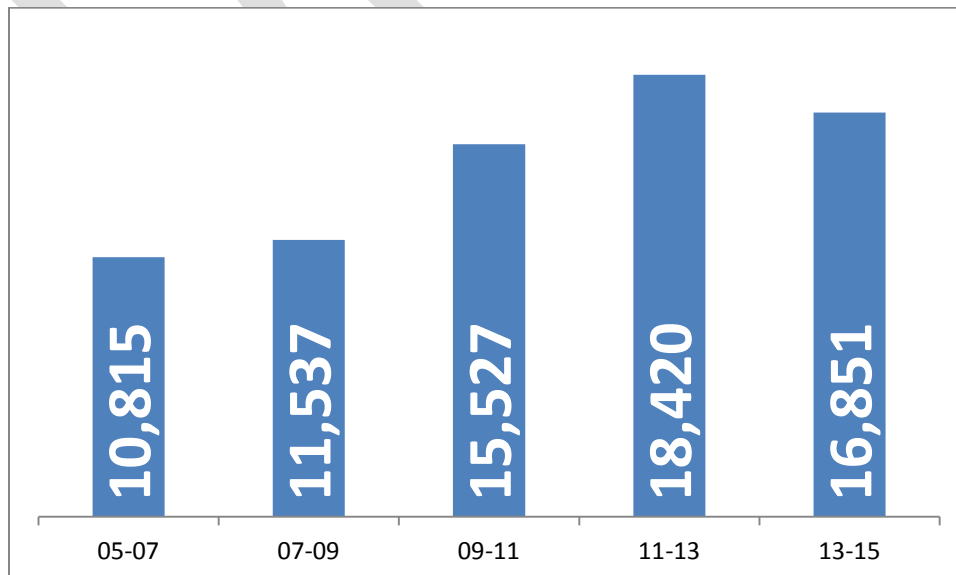
Figure 6: Investigations Completed, 2005-07 to 2013-15 Biennia



Complaint Closures before Adjudicative Proceedings

The following chart shows the change in closures before adjudicative proceedings. These are cases closed with no action. In these cases, evidence disproved the allegations, the complaint was below the threshold for investigation, the disciplinary authority did not have jurisdiction, the allegations were withdrawn, or a Notice of Correction (NOC) was issued. This represents a 9% decrease in closures before adjudicative proceedings over the last biennium.

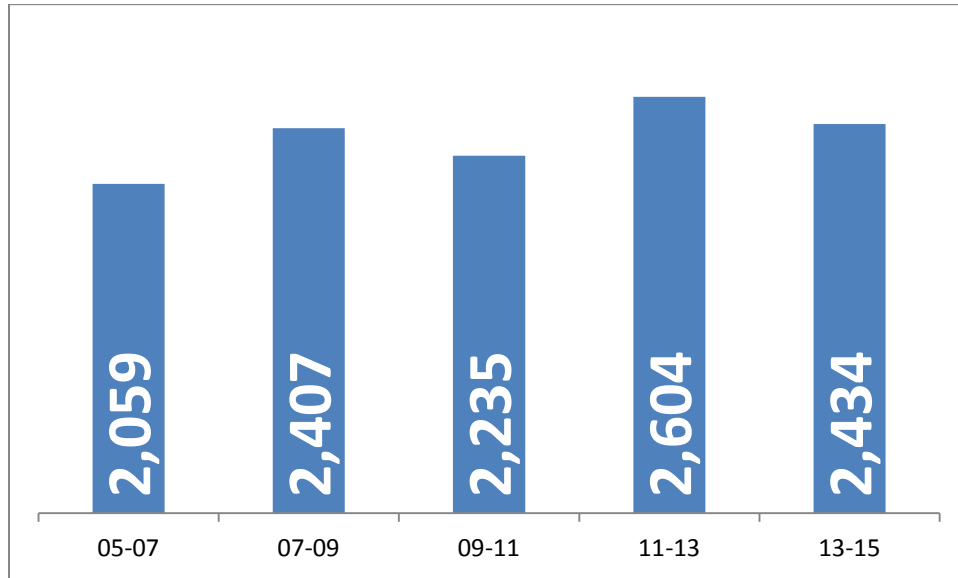
Figure 7: Complaint Closures before Adjudicative Proceedings, 2005-07 to 2013-15 Biennia



Complaint Closures after Adjudicative Proceedings

The following chart shows the 7 percent decrease in cases resolved with corrective or disciplinary action over the 2011-13 biennium. They include cases closed by default orders, informal dispositions, agreed orders, final orders after hearing, unlicensed practice cease-and-desist orders, and notices of decision.

Figure 8: Complaint Closures after Adjudicative Proceedings, 2005-07 to 2013-15 Biennia



DRAFT

Criminal Background Checks

RCW 18.130.064 allows the department to conduct a criminal history background check on all new applicants and current license holders. The purpose of the statute is to ensure patient safety by identifying those who may not be qualified to practice safely.

The department has checked criminal history background on new applicants for credentials since 2000. The tables below provide statistics on the process of evaluative steps in applying the results of background checks on applicants. The department performed over 140,000 background checks on applications during the 2013-2015 biennium. Checks through the Washington State Patrol's WATCH database returned reports for 3,075 applicants.

Of the 3,075 reports (which may include unrelated items such as applications for concealed weapons permits), the department opened 701 cases on applicants based on state background check information. Of these applicants, 73 percent disclosed a conviction on the application. The full report (Table 18) contains additional details about applicants for each profession.

**Table 17: HSQA Background Check Activity Summary
2013-15 Biennium**

Total Applicants	143,435
Applicants with background reports	3,075
Cases opened on applicants with background reports	701
Applicants who disclosed (% of cases)	513 (73%)
Applicants not disclosing (% of cases)	188 (27%)

Also as part of this background check process, all new applicants are checked against a national disciplinary data bank, the National Practitioner Data Bank (NPDB). The NPDB includes information about actions in other states, including some criminal convictions, to help determine the need for further review.

Beginning January 1, 2009, the department requires federal fingerprint checks for certain applicants and licensees. The 2008 legislature authorized the department to perform these checks when a state background check is inadequate. The checks are processed through the FBI's Criminal Justice Information Services (CJIS) Division. The department focuses on applicants coming from outside of Washington and certain applicants with a criminal history in Washington.

Background reports using fingerprint data can reveal convictions as well as non-conviction information. Due to length of the fingerprint process, especially when unreadable fingerprints must be repeated, the department may grant temporary practice permits to applicants who satisfy all licensing requirements but are waiting on FBI results. This helps improve access to care by avoiding delays. The temporary practice permit expires if criminal history is identified and a Notice of Decision is issued.

**Table 18: Criminal Background Reports
2013-15 Biennium**

Profession	Total Applicant Checks Made	WATCH Reports Produced	Cases Opened on Applicants	Self-Disclosed		% Disclosed	Actions Taken
				Yes	No		
Advanced Emergency Medical Technician	50	1	0	0	0		0
Advanced Registered Nurse Practitioner	1385	8	0	0	0		0
Animal Massage Practitioner	32	1	0	0	0		0
Athletic Trainer	176	0	0	0	0		0
Audiologist	63	0	0	0	0		0
Cardiovascular Invasive Specialist	80	4	0	0	0		0
Chemical Dependency Professional	437	111	25	24	1	96%	22
Chemical Dependency Professional Trainee	1213	264	101	96	5	95%	69
Chiropractic X-Ray Technician	101	9	1	1	0	100%	0
Chiropractor	318	10	0	0	0		0
Counselor, Agency Affiliated	4258	215	28	26	2	93%	16
Counselor, Certified	144	9	0	0	0		0
Counselor, Certified Advisor	1	0	0	0	0		0
Dental Assistant	4602	4	28	13	15	46%	8
Dental Hygienist	671	2	1	0	1	0%	1
Dentist	832	1	5	2	3	40%	1
Denturist	29	1	1	1	0	100%	1
Dietitian/Nutritionist	377	4	0	0	0		0
Dispensing Optician	110	10	1	1	0	100%	0
Dispensing Optician Apprentice	337	18	0	0	0		0
East Asian Medicine Practitioner	180	3	0	0	0		0
Emergency Medical Responder	120	3	0	0	0		0
Emergency Medical Technician	2292	83	6	6	0	100%	3
Expanded Function Dental Auxiliary	35	1	0	0	0		0
Genetic Counselor	65	0	0	0	0		0
Health Care Assistant	3	0	0	0	0		0
Hearing Instrument Fitter and Dispenser	46	3	0	0	0		0
Home Care Aide	11482	564	74	33	41	45%	24
Hypnotherapist	237	8	0	0	0		0
Licensed Practical Nurse	2409	63	9	7	2	78%	4
Marriage and Family Therapist	249	3	0	0	0		0
Marriage and Family Therapist Associate	314	2	1	1	0	100%	0
Massage Practitioner	2254	114	55	38	17	69%	9
Medical Assistant	34561	307	99	90	9	91%	33
Mental Health Counselor	959	21	1	0	1	0%	0

Profession	Total Applicant Checks Made	WATCH Reports Produced	Cases Opened on Applicants	Self- Disclosed		% Disclosed	Actions Taken
				Yes	No		
Mental Health Counselor Associate	1100	22	2	2	0	100%	0
Midwife	47	0	0	0	0		0
Naturopathic Physician	176	1	1	0	1	0%	0
Nursing Assistant	29180	553	165	106	59	64%	69
Nursing Home Administrator	108	0	0	0	0		0
Nursing Technician	527	5	0	0	0		0
Occupational Therapist	599	2	0	0	0		0
Occupational Therapy Assistant	347	8	2	2	0	100%	1
Ocularist	1	0	0	0	0		0
Optometrist	174	1	0	0	0		0
Orthoist/Prosthetist	46	0	0	0	0		0
Osteopathic Physician	500	1	0	0	0		0
Osteopathic Physician Assistant	30	0	0	0	0		0
Paramedic	336	6	0	0	0		0
Pharmacist	1652	5	2	0	2	0%	1
Pharmacist Intern	865	3	4	3	1	75%	1
Pharmacy Assistant	5679	160	40	27	13	68%	9
Pharmacy Technician	1424	69	4	3	1	75%	1
Physical Therapist	1013	4	2	2	0	100%	2
Physical Therapist Assistant	537	12	6	5	1	83%	5
Physician	4055	7	0	0	0		0
Physician Assistant	632	0	0	0	0		0
Podiatric Physician	46	0	0	0	0		0
Psychologist	422	3	0	0	0		0
Radiological Technologist	887	47	2	2	0	100%	0
Radiologist Assistant	1	0	0	0	0		0
Recreational Therapist	37	0	0	0	0		0
Registered Nurse	17636	178	21	14	7	67%	4
Respiratory Care Practitioner	588	16	4	2	2	50%	2
Sex Offender Treatment Provider	13	0	0	0	0		0
Social Worker Advanced	43	0	0	0	0		0
Social Worker Associate Advanced	85	1	0	0	0		0
Social Worker Independent Clinical	566	11	0	0	0		0
Speech Language Pathologist	583	1	0	0	0		0
Speech Language Pathology Assistant	52	0	0	0	0		0
Surgical Technologist	782	37	6	3	3	50%	0
Veterinarian	435	4	1	0	1	0%	0
Veterinary Medication Clerk	536	15	1	1	0	100%	1

Profession	Total Applicant Checks Made	WATCH Reports Produced	Cases Opened on Applicants	Self-Disclosed		% Disclosed	Actions Taken
				Yes	No		
Veterinary Technician	477	11	0	0	0		0
X-Ray Technician	796	45	2	2	0	100%	1
Totals	143435	3075	701	513	188	73%	288

DRAFT

Board and Commission Supplemental Reports

RCW 18.130.310(2) allows health professions boards and commissions to prepare a biennial report to complement the UDA report. The reports may provide additional information about disciplinary activities, rule-making and policy activities, and receipts and expenditures.

The following reports were prepared by boards and commissions with regulatory authority for health professions. Note that the Board of Massage and the Board of Denturists are dual authority boards, where certain licensing and/or examination functions are the authority of the board, while disciplinary authority resides with the department; in these cases, disciplinary charts have been omitted.

Reviewing the Disciplinary Graphs

The report for each full authority board or commission includes three graphs:

- 1) The first summarizes, by fiscal year, the number of complaints received, and investigations authorized and completed over the last four years. It also includes the average number of days for investigative activities each year.
- 2) The second depicts the types of disciplinary case outcomes for each board or commission over the past four years, by fiscal year.
- 3) The third illustrates the number of summary actions that have been taken by the board or commission over the last four years, by fiscal year. Summary actions immediately suspend or restrict the practitioner's credential pending the outcome of a final hearing and are only used only when there is imminent risk of harm to the public. There are three categories of summary actions: 1) actions based on conduct, such as criminal conviction; 2) actions based on practice below the standard of care; and 3) suspensions mandated by law based on a prohibition to practice in another state.

For a complete list of definitions, please see Appendix A.

Chiropractic Quality Assurance Commission

Four Year Disciplinary Summary

<p>Complaints</p> <table border="1"> <thead> <tr> <th>Fiscal Year</th> <th>Complaints Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>150</td> <td>120</td> <td>115</td> <td>185</td> </tr> <tr> <td>FY13</td> <td>120</td> <td>70</td> <td>95</td> <td>175</td> </tr> <tr> <td>FY14</td> <td>170</td> <td>105</td> <td>80</td> <td>180</td> </tr> <tr> <td>FY15</td> <td>155</td> <td>120</td> <td>130</td> <td>150</td> </tr> </tbody> </table>	Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	150	120	115	185	FY13	120	70	95	175	FY14	170	105	80	180	FY15	155	120	130	150	<p>Complaints received and investigated increased significantly during FY14 and FY15</p> <p>Average number of days to complete investigation decreased during FY15.</p>
Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	150	120	115	185																						
FY13	120	70	95	175																						
FY14	170	105	80	180																						
FY15	155	120	130	150																						
<p>Cases</p> <table border="1"> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>22</td> <td>8</td> <td>7</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>13</td> <td>7</td> <td>5</td> <td>2</td> </tr> <tr> <td>FY14</td> <td>4</td> <td>6</td> <td>4</td> <td>2</td> </tr> <tr> <td>FY15</td> <td>13</td> <td>10</td> <td>2</td> <td>1</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	22	8	7	0	FY13	13	7	5	2	FY14	4	6	4	2	FY15	13	10	2	1	<p>Cases resolved with informal agreements and agreed orders increased significantly in FY15 compared to FY14.</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	22	8	7	0																						
FY13	13	7	5	2																						
FY14	4	6	4	2																						
FY15	13	10	2	1																						
<p>Summary Actions</p> <table border="1"> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>1</td> <td>0</td> <td>1</td> </tr> <tr> <td>FY13</td> <td>1</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>1</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>1</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	1	0	1	FY13	1	0	0	FY14	1	0	0	FY15	1	0	0	<p>Summary actions remained low during FY14 and FY15</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	1	0	1																							
FY13	1	0	0																							
FY14	1	0	0																							
FY15	1	0	0																							

Rulemaking and Policy Activity

Rules and Policies

- The commission is required by [RCW 18.25.005](#) to maintain a list of diagnostic and analytical devices and procedures under the designation of [approved, non-approved, and research or investigational](#). The Commission created a [new approval process](#) that promotes transparency for items being added to the [Classification of Chiropractic Procedures and Instrumentation List](#).
- On January 1, 2014, the Department of Health decreased the chiropractic application and renewal [fees](#) by \$100 after conducting a six-year budget analysis focusing on spending trends.

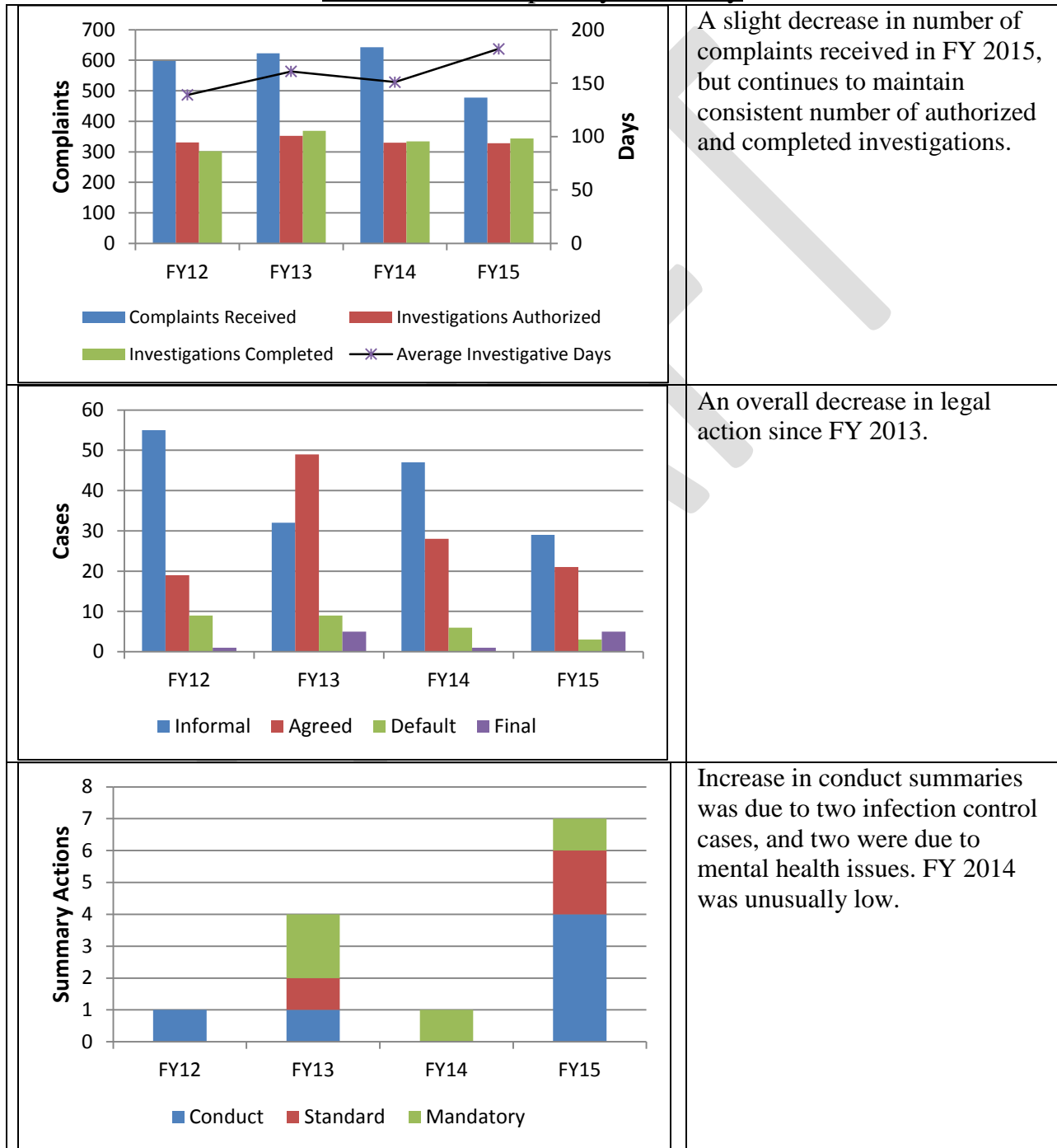
DRAFT

Dental Quality Assurance Commission

The Dental Quality Assurance Commission protects the public by credentialing and disciplining dentists, expanded function dental auxiliaries, dental assistants, and dental anesthesia assistants. The commission regulates the professions by developing rules, policies, and guidelines.

The governor appoints 16 commission members — 12 dentists, two expanded-function dental auxiliaries, and two public members. All serve four-year terms.

Four Year Disciplinary Summary



Rulemaking and Policy Activity

Legislation

Second Substitute Senate Bill 5620 passed in 2012 created certification of dental anesthesia assistants. Dental anesthesia assistants work under close and direct visual supervision of an oral and maxillofacial surgeon or a dental anesthesiologist. The Dental Quality Assurance Commission (commission) adopted rules to implement the new credential July 23, 2013.

House Bill 1534 passed in 2013, increasing a licensed dentist surcharge from \$25 to \$50. The increased fee is paid to the Washington Physicians Health Program (WPHP) to continue to provide services to impaired dentists.

House Bill 1330 passed in 2013 which allows application of topical anesthetics for dental hygienists, dental assistants, and expanded function dental auxiliaries under appropriate dentist supervision. The bill creates new practice setting/location for dental hygienists to provide services to homebound patients under general supervision of a dentist. The commission modified WAC 246-817-550 to include allowing dental hygienists to apply topical anesthetic under general supervision of a licensed dentist.

Senate Bill 5606, passed in 2015, allows:

- a dental hygienist to take a tooth impression for any purpose that is allowed for a dental assistant registered under chapter 18.260 RCW, or as a delegated duty for a dental hygienist under rules adopted by the commission;
- allows for a dental hygiene initial limited license for a dental hygienist who is actively practicing or licensed in a Canadian province; and
- allows a dental assistant to take impressions as a delegated duty under rules adopted by the dental commission.

The bill provides clear statutory authority for the taking of impressions for dental assistants, resolving a current conflict between statute and rule. The commission is considering rule modification in the dental assistant delegation rules.

Senate Bill 5810 passed in 2015 removes the barrier of making dentists notarize applications. The commission is modifying WAC 246-817-110 and 246-817-150 to remove the notarization requirement in the 2015-2016 fiscal year.

Rules and Policies

The commission is amending WAC 246-817-310, Maintenance and Retention of Records – which provides licensed dentists with requirements for maintaining and retaining dental records. The commission identified the need to provide clarity in what should be contained in dental records. The commission has held two rules hearing to consider adoption of modified rules and determined each time to continue rule modification due to stakeholder concerns regarding electronic records, retention period, and business records accessibility. The commission continues to work with stakeholders on rule modification.

The commission is amending WAC 246-817-740, 745, 755, 760, and 772 to update the monitoring and equipment requirements to align with the American Dental Association (ADA) and the American Society of Anesthesiology (ASA) national standards currently being used by

dentists. The commission continues to work with stakeholders to address concerns with monitoring requirements when administering moderate sedation.

The commission is amending WAC's 246-817-510, 520, 525, 540, and 545 related to the delegation of dental duties for dental assistants and expanded function dental auxiliaries. Current rules need to be modified to clarify and amend practice standards to address concerns and confusion. The commission continues to work with stakeholders.

The commission is amending WAC 246-817-160 to clarify required clinical education and examination eligibility process. The rule amendment is needed to ensure clinical education is obtained and to specifically identify when examination eligibility can be met.

The commission is amending WAC 246-817-120 to update the name of one of the examination organizations, clarify complete practical examinations are required, and whether examinations from other states and Canada are acceptable.

The commission completed and implemented the following rule modifications:

- WAC 246-817-770 – Added end-tidal CO₂ monitoring requirements when administering general anesthesia.
- WAC 246-817-160 – Modified education requirements for graduates of non-accredited dental schools.
- WAC 246-817-187 – Added a new section to establish process and criteria for temporary practice permits to be issued to military spouses or state-registered domestic partner credential applicants.
- WAC 246-817-360 – Repealed this rule. The rule is unnecessary as statute provides clear authority for dentists to prescribe any controlled substance or legend drug necessary in the practice of dentistry in RCW 18.32.685.
- WAC 246-817-230 - Added a new section to Chapter 246-817 WAC to establish a retired active status dentist license, which allows a dentist to provide dental services in emergent or intermittent circumstances with no compensation.
- WAC 246-817-460 - Clarified what forcible or nonconsensual acts are within the definition of sexual misconduct by a dental provider.
- WAC 246-817-550 – Added allowing dental hygienists to apply topical anesthetic under general supervision of a licensed dentist.
- WAC 246-817-205, 445, and 771 – Added new sections to implement certification of dental anesthesia assistants.

The Dental Quality Assurance Commission established:

- The Dental Corporate Practice Committee to evaluate laws and practices of corporate/group dental clinics.
- The Educational Outreach Committee to educate and communicate with practitioners and other stakeholders dental related topics. The committee publishes a newsletter with three publications per year.
- The Dental Collaboration Committee to work with dental hygienists and denturists on dental related topics affecting dentistry, dental hygiene, and denturism.

The Dental Quality Assurance Commission finalized an interpretive statement on the use of botulinum toxin injections and dermal fillers by dentists on July 26, 2013.

The use of botulinum toxin injections or dermal fillers in the soft tissues throughout the face can be within the scope of practice of a dentist licensed under chapter 18.32 RCW when:

- Used to treat functional or esthetic dental conditions and their direct esthetic consequences, and
- The treating dentist has appropriate, verifiable training and experience.

The use of botulinum toxin injections or dermal fillers outside the treatment of dental related conditions for purely cosmetic purposes is not within the scope of practice of dentists not specialty trained as an oral and maxillofacial surgeon.

BUDGET

The Department of Health reduced application and renewal fees on January 1, 2014. A preliminary positive fund balance for May 31, 2015 of \$4,196,212 grew from a beginning balance of \$3,721,826 on July 1, 2013.

DRAFT

Board of Denturists

The Board of Denturists protects the public by examining, credentialing and disciplining denturists. The board regulates the profession by developing rules, policies, and guidelines. The secretary appoints seven board members – four denturists, one dentist and two public members. Neither public member may be affiliated with a health care profession or facility. At least one of the public members must be over the age of 65 representing the senior population.

Four Year Disciplinary Summary

<table border="1" style="margin: 10px auto; border-collapse: collapse; text-align: center;"> <caption>Complaints and Investigative Days Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Complaints Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>22</td> <td>16</td> <td>26</td> <td>165</td> </tr> <tr> <td>FY13</td> <td>22</td> <td>14</td> <td>6</td> <td>135</td> </tr> <tr> <td>FY14</td> <td>29</td> <td>18</td> <td>21</td> <td>175</td> </tr> <tr> <td>FY15</td> <td>26</td> <td>16</td> <td>18</td> <td>205</td> </tr> </tbody> </table>	Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	22	16	26	165	FY13	22	14	6	135	FY14	29	18	21	175	FY15	26	16	18	205	<p>Complaints received, rose last biennium, as did average investigative days.</p>
Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	22	16	26	165																						
FY13	22	14	6	135																						
FY14	29	18	21	175																						
FY15	26	16	18	205																						
<table border="1" style="margin: 10px auto; border-collapse: collapse; text-align: center;"> <caption>Disciplinary Cases Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>1</td> <td>4</td> <td>3</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>0</td> <td>1</td> <td>1</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>3</td> <td>1</td> <td>1</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>3</td> <td>2</td> <td>0</td> <td>1</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	1	4	3	0	FY13	0	1	1	0	FY14	3	1	1	0	FY15	3	2	0	1	<p>Legislation in 2013 gave the board disciplinary authority. Since this time the board has concluded a number of disciplinary cases through settlement by informal resolutions known as Stipulations to Informal Disposition (STID) and Agreed Orders.</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	1	4	3	0																						
FY13	0	1	1	0																						
FY14	3	1	1	0																						
FY15	3	2	0	1																						
<table border="1" style="margin: 10px auto; border-collapse: collapse; text-align: center;"> <caption>Summary Actions Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	0	0	0	FY13	0	0	0	FY14	0	0	0	FY15	0	0	0	<p>There were no summary actions during the FY 13-15 biennium. This is normal for the profession.</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	0	0	0																							
FY13	0	0	0																							
FY14	0	0	0																							
FY15	0	0	0																							

Rulemaking and Policy Activity

Legislation

Substitute House Bill (SHB) 1270, making the Board of Denturists (board), passed during the 2013 legislative session. The bill made the Board of Denturists the profession's disciplinary authority instead of the secretary of the Department of Health. The board adopted rules to implement the new law September 26, 2014.

Substitute House Bill (SHB) 1271, relating to the practice of denturism, passed during the 2013 legislative session. The bill allows denturists to provide non-orthodontic removable oral devices and teeth whitening services. The Board of Denturists was required to specify the education and training that was required for a licensed denturist to provide these services. The board adopted rules to implement the new law on April 25, 2014.

Rules and Policies

In response to SHB 1270 and SHB 1271, the board chose to open up and review all of rules in Chapter 246-812 WAC. The rulemaking process included:

- Changing the disciplinary authority from the secretary of the Department of Health to the Board of Denturists;
- Housekeeping changes;
- Amending the continuing competency requirements;
- Clarifying the inactive status license requirements;
- Adopting sexual misconduct rules;
- Changing the times of the chapter from Board of Denture Technology to Board of Denturists;
- Defining the term "bruxism device;"
- Specifying the education and training required for a licensed denturist to provide non-orthodontic removable devices and teeth whitening services; and
- Other rule changes.

The board schedules two practical (clinical) exams a year however they require a minimum of five applicants in order to administer the practical exams. From July 1, 2013 through June 30, 2015, the board administered four practical exams and staff administered 12 written (computerized) exams.

The graph below depicts a five-year exam summary.

Fiscal Year	# of applicants for written exam	# passing written exam	# of applicants for practical exam	# passing practical exam
2011	10	8	11	10
2012	15	8	9	7
2013	4	4	0	0
2014	18	16	17	14
2015	9	9	11	9

Board of Hearing and Speech

The Board of Hearing and Speech protects the public by credentialing and disciplining hearing and speech professions, and by developing rules, policies, and guidelines regulating the practice of audiologists, hearing aid specialists, speech-language pathologists, and speech-language pathology assistants. The governor appoints 11 board members to serve three-year terms. The board consists of two audiologists, two hearing aid specialists, two speech-language pathologists, three public members, one advisory medical physician, and one non-voting speech-language pathology assistant.

Four Year Disciplinary Summary

<p>Complaints and Investigative Days Data:</p> <table border="1" style="display: none;"> <thead> <tr> <th>Fiscal Year</th> <th>Complaints Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>35</td> <td>18</td> <td>15</td> <td>220</td> </tr> <tr> <td>FY13</td> <td>13</td> <td>10</td> <td>13</td> <td>130</td> </tr> <tr> <td>FY14</td> <td>15</td> <td>2</td> <td>3</td> <td>155</td> </tr> <tr> <td>FY15</td> <td>18</td> <td>7</td> <td>5</td> <td>155</td> </tr> </tbody> </table>	Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	35	18	15	220	FY13	13	10	13	130	FY14	15	2	3	155	FY15	18	7	5	155	<p>notes</p>
Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	35	18	15	220																						
FY13	13	10	13	130																						
FY14	15	2	3	155																						
FY15	18	7	5	155																						
<p>Cases by Disposition Data:</p> <table border="1" style="display: none;"> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>0</td> <td>0</td> <td>9</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>0</td> <td>0</td> <td>4</td> <td>1</td> </tr> <tr> <td>FY14</td> <td>0</td> <td>1</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	0	0	9	0	FY13	0	0	4	1	FY14	0	1	0	0	FY15	1	0	0	0	<p>Most cases are settled through a Stipulation to Informal Disposition (STID), an informal resolution, or an agreed order. When the board issues a Statement of Charges (SOC) against a licensee, the licensee has 20 days in which to respond. If the licensee doesn't respond, it is considered a default</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	0	0	9	0																						
FY13	0	0	4	1																						
FY14	0	1	0	0																						
FY15	1	0	0	0																						
<p>Summary Actions Data:</p> <table border="1" style="display: none;"> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	0	0	0	FY13	0	0	0	FY14	0	0	0	FY15	0	0	0	<p>There were no summary actions during the FY 13-15 biennium. This is normal for the profession.</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	0	0	0																							
FY13	0	0	0																							
FY14	0	0	0																							
FY15	0	0	0																							

Rulemaking and Policy Activity

Legislation

Engrossed House Bill (EHB) 2108 passed during the 2014 legislative session. EHB 2108 changed the name of the hearing instrument fitter/dispenser credential to a hearing aid specialist credential and added a nine-month certificate program and a practical exam as a route to licensure for hearing aid specialists.

Rules and Policies

The Board of Hearing and Speech (board) developed and revised rules that were filed with the code reviser's office on June 29, 2015. The rules were effective July 1, 2015 and revisions were made to all sections of chapter 246-828 WAC. Rule revisions included:

- Implementing EHB 2108 to change the hearing instrument fitter/dispenser credential to a hearing aid specialist credential. The rules also set standards for board approval of nine-month programs, outline curriculum requirements, and add a practical exam for graduates of nine-month programs.
- Adding continuing education requirements for speech-language pathology assistants and multicultural education as an acceptable CE category.
- Adding a temporary practice permit for military spouses per RCW 18.340.020.
- Updating sexual misconduct standards.
- Updating exam standards.
- Making general housekeeping updates to clarify rule language.

Board of Massage

The Board of Massage protects the public’s health and safety by regulating the competency and quality of licensed massage practitioners. The governor appoints four massage practitioners and one public member to four-year terms. The professional members must have at least three years of experience as a massage practitioner immediately preceding appointment. The public member cannot be an employee of the state or a present or former member of another licensing board.

Four Year Disciplinary Summary

<table border="1"> <caption>Complaints and Investigative Days Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Complaints Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>220</td> <td>200</td> <td>150</td> <td>155</td> </tr> <tr> <td>FY13</td> <td>220</td> <td>200</td> <td>230</td> <td>165</td> </tr> <tr> <td>FY14</td> <td>410</td> <td>230</td> <td>170</td> <td>170</td> </tr> <tr> <td>FY15</td> <td>730</td> <td>280</td> <td>340</td> <td>100</td> </tr> </tbody> </table>	Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	220	200	150	155	FY13	220	200	230	165	FY14	410	230	170	170	FY15	730	280	340	100	<p>There has been a significant increase in complaints, likely due to RCW 18.108.195 which authorizes the secretary to inspect the premises of any massage or reflexology business establishment. For a significant number of the random inspections, the department has had to open 2-5 cases for unlicensed practice per inspection.</p>
Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	220	200	150	155																						
FY13	220	200	230	165																						
FY14	410	230	170	170																						
FY15	730	280	340	100																						
<table border="1"> <caption>Cases by Resolution Type</caption> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>6</td> <td>8</td> <td>8</td> <td>5</td> </tr> <tr> <td>FY13</td> <td>8</td> <td>14</td> <td>28</td> <td>5</td> </tr> <tr> <td>FY14</td> <td>4</td> <td>11</td> <td>8</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>4</td> <td>19</td> <td>6</td> <td>3</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	6	8	8	5	FY13	8	14	28	5	FY14	4	11	8	0	FY15	4	19	6	3	<p>The disciplining authority of the massage profession falls under the Secretary of the Department of Health.</p> <p>There has been a decrease in respondents not responding to charges and an increase of them signing and agreed order.</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	6	8	8	5																						
FY13	8	14	28	5																						
FY14	4	11	8	0																						
FY15	4	19	6	3																						
<table border="1"> <caption>Summary Actions by Type</caption> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>0</td> <td>0</td> <td>1</td> </tr> <tr> <td>FY13</td> <td>5</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>2</td> <td>0</td> <td>1</td> </tr> <tr> <td>FY15</td> <td>6</td> <td>0</td> <td>2</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	0	0	1	FY13	5	0	0	FY14	2	0	1	FY15	6	0	2	<p>Due to the nature of the profession, the majority of summary actions are based on cases of sexual misconduct.</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	0	0	1																							
FY13	5	0	0																							
FY14	2	0	1																							
FY15	6	0	2																							

Rulemaking and Policy Activity

Legislation

Substitute House Bill 1252 – Prescribing penalties for allowing or permitting unlicensed practice of massage therapy or reflexology passed in the 2015 legislative session. The bill added a new section to chapter 18.108 RCW. Any person allowing the unlicensed practice of massage or reflexology is guilty of a misdemeanor and, for subsequent violations, guilty of a gross misdemeanor, punishable under chapter 9A.20 RCW

Rules and Policies

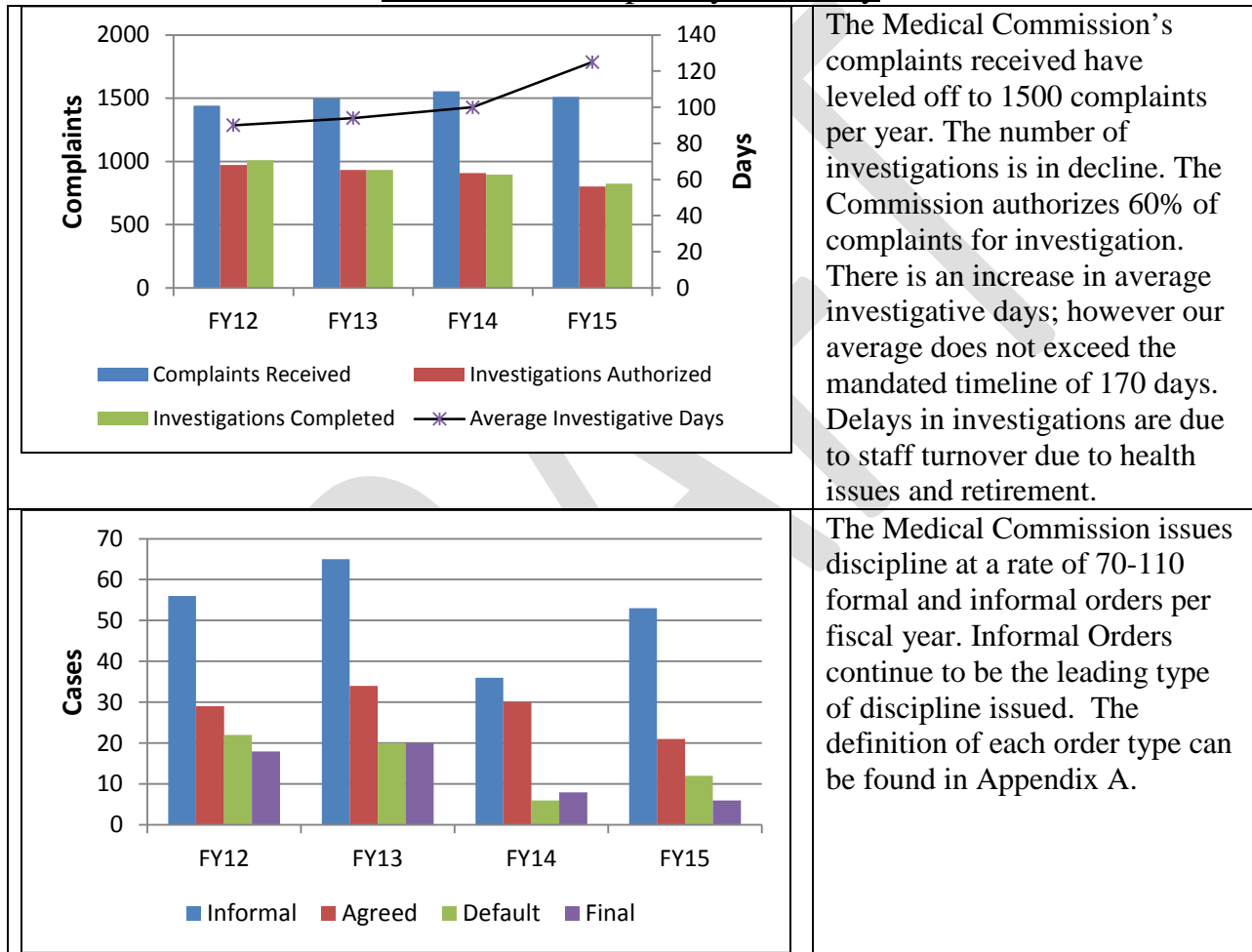
Chapter 246-830 WAC, Massage Practitioners, was opened to consider clarifying, streamlining, and modernizing regulations. The Department of Health has not conducted a comprehensive review of chapter 246-830 WAC since its adoption in the early 1990s.

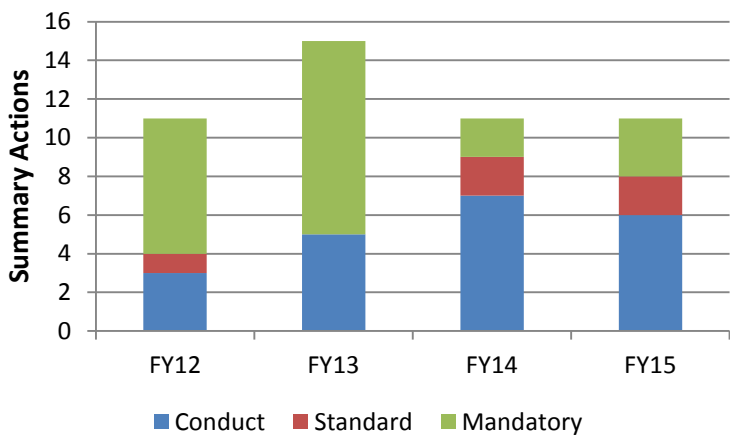
The Department and Board intend to adopt new rules regarding draping, recordkeeping, and transfer of training hours to board-approved programs. The training of transfer hours rule is in response to a health-law judge's order that denied an applicant a massage license. The new rule will clarify language in RCW 18.108.010, Qualifications for licensure or certification.

Medical Quality Assurance Commission

The Medical Quality Assurance Commission (MQAC) promotes patient safety and enhances the integrity of the profession through licensing, discipline, rule making, and education. The Governor appoints 21 commission members to four-year terms: thirteen physicians, two physician assistants and six public members. SHB 1518, passed in 2013, which made permanent the additional authority granted to the Commission, began the process of organizational analysis to better address the medical regulatory needs of Washington and how the Commission will meet them. The Commission continues to pursue work furthering the Governor’s goal of healthy and safe communities.

Four Year Disciplinary Summary





The Medical Commission takes summary action at a rate of 10-15 orders per fiscal year.

DRAFT

Rulemaking and Policy Activity

Legislation

2015

- **SB 5772 MD, DO, PA Demographics.** This bill was passed in the Health Care Committee, but while on the Senate floor, it missed cutoff. The bill language was later attached to HB 1485 funding physician residencies, which was passed and concurred with by the opposite house. The Governor signed the bill into law on May 14th, 2015 and was effective July 24th, 2015. We are implementing steps to add demographic information to all initial applications, force completion in online renewal, and changing all communications in paper renewal.
- **SSB 5448 Lyme Disease Treatment:** Passed and signed into law. The Commission must conduct a study/literature review and report by the end of the year to Gov. The report was approved by the Commission.

Budget Decision Package: MQAC Discipline Enhancement: The Medical Commission was granted additional spending authority for the purpose of adding professional level discipline staff and addressing growing discipline costs related to expert witness and prosecution functions. The decision package also includes funding for anticipated increased research and investigative tasks related to medical marijuana authorization and complaints.

Policies

The Medical Commission has issued or revised the following policies, procedures and guidelines.

MD2015-08	Revised	A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety
MD2015-07	Revised	Delegation of Signature of Authority for Credentialing, Disciplinary and Rulemaking
MD2015-06	New	Ownership of Clinics by Physician Assistants
MD2015-05	Revised	Stipulations to Informal Disposition
MD2015-04	New	Possession and Administration of Naloxone
MD2015-02	Revised	Transmission of Time Critical Medical Information
MD2015-01	Revised	Consent Agenda Procedure
MD2014-07	New	Medical Marijuana Authorization Guidelines
MD2014-03	New	Appropriate Use of Telemedicine
MD2014-02	New	Professionalism and Electronic Media (Social media)

Rulemaking

The Medical Commission revised physician assistant rules to comply with SHB 1737. WAC 246-918 was adopted 12/05/2014.

Board of Naturopathy

The Board of Naturopathy (board) protects public health, and enhances patient safety and the integrity of the naturopathic physician profession through licensing, disciplinary action, rulemaking, and education.

The governor appoints seven board members – five naturopathic physicians and two public members. Neither public member may be affiliated with a health care profession or facility.

Four Year Disciplinary Summary

<table border="1"> <caption>Complaints and Investigations Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Complaints Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>40</td> <td>35</td> <td>32</td> <td>135</td> </tr> <tr> <td>FY13</td> <td>62</td> <td>52</td> <td>42</td> <td>165</td> </tr> <tr> <td>FY14</td> <td>65</td> <td>58</td> <td>48</td> <td>195</td> </tr> <tr> <td>FY15</td> <td>48</td> <td>38</td> <td>55</td> <td>175</td> </tr> </tbody> </table>	Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	40	35	32	135	FY13	62	52	42	165	FY14	65	58	48	195	FY15	48	38	55	175	<p>The increase in the number of complaints received compared to previous years appears to have leveled off.</p>
Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	40	35	32	135																						
FY13	62	52	42	165																						
FY14	65	58	48	195																						
FY15	48	38	55	175																						
<table border="1"> <caption>Disciplinary Cases Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>2</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>5</td> <td>3</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>8</td> <td>6</td> <td>1</td> <td>1</td> </tr> <tr> <td>FY15</td> <td>3</td> <td>10</td> <td>1</td> <td>5</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	2	0	0	0	FY13	5	3	0	0	FY14	8	6	1	1	FY15	3	10	1	5	<p>Since its creation in 2011, the board has concluded a number of disciplinary cases through Stipulations to Informal Disposition (STID) and agreed orders. In addition the board has had two default orders and held a number of formal disciplinary hearings that resulted in final orders.</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	2	0	0	0																						
FY13	5	3	0	0																						
FY14	8	6	1	1																						
FY15	3	10	1	5																						
<table border="1"> <caption>Summary Actions Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>1</td> <td>0</td> <td>1</td> </tr> <tr> <td>FY14</td> <td>1</td> <td>1</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	0	0	0	FY13	1	0	1	FY14	1	1	0	FY15	0	0	0	<p>The board has had two summary actions for the 2013-2015 biennium, which is consistent with the number of summary actions for 2011-2013 biennium report.</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	0	0	0																							
FY13	1	0	1																							
FY14	1	1	0																							
FY15	0	0	0																							

Rulemaking and Policy Activity

Rules and Policies

- The board amended WAC 246-836-020, 030, 040, 110, and 120, and repealed WAC 246-836-050. These amendments and repeal make Washington State naturopathic physician examination rules consistent with national standards. In addition, the amendments helped to clarify the board's jurisprudence examination requirement.
- The board is amending WAC 246-836-080 to address the one-time, six-hour requirement for naturopathic physicians to obtain training in suicide assessment, treatment, and management as determined by Engrossed Substitute House Bill 2315 (Laws of 2014) and updated by Substitute House Bill 1424 (Laws of 2015).
- The board is considering modification to WAC 246-836-010 and 210 to clarify the types of nonsurgical cosmetic procedures that may or may not be performed by naturopathic physicians.
- The board participated in a workgroup with the Medical Quality Assurance Commission, Nursing Care Quality Assurance Commission, and the Board of Osteopathic Medicine and Surgery to create and adopt shared professional standards expected of health care professionals who authorize medical marijuana under Washington State law. The resulting guidelines are expected to improve patient safety and maintain the dignity of the health professions in the state of Washington.

Nursing Care Quality Assurance Commission

Four Year Disciplinary Summary

<p>Complaints</p> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th>Fiscal Year</th> <th>Complaints Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>1850</td> <td>650</td> <td>700</td> <td>220</td> </tr> <tr> <td>FY13</td> <td>1650</td> <td>550</td> <td>800</td> <td>180</td> </tr> <tr> <td>FY14</td> <td>1550</td> <td>650</td> <td>650</td> <td>100</td> </tr> <tr> <td>FY15</td> <td>1550</td> <td>550</td> <td>500</td> <td>110</td> </tr> </tbody> </table>	Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	1850	650	700	220	FY13	1650	550	800	180	FY14	1550	650	650	100	FY15	1550	550	500	110	<p>Complaints received in FY14 and FY15 are slightly less than the previous biennium. Investigations authorized decreased from FY14 to FY15. Investigations completed are down as a result of the elimination of the backlog of cases in investigation.</p>
Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	1850	650	700	220																						
FY13	1650	550	800	180																						
FY14	1550	650	650	100																						
FY15	1550	550	500	110																						
<p>Cases</p> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>65</td> <td>65</td> <td>85</td> <td>10</td> </tr> <tr> <td>FY13</td> <td>80</td> <td>75</td> <td>75</td> <td>15</td> </tr> <tr> <td>FY14</td> <td>85</td> <td>75</td> <td>85</td> <td>20</td> </tr> <tr> <td>FY15</td> <td>65</td> <td>85</td> <td>75</td> <td>10</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	65	65	85	10	FY13	80	75	75	15	FY14	85	75	85	20	FY15	65	85	75	10	<p>Cases closed with action continued to increase in FY14, lessening in FY15. This is due, in part, to the investigations being completed sooner and moving forward for resolution.</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	65	65	85	10																						
FY13	80	75	75	15																						
FY14	85	75	85	20																						
FY15	65	85	75	10																						
<p>Summary Actions</p> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>1</td> <td>0</td> <td>32</td> </tr> <tr> <td>FY13</td> <td>2</td> <td>0</td> <td>30</td> </tr> <tr> <td>FY14</td> <td>1</td> <td>4</td> <td>27</td> </tr> <tr> <td>FY15</td> <td>7</td> <td>2</td> <td>21</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	1	0	32	FY13	2	0	30	FY14	1	4	27	FY15	7	2	21	<p>Most nursing summary suspensions in Washington are issued based on action in another state. FY15 shows an increase in cases based on conduct.</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	1	0	32																							
FY13	2	0	30																							
FY14	1	4	27																							
FY15	7	2	21																							

Rulemaking and Policy Activity

Legislation

House Bill 2080 Next Generation Identification “RapBack”

This legislation that would authorize the Nursing Commission (and other health professions who choose to participate) to conduct federal background checks on all applicants and licensees *and* allow the Washington State Patrol and FBI to retain non-criminal fingerprints of those applicants and licensees for the purpose of participating in RapBack. RapBack is an FBI service offered to subscribers that notifies subscribing agencies of existing criminal history or change in criminal history of licensees soon after it occurs anywhere in the country.

Substitute House Bill 1727 Nursing Assistant Scope of Practice

Legislation enacted in 2015 that permits individuals to work under their nursing assistant credential in licensed mental health care facilities requires alignment of the rules with the new law. The Nursing Commission has the authority to define scope of practice for nursing assistants. The Nursing Commission will begin the rules process in 2016.

Rules and Policies

WAC 246-840-740	Sexual Misconduct Prohibited	Adopted 9/12/14
WAC 246-840-125, 202-207	Continuing Competency/Suicide Prevention - In Process	In Process
WAC 246-840-010, 020, 300-455	Clinical Nurse Specialist	In Process
WAC 246-840-045, 090, 130, 455, 500-575	Education - In Process	In Process
WAC 246-841-535	Alternative Programs	In Process

Board of Nursing Home Administrators

The mission and purpose of the Board of Nursing Home Administrators is to protect the health of the people of Washington through the proper licensing of nursing home administrators, and through the objective enforcement of the nursing home administrators practice act or other laws governing the professional behavior of its licensees.

The board consists of four licensed nursing home administrators, four health care professionals and one public member, all of which serve five-year terms.

Four Year Disciplinary Summary

<table border="1" style="margin-top: 10px; width: 100%; border-collapse: collapse;"> <caption>Disciplinary Metrics Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Complaints Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>50</td> <td>35</td> <td>40</td> <td>155</td> </tr> <tr> <td>FY13</td> <td>85</td> <td>35</td> <td>30</td> <td>135</td> </tr> <tr> <td>FY14</td> <td>90</td> <td>28</td> <td>32</td> <td>185</td> </tr> <tr> <td>FY15</td> <td>130</td> <td>45</td> <td>32</td> <td>150</td> </tr> </tbody> </table>	Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	50	35	40	155	FY13	85	35	30	135	FY14	90	28	32	185	FY15	130	45	32	150	<p>The number of complaints received has been increasing steadily since FY 12. There have been many more complaints received directly from individuals (rather than from other state agencies) during that time-frame. This corresponds to a change in the Department of Health website which made the complaint form more visible.</p>
Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	50	35	40	155																						
FY13	85	35	30	135																						
FY14	90	28	32	185																						
FY15	130	45	32	150																						
<table border="1" style="margin-top: 10px; width: 100%; border-collapse: collapse;"> <caption>Cases Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>2</td> <td>0</td> <td>1</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>4</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>4</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	1	0	0	0	FY13	2	0	1	0	FY14	4	0	0	0	FY15	4	0	0	0	<p>The small number of actions for nursing home administrators corresponds to a small number of individuals licensed.</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	1	0	0	0																						
FY13	2	0	1	0																						
FY14	4	0	0	0																						
FY15	4	0	0	0																						
<table border="1" style="margin-top: 10px; width: 100%; border-collapse: collapse;"> <caption>Summary Actions Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	0	0	0	FY13	0	0	0	FY14	0	0	0	FY15	0	0	0	<p>There were no summary actions during the FY 13-15 biennium. This is normal for the nursing home administrator profession.</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	0	0	0																							
FY13	0	0	0																							
FY14	0	0	0																							
FY15	0	0	0																							

Rulemaking and Policy Activity

Legislation

There was not legislation passed relating to Nursing Home Administrators during the 2013-15 biennium.

Rules and Policies

The Board of Nursing Home Administrators filed a CR101 to open all of their rules on March 31, 2015. Two workshops were held in May, 2015. The board will continue to work on these changes in the up-coming biennium.

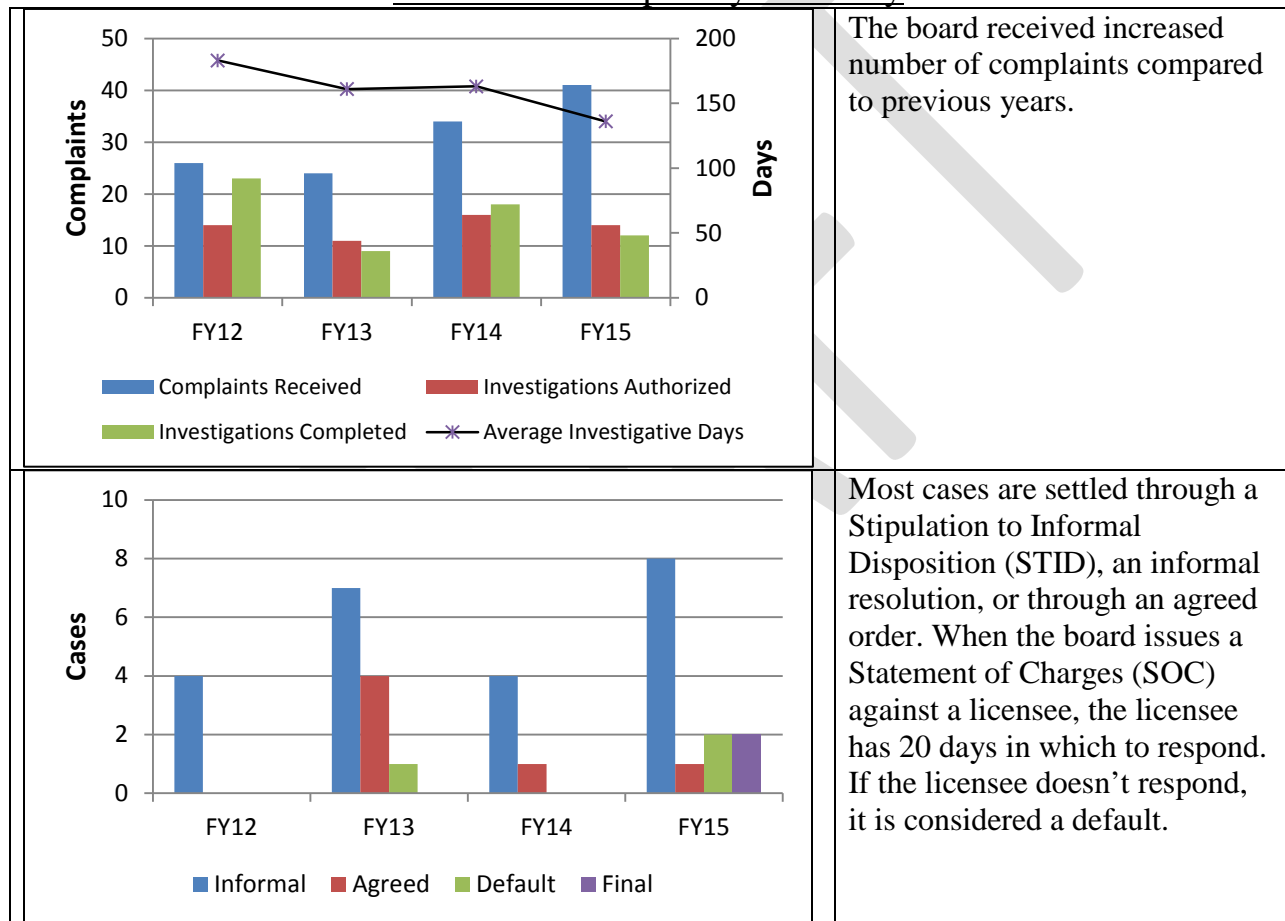
DRAFT

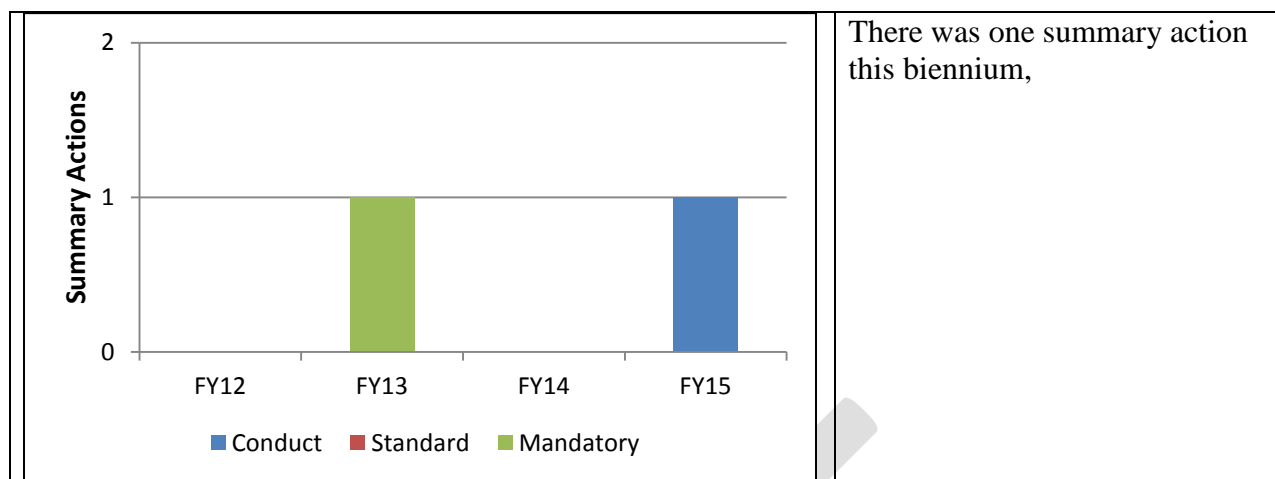
Board of Occupational Therapy Practice

The mandate of the Occupational Therapy Practice Board is to protect the public’s health and safety and to promote the welfare of the state by regulating the competency and quality of professional healthcare providers under its jurisdiction. The board accomplishes this mandate through a variety of activities working with the Department of Health, Health Systems Quality Assurance division.

The board is made up of three occupational therapists, one occupational therapist assistant and one public member appointed by the governor. The professional members must have been in active practice in occupational therapy for at least five years immediately preceding appointment. All members must be residents of Washington State.

Four Year Disciplinary Summary





There was one summary action this biennium,

Rulemaking and Policy Activity

Legislation

SHB 1376 Clarifying CE requirements for suicide assessment, treatment and management re ESHB 2366 (2012). The legislature stated in SHB 1376 (chapter 78, laws of 2013) its intent to educate certain health care practitioners in suicide assessment training in order to help lower the suicide rate in Washington.

Rules and Policies

The Board of Occupational Therapy (board) created rules to implement ESHB 2366 (Chapter 181, Laws of 2012) and SHB 1376 (Chapter 78, Laws of 2013), which clarifies continuing education requirements for suicide assessment training. SHB 1376 authorized the board to determine if only three hours of suicide training would be required based on the occupational therapy practitioner scope of practice. It also authorized the board to exempt certain practitioners who have brief or limited patient contact. The board determined that three hours of training in suicide assessment, screening, and referral was appropriate for all occupational therapists and occupational therapy assistants. The board chose not to exempt any practitioners from the training requirement. The amended rules also specify the standards a program must meet to qualify as a suicide prevention training program pursuant to SHB 1376.

In 2014, the board began working on various parts of the chapter that were opened in 2008, prior to the rules moratorium of 2010. Once the board started looking at the rule sections opened and proposed draft language, the board decided to withdraw the 2008 CR 101 form and start a fresh one to reflect current board members.

Board of Optometry

The Board of Optometry protects the public by credentialing and disciplining optometrists. The board regulates the profession by developing rules, policies, and guidelines.

The governor appoints six members – five licensed optometrists and one public member – to serve three-year terms.

Four Year Disciplinary Summary

<table border="1" style="width: 100%; margin-top: 10px;"> <caption>Complaints and Investigative Data (FY12-FY15)</caption> <thead> <tr> <th>Fiscal Year</th> <th>Complaints Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>33</td> <td>17</td> <td>14</td> <td>100</td> </tr> <tr> <td>FY13</td> <td>33</td> <td>13</td> <td>12</td> <td>150</td> </tr> <tr> <td>FY14</td> <td>29</td> <td>10</td> <td>17</td> <td>200</td> </tr> <tr> <td>FY15</td> <td>28</td> <td>9</td> <td>8</td> <td>150</td> </tr> </tbody> </table>	Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	33	17	14	100	FY13	33	13	12	150	FY14	29	10	17	200	FY15	28	9	8	150	<p>The number of complaints has dropped since 2012. The number of investigations has also decreased over the same period of time. While the average investigative days increased from 2012-14, that number has decreased in 2015.</p>
Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	33	17	14	100																						
FY13	33	13	12	150																						
FY14	29	10	17	200																						
FY15	28	9	8	150																						
<table border="1" style="width: 100%; margin-top: 10px;"> <caption>Case Resolution Data (FY12-FY15)</caption> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>1</td> <td>1</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td> </tr> <tr> <td>FY14</td> <td>2</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>0</td> <td>0</td> <td>1</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	1	1	0	0	FY13	0	0	0	1	FY14	2	0	0	0	FY15	0	0	1	0	<p>The board has few formal hearings. Cases are generally settled through a Stipulation to Informal Disposition (STID), an informal resolution, or through an agreed order. Both the STID and agreed order are subject to national data bank reporting.</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	1	1	0	0																						
FY13	0	0	0	1																						
FY14	2	0	0	0																						
FY15	0	0	1	0																						
<table border="1" style="width: 100%; margin-top: 10px;"> <caption>Summary Actions Data (FY12-FY15)</caption> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>0</td> <td>1</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>0</td> <td>1</td> <td>1</td> </tr> <tr> <td>FY14</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>1</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	0	1	0	FY13	0	1	1	FY14	0	0	0	FY15	1	0	0	<p>The board can issue summary or immediate suspensions and summary restrictions. A restriction allows the licensee to continue to practice with certain conditions until the outcome of a formal hearing. A mandatory summary action based on orders from other states is required. All of these actions are rare. Over four years, the board has ordered four summary actions.</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	0	1	0																							
FY13	0	1	1																							
FY14	0	0	0																							
FY15	1	0	0																							

Rulemaking and Policy Activity

Legislation

In the 2015 Legislative session, substitute senate bill 5293 was passed to preserve the ability of licensed optometrists to use hydrocodone products to treat pain, regardless of potential action by agencies of the federal government to reclassify these products as schedule II narcotics.

Rules and Policies

The following rules were adopted by the Board of Optometry between July 1, 2013 and June 30, 2015:

- **WAC 246-851-610 Approval or removal of medications.** House Bill 1609 (CH. 19, L. 2013), effective July 28, 2013, changed title and reference of the Board of Pharmacy to the Pharmacy Quality Assurance Commission. This rule updates references to the Board of Pharmacy accordingly. The rule was proposed using the expedited rule making process.
- **WAC 246-851-420 Optometrist with prescriptive authorization.** This law removed the requirement in WAC 246-851-420(1) for optometrists to include the letters "TX" on a prescription for legend drugs for therapeutic purposes signifying that the optometrists had completed required training. Statutory changes in 2006 required that all licensed optometrists complete required training and be certified to prescribe legend drugs for therapeutic purposes making it no longer necessary to include the letters "TX".
- **WAC 246-851-235 Credits for cultural competency in clinical care.** This rule provides licensed optometrists optional credit for educational courses which increase cultural competency in health care. The rule addresses the increasing demand for health care practitioners to provide effective care for patients of diverse cultural and social origins. The rule did not change the continuing education credit requirements for optometrists.

Board of Osteopathic Medicine and Surgery

The mission and purpose of the Washington State Board of Osteopathic Medicine and Surgery is to protect the health of the people of Washington through the proper licensing of osteopathic physicians and osteopathic physician assistants, and through the objective enforcement of the Osteopathic Medical Practice Act or other laws governing the professional behavior of its licensees.

The board consists of six practicing osteopathic physicians and one public member, all of which serve five-year terms.

Four Year Disciplinary Summary

<p>This chart displays four metrics over four fiscal years. The left y-axis represents the number of Complainants (0-150), and the right y-axis represents the number of Days (0-250). Blue bars show Complainants Received, red bars show Investigations Authorized, and green bars show Investigations Completed. A purple line with asterisk markers shows the Average Investigative Days.</p> <table border="1"> <thead> <tr> <th>Fiscal Year</th> <th>Complainants Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>95</td> <td>55</td> <td>55</td> <td>230</td> </tr> <tr> <td>FY13</td> <td>80</td> <td>40</td> <td>35</td> <td>150</td> </tr> <tr> <td>FY14</td> <td>115</td> <td>55</td> <td>55</td> <td>150</td> </tr> <tr> <td>FY15</td> <td>140</td> <td>95</td> <td>80</td> <td>140</td> </tr> </tbody> </table>	Fiscal Year	Complainants Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	95	55	55	230	FY13	80	40	35	150	FY14	115	55	55	150	FY15	140	95	80	140	<p>The number of complaints and investigations has risen through 2015. The increased number of complaints could be explained by growth of the profession, which has more than tripled since the board was created in 1979. Washington's only osteopathic medical school graduated its first class in 2012.</p>
Fiscal Year	Complainants Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	95	55	55	230																						
FY13	80	40	35	150																						
FY14	115	55	55	150																						
FY15	140	95	80	140																						
<p>This bar chart shows the number of cases resolved through four different methods: Informal (blue), Agreed (red), Default (green), and Final (purple) orders. The y-axis represents the number of cases (0-10).</p> <table border="1"> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>2</td> <td>8</td> <td>1</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>3</td> <td>8</td> <td>1</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>5</td> <td>6</td> <td>0</td> <td>2</td> </tr> <tr> <td>FY15</td> <td>4</td> <td>4</td> <td>3</td> <td>5</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	2	8	1	0	FY13	3	8	1	0	FY14	5	6	0	2	FY15	4	4	3	5	<p>Typically, the board has few formal hearings and final orders. Cases are mostly settled through an informal stipulation. 2015 was an outlier year in that more final orders were issued than informal or agreed orders.</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	2	8	1	0																						
FY13	3	8	1	0																						
FY14	5	6	0	2																						
FY15	4	4	3	5																						
<p>This stacked bar chart shows the number of summary actions issued, categorized by type: Conduct (blue), Standard (red), and Mandatory (green). The y-axis represents the number of actions (0-4).</p> <table border="1"> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>0</td> <td>1</td> <td>2</td> </tr> <tr> <td>FY13</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>1</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>1</td> <td>0</td> <td>2</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	0	1	2	FY13	0	0	0	FY14	1	0	0	FY15	1	0	2	<p>The board issued seven summary actions this biennium. The board has the ability to issue summary suspensions and/or restrictions if they feel that there is immediate risk to the public.</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	0	1	2																							
FY13	0	0	0																							
FY14	1	0	0																							
FY15	1	0	2																							

Rulemaking and Policy Activity

Re-entry to practice

The board recently adopted rules regarding re-entry to practice. These rules will help assure safety of the public by requiring that these physicians demonstrate certain competencies before providing care. Requirements include passage of an examination or a physician-sponsored program approved by the board.

Retired-active status

The board recently adopted rules creating a retired-active status credential for osteopathic physicians. There is no retired active status credential for an osteopathic physician. An osteopathic physician who meets the requirements for this credential may be authorized to practice on a limited or emergent basis.

Use of laser, light, radiofrequency, and plasma devices applied to the skin

These recently adopted rules will allow osteopathic physicians and osteopathic physician assistants (PA) to delegate use of laser, light, radiofrequency, and plasma devices applied to the skin to “properly trained and licensed professionals.” This is the current language in the Medical Quality Assurance Commission’s rules. Prior to adoption of this rule, osteopathic physician and osteopathic PAs could only delegate the use of these devices to professionals credentialed by the Department of Health. This revision will allow broader delegation of this equipment to professionals such as master estheticians who are licensed by the Department of Licensing.

Physician assistant rulemaking

The 2013 legislature enacted House Bill (HB) 1737 into law. Among other things, the bill directed the board to work with the Medical Quality Assurance Commission and a statewide organization representing the interest to modernize the PA rules. A committee was formed that brought interested parties throughout the state together to collaborate on changes to the allopathic and osteopathic PA chapters of rules resulting in:

- Alignment of the allopathic and osteopathic PA chapters;
- Creation of a retired active credential with a reduced fee for PAs who work on an emergent or limited basis;
- Modernization and alignment of rule sections related to CME requirements;
- A streamlined application process for currently licensed PAs who would like an osteopathic PA license, and vice-versa;
- Updated rules to reflect HB 1737’s statutory changes; and
- General housekeeping and technical edits to align medical commission and osteopathic PA chapters for consistency with national standards.

These modernized rules became effective February of 2015.

Legislation introduced to increase the size of the board

The Washington Osteopathic Medical Association (WOMA) introduced a bill during the 2015 legislative session that, if passed, would have increased the size of the board from seven members to eleven members. The bill would have added two osteopathic physicians, one osteopathic PA, and one public member to the board. The number of osteopathic physicians licensed in Washington State has more than tripled since the current seven member board was created in 1979. The bill did not get voted out of the house rules committee. The board supported this bill, has encouraged WOMA to run the bill again in the 2016 session, and will support those efforts.

House Bill 1485 concerning family medicine residencies in health professional shortage areas

A bill passed during the 2015 intended to promote residency placement in health professional shortage areas contained a provision that the board must request licensees (physicians and PAs) to submit information about their current professional practice at the time of license renewal and licensees must provide the information requested. This information may include practice setting, medical specialty, board certification, or other relevant data determined by the board. Department staff has developed an implementation plan for collecting this data and the board anticipates that they will begin collecting this data in 2016.

Outreach activities

The board holds a meeting at the Pacific Northwest University of Health Sciences in Yakima each year. After their business meeting, the board meets with students to discuss licensing and disciplinary issues that face osteopathic physicians.

Fees and Fiscal Matters

Reduction of licensing fees for osteopathic physicians

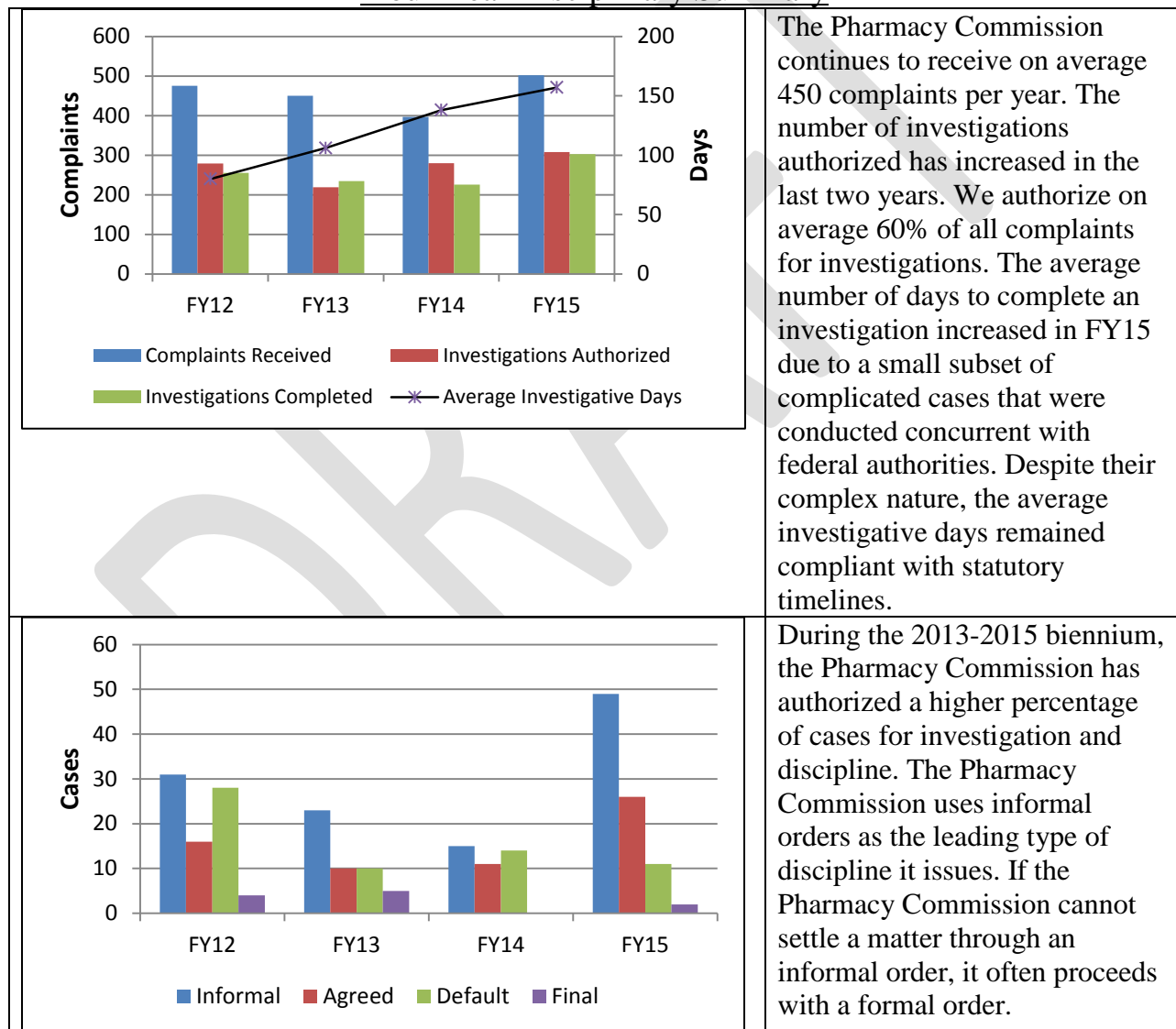
The initial licensure and renewal fees for osteopathic physicians were lowered from \$600 to \$425 effective January 1, 2014. This reduction was based on a fee study conducted by the department. The board has a consistently healthy operating reserve in its budget.

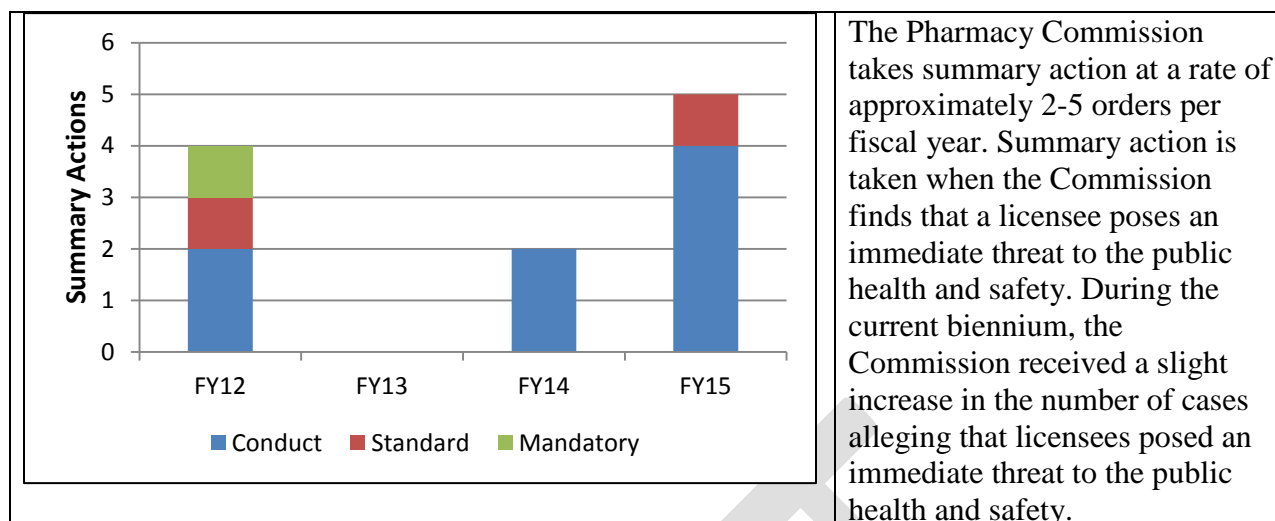
Pharmacy Quality Assurance Commission

The Pharmacy Quality Assurance Commission (commission) protects the public health, safety, and welfare through licensing and discipline of pharmacists, interns, technicians, and pharmacy assistants as well as a variety of pharmaceutical firms. The commission regulates the profession by adopting rules to establish qualifications, competencies, and standard for of practice for dispensing, distribution, wholesaling, and manufacturing of drugs and devices.

In 2013, the Board of Pharmacy was renamed the Pharmacy Quality Assurance Commission and increased the number of members from seven to fifteen. The governor appoints member of the commission with and by consent of the senate. Commission members include ten pharmacist, one pharmacy technician, and four public members.

Four Year Disciplinary Summary





Rulemaking and Policy Activity

Legislation

- House Bill 1609 passed in 2013 renamed the Board of Pharmacy to the Pharmacy Quality Assurance Commission (commission) and doubled the number of pharmacists and public members, and added a pharmacy technician.
- House Bill 1800, passed in 2013, establishes minimum standards of United States Pharmacopeia Convention for sterile and non-sterile pharmaceutical compounding products.
- Substitute Senate Bill 5416, passed in 2013, permits the electronic communication of controlled substance prescription information from a practitioner and received electronically a pharmacy. The systems must meet specific standards and must be approved by the commission. The law also made Schedule III through V controlled substance prescription valid for six months after the date the prescription was issued, which is consistent with Schedule II controlled substance prescriptions.
- Substitute Senate Bill 5459, passed in 2013, allows a pharmacist to dispense up to a 90-day supply of drugs, except controlled substance, when the valid prescription authorizes refills and meets other qualifications in the law.
- Engrossed Senate Bill 5524, passed in 2013, allows a pharmacist to dispense legend and controlled medications based on a valid prescription written by physician assistants and osteopathic physician assistants licensed in another state that meet the same qualification for prescribing as in-state physician assistants.
- Substitute Senate Bill 5148, passed in 2013, allows for the redistribution of donated medications to the indigent, uninsured or under insured. It established the conditions for when prescription drugs or supplies may be donated, accepted, or dispensed. Prescription drugs and supplies dispensed under this law are not eligible for reimbursement or the collection of any related dispensing fees, and cannot be resold. The redistribution of donated prescription drugs does not include controlled substances. Pharmacies' participation is voluntary.
- Engrossed House Bill 1808, passed in 2013, requires a manager or employee of a retail store holding a pharmacy license to notify local law enforcement or the Washington State Patrol if one ounce or less of marijuana is inadvertently left within the premises of the business.

- Engrossed Substitute House Bill 1625, passed in 2014, restricts retailers from selling over-the-counter (OTC) products that contain dextromethorphan (DXM) to persons under eighteen. The law creates civil penalties for selling or purchasing OTC DMX products in violation of the restrictions in the law and preempts local ordinances regulating the sale, distribution, receipt, or possession of DXM. The law does not apply to DXM containing products sold by prescription.
- Substitute House Bill 1625, passed in 2015, allows pharmacies operated by a hospital to provide medication to ambulance and aid services for uses associated with provided emergency medical services. The commission is working with the department of health to develop a model protocol related to the transfer of medications from the hospital pharmacy to the ambulance or aid service.
- Engrossed Substitute House Bill 1671, passed in 2015, increase access to opioid overdose medications to persons at risk or persons in a position to assist a person at risk of experiencing and opioid-related overdoses.
- Substitute Senate Bill 5293, passed in 2015 authorizes pharmacies to dispense hydrocodone combination products prescribed by Washington licensed optometrists.
- Engrossed Senate Bill 5268, passed in 2015, allows a pharmacist to dispense one early refill for topical ophthalmic products under conditions defined in law.
- Engrossed Senate Bill 5935, passed in 2015, defines interchangeable biological products and establishes conditions and process for when a pharmacist can substitute. The commission has posted a link to the federal drug enforcement agency's list of interchangeable biological products (purple book).
- Engrossed Substitute Senate Bill 5460, passed in 2015, establishes standards for dispensing outpatient medications from a hospital emergency department. The law redefines health care entity to include freestanding outpatient surgery centers, residential treatment facilities, and freestanding cardiac care centers that are not otherwise licensed by the state to acquire or possess legend drugs. The law also provides options hospital owned and operated include individual practitioner officer or multi-practitioner clinics to be added by application or renewal to the hospital pharmacy license.
- Engrossed Substitute Senate Bill 6052 - (budget proviso- effective June 30, 2015) mandating that the commission engage interested parties and stakeholders in a process for developing statutory standards and protocols for long-term care pharmacies. The commission must draft a letter report with proposed language and submit it to the legislature by November 15, 2015.

Rules and Policies

- The commission adopted rules to amend WAC 246-887-020 and repealed WAC 246-887-030 to clarify the electronic prescription and dispensing requirements for Schedule II through Schedule V controlled substances. These changes make the rules consistent with state and federal law.
- The commission is amending chapter 246-872 WAC, WAC 246-869-120, and will be adding a new chapter related to the use of technology in pharmacy practice. Technological advances in pharmacy practice have occurred rapidly. Currently, very few rules address contemporary technology in pharmacy practice such as, robotics, remote prescription dispensing, centralized pharmacy services, shared hospital services, remote medication order processing, and workload balancing. Stakeholder work is ongoing.

- The commission is amending chapter 246-869 WAC, WAC 246-863-060, WAC 246-901-100, -120, and -130. Current rules need to be amended to establish standards for pharmacy business practices as it relates to shared accountability of the pharmacist in charge and the business license holder, quality controls or improvements in error reduction, and quotas and performance metrics on clinical and prescription services. The commission continues to work with stakeholders through the Pharmacy Business Practice Committee.
- In response to a rulemaking petition, the commission is considering amending WAC 246-887-040 and -045 to add Lisdexamfetamine, a Schedule II nonnarcotic stimulant for the treatment of binge eating disorder (BED). Lisdexamfetamine is currently approved by the federal Food and Drug Administration for use in the treatment of BED
- The commission is amending chapters 246-878 WAC, 246-871 WAC, 246-903 WAC, and 246-873 WAC to update sterile pharmaceutical compounding standards. Commission is evaluating nationally recognized compounding standards to update and set practice and quality standards for the compounding of sterile and non-sterile preparation in all practice settings. The commission continues to work with stakeholder on draft revisions.
- The commission has begun the rulemaking process to amend WAC 246-869-190 related to pharmacy Inspections. The commission plans to consider evaluating the rules on how pharmacy facility inspections are current conducted using a points-based system.
- The commission is considering updating WAC 246-860-100 related sexual misconduct rules to include sexual contact that involves force, intimidation, lack of consent, or conviction of a sex offense listed in RCW 9.94A.030. The change in rule will provide clear standards of conduct and assist the commission in comply fully with an Executive Order from former Governor Gregoire.
- The commission has adopted WAC 246-869-105 under the provision for emergency rulemaking to allow pharmacists to provide a temporary prescription refill for patients when the patient's pharmacy access is disrupted. The intent of the rule is to provide continuity of care during a proclaimed emergency. The emergency rule will remain in effect for 120 days. The commission will begin rulemaking to consider permanent rules in this matter.

Board of Physical Therapy

The mandate of the Board of Physical Therapy is to protect the public’s health and safety and to promote the welfare of the state by regulating the competency and quality of professional healthcare providers under its jurisdiction. The board accomplishes this through a variety of activities working with the Department of Health, Health Systems Quality Assurance division. The Board of Physical Therapy is made up of four physical therapists, one physical therapist assistant, and one public member appointed by the governor. The board typically meets every 8 weeks.

Four Year Disciplinary Summary

<table border="1" style="margin-top: 10px; width: 100%; border-collapse: collapse;"> <caption>Complaints and Investigative Days Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Complaints Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>75</td> <td>30</td> <td>30</td> <td>200</td> </tr> <tr> <td>FY13</td> <td>55</td> <td>25</td> <td>25</td> <td>150</td> </tr> <tr> <td>FY14</td> <td>95</td> <td>50</td> <td>40</td> <td>130</td> </tr> <tr> <td>FY15</td> <td>85</td> <td>35</td> <td>45</td> <td>170</td> </tr> </tbody> </table>	Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	75	30	30	200	FY13	55	25	25	150	FY14	95	50	40	130	FY15	85	35	45	170	<p>For the last three fiscal years, the average duration of an investigation has been less than the Department’s target of 170 days for the investigative stage of the disciplinary process.</p>
Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	75	30	30	200																						
FY13	55	25	25	150																						
FY14	95	50	40	130																						
FY15	85	35	45	170																						
<table border="1" style="margin-top: 10px; width: 100%; border-collapse: collapse;"> <caption>Cases by Resolution Type</caption> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>6</td> <td>1</td> <td>0</td> <td>1</td> </tr> <tr> <td>FY13</td> <td>4</td> <td>5</td> <td>6</td> <td>2</td> </tr> <tr> <td>FY14</td> <td>2</td> <td>1</td> <td>2</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>0</td> <td>3</td> <td>0</td> <td>1</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	6	1	0	1	FY13	4	5	6	2	FY14	2	1	2	0	FY15	0	3	0	1	<p>notes</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	6	1	0	1																						
FY13	4	5	6	2																						
FY14	2	1	2	0																						
FY15	0	3	0	1																						
<table border="1" style="margin-top: 10px; width: 100%; border-collapse: collapse;"> <caption>Summary Actions by Type</caption> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>1</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>0</td> <td>0</td> <td>1</td> </tr> <tr> <td>FY14</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	1	0	0	FY13	0	0	1	FY14	0	0	0	FY15	0	0	0	<p>The board has the ability to issue summary suspensions and/or summary restrictions. A restriction allows the licensee to continue to practice but only under certain practice conditions until the outcome of a formal hearing. The Board typically does not have to take summary action against licensees.</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	1	0	0																							
FY13	0	0	1																							
FY14	0	0	0																							
FY15	0	0	0																							

Rulemaking and Policy Activity

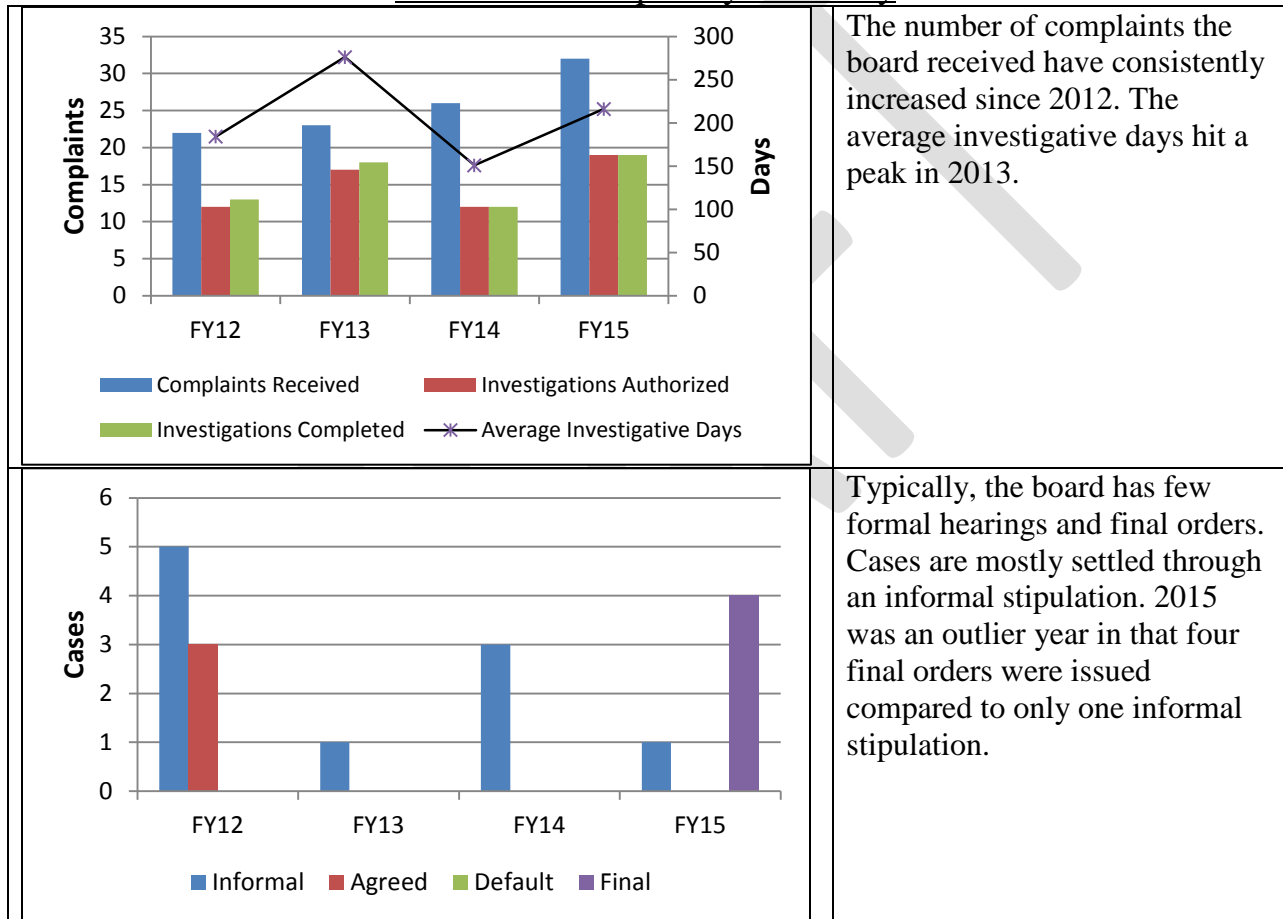
- **House Bill 2160** expands the scope of practice for physical therapists to perform spinal manipulation and manipulative mobilization of the spine and its immediate articulations. The new law is effective July 1, 2015. The rules were adopted in response to Engrossed Substitute House Bill (ESHB) 2160 and ESHB 2315 from the 2014 legislative session.
- **Spinal Manipulation:** The Board of Physical Therapy (board) created rules to implement ESHB 2160 (chapter 116, laws of 2014), which expands the scope of practice of physical therapists (PT) to perform spinal manipulation. The rules adopt the requirements established in ESHB 2160 that set the education and training requirements needed, including supervision to receive an initial endorsement to perform spinal manipulation and manipulative mobilization of the spine. The amended rules also adopt the requirements in ESHB 2160 that identify continuing education and standards of care requirements for those providers who receive this endorsement. The amended rules also define the qualifications required for a licensed PT to be a clinical supervisor.
- **Suicide Screening and Referral:** The legislature stated in ESHB 2315 (chapter 7, laws of 2014) its intent to educate PTs, Physical Therapist Assistants (PTA), and other health care practitioners in suicide assessment, treatment and management in order to help lower the suicide rate in Washington. The board amended rules to meet this intent by establishing criteria for acceptable training programs for PTs and PTAs, which includes a required one-time, three hour training for suicide screening and referral. The amended rules also specify the standards a program must meet to qualify as a suicide prevention training program pursuant to ESHB 2315.

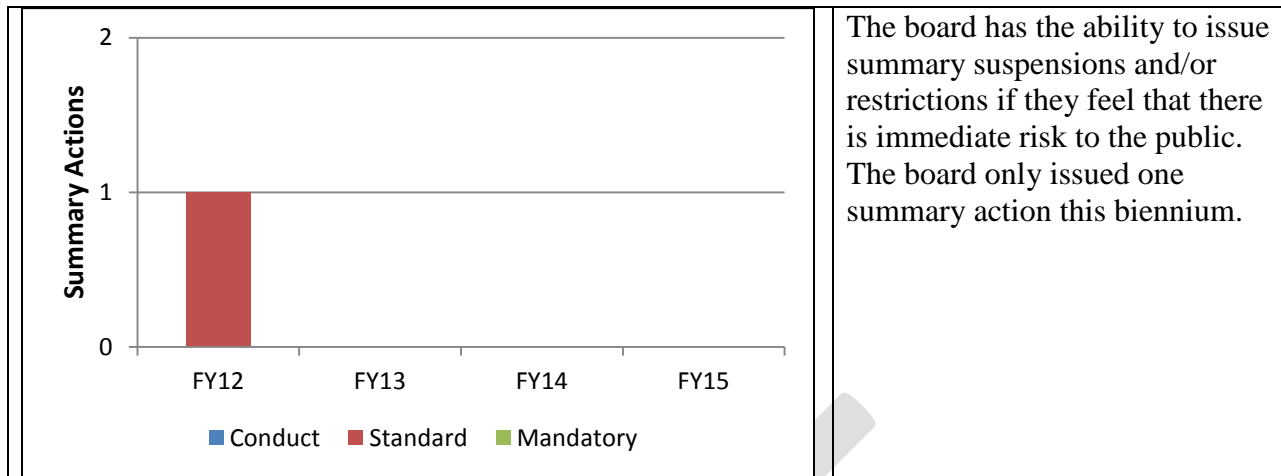
Podiatric Medical Board

The mission and purpose of the Podiatric Medical Board is to protect the public’s health and safety and to promote the welfare of the state by regulating the competency and quality of professional health care providers under its jurisdiction. This is accomplished by establishing and enforcing qualifications for licensure and standards of practice, and where appropriate, by disciplining and monitoring practitioners. Only individuals who meet and maintain prescribed standards of competence and conduct shall be allowed to engage in the practice of podiatry as defined and authorized by Chapter 18.22 RCW.

The board consists of four practicing podiatric physicians and one public member, all of which serve five year terms and may not serve more than two consecutive terms.

Four Year Disciplinary Summary





Rulemaking and Policy Activity

Acts that may be delegated to an unlicensed person

The board is repealing WAC 246-922-100 in light of the new medical assistant law. This section of WAC allowed assistive podiatric personnel to perform certain tasks without a credential. The new medical assistant law sets a scope of practice in statute for medical assistants. The board determined that this section of their WAC is no longer necessary and they will credential their current unlicensed assistive personnel as medical assistants. Development and stakeholder work for these rules will occur from summer of 2013 through spring of 2014.

Update and housekeeping for other sections of rule

The board agreed to amend other sections of their chapter that are out- of-date or contain incorrect information. This includes updating the approved schools of podiatric medicine and the exam requirements for podiatric physicians.

Fees and Fiscal Matters

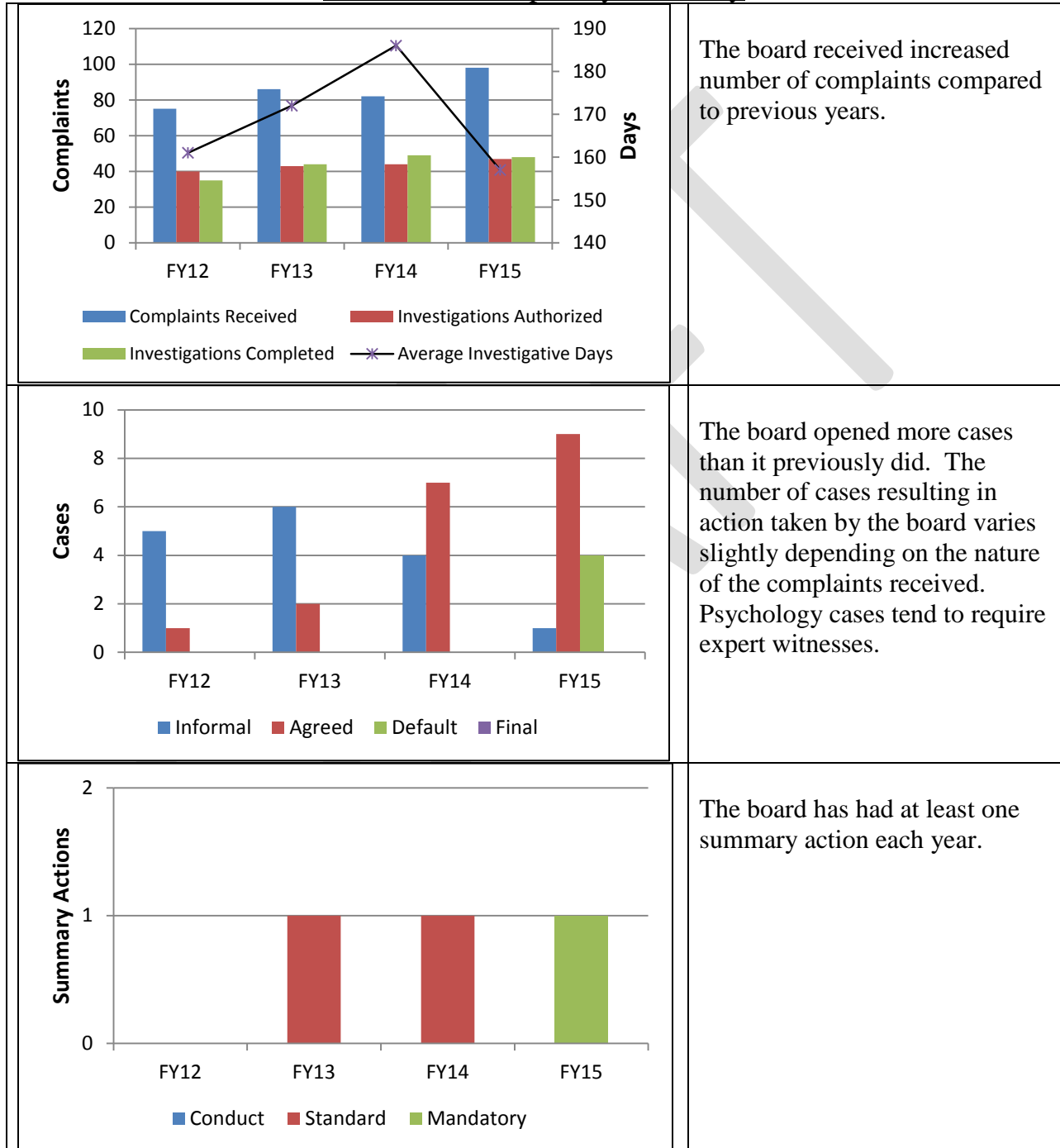
Reduction of licensing fees for podiatric physicians

The initial licensure and renewal fees for podiatric physicians were lowered from \$975 to \$650 effective January 1, 2014. This reduction was based on a fee study conducted by the department. The board has a consistently healthy operating reserve in their budget.

Examining Board of Psychology

- 1) The mission of the board is to protect the public.
- 2) The mission is accomplished through licensing and disciplining psychologists. The board also develops rules, policies, and guidelines regulating the practice of psychology.
- 3) The Governor appoints nine board members to serve five year terms. The board consists of seven psychologists and two public members.

Four Year Disciplinary Summary



Rulemaking and Policy Activity

Legislation

Rules and Policies

Sexual Misconduct

RCW 18.130.050 and RCW 18.83.050(5) authorize the Examining Board of Psychology (board) to establish a comprehensive definition of sexual misconduct. The proposed rule clarifies and expands the definition of sexual misconduct for psychologists.

Allowable coursework

Under a plain reading of [WAC 246-924-046](#), only courses taken as part of the degree granting program count towards meeting the educational components for licensure. In some circumstances, specific courses may have been unavailable during an applicant's doctoral program. This results in an applicant receiving a doctoral degree, but the specific course requirements under [WAC 246-924-046 \(3\)](#) may not have been met. Applicants may have taken pre or post-doctoral courses to fulfill the course requirements and these applicants are qualified for licensure in Washington State.

The board's proposed rules establish the circumstances when additional coursework could be applied to fulfill the educational requirements. Some of these circumstances were initially identified in the interpretive policy statement filed with the Code Reviser as [WSR 12-08-020](#). The board believes that the proposed rules will allow qualified applicants to obtain licensure while fulfilling the board's duty to grant licensure to qualified applicants and to deny licensure to unqualified applicants to "safeguard the people of the state of Washington from the unqualified and improper practice of psychology." [[RCW 18.83.020\(1\)](#)]

Veterinary Board of Governors

The Veterinary Board of Governors protects the public by credentialing and disciplining veterinarians, veterinary technicians, and veterinary medication clerks. The board regulates the professions by developing rules, policies, and guidelines.

The governor appoints seven members – five licensed veterinarians, one licensed veterinary technician, and one public member – to serve five-year terms.

Four Year Disciplinary Summary

<table border="1"> <caption>Complaints and Investigative Days Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Complaints Received</th> <th>Investigations Authorized</th> <th>Investigations Completed</th> <th>Average Investigative Days</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>145</td> <td>105</td> <td>85</td> <td>120</td> </tr> <tr> <td>FY13</td> <td>140</td> <td>90</td> <td>100</td> <td>140</td> </tr> <tr> <td>FY14</td> <td>135</td> <td>75</td> <td>75</td> <td>155</td> </tr> <tr> <td>FY15</td> <td>120</td> <td>70</td> <td>80</td> <td>185</td> </tr> </tbody> </table>	Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days	FY12	145	105	85	120	FY13	140	90	100	140	FY14	135	75	75	155	FY15	120	70	80	185	<p>The number of complaints received and investigated has modestly declined over the past four years. Average investigative days, however, have steadily increased.</p>
Fiscal Year	Complaints Received	Investigations Authorized	Investigations Completed	Average Investigative Days																						
FY12	145	105	85	120																						
FY13	140	90	100	140																						
FY14	135	75	75	155																						
FY15	120	70	80	185																						
<table border="1"> <caption>Cases Resolution Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Informal</th> <th>Agreed</th> <th>Default</th> <th>Final</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>19</td> <td>2</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>10</td> <td>5</td> <td>6</td> <td>1</td> </tr> <tr> <td>FY14</td> <td>11</td> <td>17</td> <td>1</td> <td>12</td> </tr> <tr> <td>FY15</td> <td>5</td> <td>3</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Informal	Agreed	Default	Final	FY12	19	2	0	0	FY13	10	5	6	1	FY14	11	17	1	12	FY15	5	3	0	0	<p>The board has few formal hearings. Most cases are settled through a Stipulation to Informal Disposition (STID), an informal resolution, or through an agreed order.</p>
Fiscal Year	Informal	Agreed	Default	Final																						
FY12	19	2	0	0																						
FY13	10	5	6	1																						
FY14	11	17	1	12																						
FY15	5	3	0	0																						
<table border="1"> <caption>Summary Actions Data</caption> <thead> <tr> <th>Fiscal Year</th> <th>Conduct</th> <th>Standard</th> <th>Mandatory</th> </tr> </thead> <tbody> <tr> <td>FY12</td> <td>1</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY13</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY14</td> <td>1</td> <td>0</td> <td>0</td> </tr> <tr> <td>FY15</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	Fiscal Year	Conduct	Standard	Mandatory	FY12	1	0	0	FY13	0	0	0	FY14	1	0	0	FY15	0	0	0	<p>The board has the ability to issue summary (immediate) suspensions and/or summary restrictions. A restriction allows the licensee to continue to practice but only under certain practice conditions until the outcome of a formal hearing. A mandatory summary action based on orders from other states is required. Two licensees have been summarily suspended in the past four years.</p>					
Fiscal Year	Conduct	Standard	Mandatory																							
FY12	1	0	0																							
FY13	0	0	0																							
FY14	1	0	0																							
FY15	0	0	0																							

Rulemaking and Policy Activity

Legislation

None

Rules and Policies

The following rules were adopted by the Veterinary Board of Governors between July 1, 2013 and June 30, 2015:

- **WAC 246-933-460 Courses approved by the veterinary board.** This rule amended WAC 246-933-460 so that licensed veterinarians can potentially receive “pre-approved” Continuing Veterinary Medicine Education (CVME) credits for attending courses offered by a number of qualified providers. Adding these providers helps licensees access more CVME that meets the board’s requirements and saves board and staff time previously used to pre-approve courses on a case-by-case basis.
- **WAC 246-933-275 Reactivation of expired veterinary license.** This rule sets requirements to re-instate a veterinary license that has expired for more than three years. Veterinarians who haven’t been actively engaged in the practice of veterinary medicine now must successfully complete the current North American Veterinary Licensing Examination (NAVLE). The purpose of the rule is to ensure patient safety by re-testing veterinarians who have not been in active practice in more than three years.
- **WAC 246-933-530 Purchase and use of legend drugs and controlled substances; WAC 246-933-550 Investigation.** House Bill 1609 (CH. 19, L. 2013), effective July 28, 2013, changed title and reference of the Board of Pharmacy to the Pharmacy Quality Assurance Commission. This rule updates references to the Board of Pharmacy accordingly.

Appendices

DRAFT

Appendix A: Definitions

Agreed Order: The document, formally called Stipulated Findings of Fact, Conclusions of Law, and Agreed Order, is a negotiated settlement between the health care provider and representatives of the agency. It states the substantiated violations of law and the sanctions being placed on the health care provider's credential. The health care provider agrees to the conditions in the order. The Agreed Order is presented to the disciplinary authority and if approved, becomes final. The order is reported to national data banks and the public through a press release.

Board or Commission: A board or commission is a part-time, statutory entity which has rule-making authority, performs quasi-judicial functions, has responsibility for the administration or policy direction of a program, or performs regulatory or licensing functions with respect to a specific profession. See also [Chapter 43.03 RCW](#).

Certification: This credential demonstrates that the professional has met certain qualifications. The regulatory authority – a board, commission, or the secretary of health – sets the qualifications. With some professions, someone who isn't certified may perform the same tasks, but may not use "certified" in their title.

Default Orders: A Default Order is issued when the credentialed health care provider is given notice, but either fails to answer the allegations or fails to participate in the adjudicative process as required by law.

Deterrent Sanctions: These include items such as reprimands and fines.

Final Order after Hearing: The document is formally called Findings of Fact, Conclusions of Law and Order. This document is issued after a formal hearing has been held. The hearing may be before a health law judge representing the secretary as the decision-maker or before a panel of board or commission members with a health law judge acting as the presiding officer. The document identifies the proven violations of law and the sanctions being placed on the health care provider's credential. The health care provider has the right to ask for reconsideration of the decision or to appeal to a superior court. The order is reported to national data banks, and released to the public through a press release.

License: This credential allows people to practice if they meet certain qualifications. Practicing without a license is illegal. Licensing regulates what practitioners are trained and authorized to do.

Notice of Decision (NOD): The document issued pursuant to RCW 18.130.055 when the disciplining authority decides to deny an application for licensure or grant the license with conditions.

Registration: The state keeps an official register of names and addresses of the people in a given profession. This credential signifies the professional is on that register. If required, a description and the location of the service are included; however, registrations do not include training, examination, or continuing education requirements.

Rehabilitative Sanctions: These include probation of license, substance abuse treatment and monitoring, remedial education, counseling, and limitations or restrictions on the practice. The health care provider continues to practice with conditions imposed.

Removal from Practice: The health care provider's credential is revoked or indefinitely suspended.

Removal from Practice with Conditions: The health care provider's credential is suspended for a specified period. Conditions for rehabilitation and reinstatement must be met before the credential can be returned to good standing.

Stipulation to Informal Disposition: A Stipulation to Informal Disposition (STID) is an informal resolution. If the health care provider agrees to sign the STID, he or she does not admit to unprofessional conduct, but does agree to corrective action. STIDs are reported to national data banks, but because they are informal they do not result in a press release.

Surrender: The health care provider relinquishes the right to practice. This type of sanction is only permitted, once a complaint is filed, through a stipulation to informal disposition or a formal order. Surrender is not used if the practitioner intends to practice in another jurisdiction or if the disciplining authority believes return to practice is reasonably possible.

**Appendix B: Licensee Counts by Profession
2013-15 Biennium**

Profession	2009	2010	2011	2012	2013	2014	2015	Annual Growth Rate
Advanced Emergency Medical Technician			398	395	391	367	362	-2.9%
Advanced Registered Nurse Practitioner	4,535	4,791	5,035	5,291	5,530	5,975	6,404	6.6%
Animal Massage Practitioner				13	29	45	59	42.6%
Athletic Trainer	372	411	460	499	520	548	587	5.6%
Audiologist	386	380	396	403	399	399	409	0.5%
Cardiovascular Invasive Specialist				90	166	188	224	16.2%
Chemical Dependency Professional	2,654	2,777	2,821	2,843	2,852	2,866	2,878	0.4%
Chemical Dependency Professional Trainee		1,071	1,452	1,462	1,457	1,503	1,446	-0.4%
Chiropractic X-Ray Technician	234	232	227	215	210	204	209	-0.9%
Chiropractor	2,249	2,260	2,334	2,328	2,359	2,383	2,467	2.0%
Counselor, Agency Affiliated		5,220	6,060	5,939	6,334	6,615	7,611	8.6%
Counselor, Certified		304	728	735	717	692	630	-5.0%
Counselor, Certified Advisor			10	10	4	2	3	-33.1%
Dental Assistant	9,339	9,836	11,036	11,709	12,698	13,220	13,692	5.4%
Dental Hygienist	5,196	5,370	5,562	5,696	5,810	5,901	6,056	2.1%
Dentist	5,923	6,072	6,155	6,080	6,048	6,170	6,355	1.5%
Denturist	140	142	151	138	147	160	143	1.2%
Dietitian Nutritionist	1,323	1,419	1,541	1,559	1,450	1,484	1,733	3.6%
Dispensing Optician	934	961	990	1,006	1,019	1,025	1,048	1.4%
Dispensing Optician Apprentice	1,018	999	1,049	1,028	990	968	966	-2.1%
East Asian Medicine Practitioner*	1,131	1,203	1,262	1,253	1,296	1,345	1,387	3.4%
Emergency Medical Responder*	806	704	628	551	468	405	394	-10.6%
Emergency Medical Technician	14,376	13,954	14,095	13,838	13,466	12,932	12,870	-2.4%
Expanded Function Dental Auxiliary	3	56	114	161	188	192	212	9.6%
Genetic Counselor			61	83	105	114	136	17.9%
Health Care Assistant	15,991	16,665	17,880	18,515	21,207	0**	0**	
Hearing Instrument Fitter and Dispenser	263	275	285	290	296	300	302	1.4%
Home Care Aide				15	2941	6570	10708	90.8%

Profession	2009	2010	2011	2012	2013	2014	2015	Annual Growth Rate
Humane Society	6	5	13	17	19	19	18	1.9%
Hypnotherapist	577	621	683	692	690	713	788	4.4%
Intermediate Life Support Technician	358	394	0	0	0	0	0	
Intravenous Therapy Technician	597	573	0	0	0	0	0	
Licensed Practical Nurse	14,085	13,973	13,975	13,380	13,060	12,433	11,944	-3.7%
Marriage and Family Therapist	1,056	1,138	1,237	1,239	1,286	1,378	1,486	6.2%
Marriage and Family Therapist Associate		223	297	345	393	434	466	10.5%
Massage Practitioner	13,018	13,276	13,864	13,927	13,708	13,759	13,656	-0.7%
Medical Assistant	0	0	0	0	0	27,357	31,291	
Mental Health Counselor	4,521	4,827	5,099	5,312	5,515	5,765	6,059	4.5%
Mental Health Counselor Associate		905	1,233	1,329	1,482	1,656	1,789	10.4%
Midwife	105	108	108	116	123	140	161	11.5%
Naturopathic Physician	939	967	1,035	1,096	1,146	1,186	1,231	3.9%
Nursing Assistant	66,991	71,671	74,975	75,715	75,555	75,346	76,056	0.1%
Nursing Home Administrator	443	448	453	460	459	439	441	-1.4%
Nursing Pool Operator	201	186	187	172	157	147	158	-2.8%
Nursing Technician	551	432	415	360	331	355	396	3.2%
Occupational Therapist	2,644	2,747	2,876	2,966	3,078	3,174	3,271	3.3%
Occupational Therapy Assistant	565	594	625	694	762	873	956	11.3%
Ocularist	8	8	8	9	7	7	8	-3.9%
Optometrist	1,475	1,464	1,395	1,428	1,486	1,513	1,547	2.7%
Orthotics Prosthetics	245	264	283	291	301	313	330	4.3%
Osteopathic Physician	1,119	1,206	1,261	1,328	1,437	1,598	1,769	10.0%
Osteopathic Physician Assistant	45	45	50	48	52	53	59	7.1%
Paramedic	2,103	2,178	2,318	2,464	2,525	2,548	2,568	1.4%
Pharmacies and Other Pharmaceutical Firms	3,197	3,311	3,384	3,501	4,306	4,024	4,190	6.2%
Pharmacist	8,216	8,556	8,861	8,983	9,289	9,391	9,627	2.3%
Pharmacist Intern	1,141	1,232	1,236	1,314	1,419	1,413	1,394	2.0%
Pharmacy Assistant	6,123	7,574	8,364	9,059	9,284	9,658	10,299	4.4%
Pharmacy Technician	8,568	8,815	9,257	9,521	9,482	9,108	8,867	-2.3%
Physical Therapist	5,042	5,300	5,577	5,615	5,798	5,966	6,188	3.3%

Profession	2009	2010	2011	2012	2013	2014	2015	Annual Growth Rate
Physical Therapist Assistant	1,258	1,381	1,531	1,631	1,779	1,866	1,971	6.5%
Physician	24,670	25,135	25,783	26,167	26,536	27,044	27,692	1.9%
Physician Assistant	2,220	2,358	2,472	2,569	2,691	2,814	3,018	5.5%
Podiatric Physician	309	322	328	334	317	335	353	1.9%
Psychologist	2,195	2,337	2,422	2,498	2,579	2,673	2,796	3.8%
Radiological Technologist	5,607	5,743	5,830	6,008	5,975	6,071	6,200	1.1%
Radiologist Assistant			3	6	7	8	8	10.1%
Recreational Therapist	131	140	139	134	134	134	146	2.9%
Registered Nurse	79,740	82,094	83,381	84,258	86,091	87,359	87,097	1.1%
Respiratory Care Practitioner	2,384	2,426	2,516	2,593	2,657	2,692	2,794	2.5%
Retired Volunteer Medical Worker	4	6	6	7	7	4	4	-17.0%
Sex Offender Treatment Provider	151	148	149	146	138	135	129	-4.0%
Social Worker Advanced		94	96	98	100	114	119	6.7%
Social Worker Associate Advanced		128	174	181	207	207	201	3.6%
Social Worker Associate Independent Clinical		632	773	873	974	1114	1346	15.5%
Social Worker Independent Clinical	3,116	3,176	3,322	3,448	3,578	3,736	3,858	3.8%
Speech Language Pathologist	1,662	1,736	1,841	1,912	2,113	2,377	2,508	9.5%
Speech Language Pathology Assistant			151	204	206	206	209	0.8%
Surgical Technologist	2,544	2,824	3,041	2,952	2,923	2,898	2,980	0.3%
Veterinarian	3,023	3,166	3,343	3,416	3,417	3,481	3,586	1.6%
Veterinary Medication Clerk	381	425	542	597	656	739	825	11.4%
Veterinary Technician	1,433	1,569	1,610	1,699	1,817	1,886	2,027	6.1%
X-Ray Technician	1,928	1,890	1,837	1,711	1,567	1,551	1,580	-2.6%
Total	343,568	365,873	381,089	386,850	397,620	412,783	427,751	

** The Health Care Assistant credential has been abolished. See Medical Assistant counts.

Appendix C: Alternative Programs – Chemically Impaired Practitioners 2013-15 Biennium

The law provides a way to assure practitioners provide services according to regulatory standards. RCW 18.130.175 allows disciplining authorities to refer a practitioner to a voluntary substance abuse monitoring program instead of disciplinary action. The disciplining authority can also require that a chemically dependent health care provider participate in a substance abuse program.

Profession	Program	Total Mandated	Total Voluntary*	Total Enrolled in Biennium	Successful Completions
Advanced Registered Nurse Practitioner	WHPS	15	5	20	4
Certified Registered Nurse Anesthetist	WHPS	1	2	3	1
Chemical Dependency Professional/Trainee	WRAMP	110	5	115	47
Chiropractor	WRAMP	4	1	5	0
Counselor, Agency Affiliated	WRAMP	11	1	12	5
Counselor, Certified	WRAMP	2	0	2	0
Dental Assistant	WRAMP	13	0	13	0
Dental Hygienist	WRAMP	3	0	3	0
Dentist	WPHP	14	1	15	4
Dispensing Optician	WRAMP	1	1	2	0
Emergency Medical Technician	WRAMP	7	1	8	5
Home Care Aide	WRAMP	6	0	6	1
Licensed Practical Nurse	WHPS	36	15	51	11
Marriage and Family Therapist/Associate	WRAMP	3	0	3	0
Massage Practitioner	WRAMP	5	0	5	1
Medical Assistant/Health Care Assistant	WRAMP	19	1	20	4
Mental Health Counselor/Associate	WRAMP	4	0	4	0
Nursing Assistant	WRAMP	36	1	37	5
Occupational Therapist/Assistant	WRAMP	3	1	4	0
Osteopathic Physician	WPHP	6	0	6	10
Paramedic	WRAMP	5	2	7	1
Pharmacist/Technician/Intern	WRAPP	59	68	127	16
Physical Therapist/Assistant	WRAMP	6	1	7	1
Physician	WPHP	115	2	117	97
Physician Assistant	WPHP	16	0	16	11
Podiatric Physician	WPHP	1	0	1	1
Psychologist	WRAMP	4	1	5	1
Radiological Technologist	WRAMP	4	3	7	1
Registered Nurse	WHPS	281	140	421	101
Respiratory Care Practitioner	WRAMP	2	0	2	1
Social Worker	WRAMP	2	0	2	0

Profession	Program	Total Mandated	Total Voluntary*	Total Enrolled in Biennium	Successful Completions
Speech Language Pathologist	WRAMP	1	0	1	0
Surgical Technologist	WRAMP	3	1	4	1
Veterinarian	WPHP	2	1	3	5
Veterinary Technician/Medication Clerk	WRAMP	2	0	2	1
X-Ray Technician	WRAMP	2	0	2	0
Totals					

* Includes Voluntary and In-lieu of Discipline enrollments

DRAFT

**Appendix D: Distribution of Staff Attorney Workload
2013-15 Biennium**

Profession	Staff Attorney											
	1	2	3	4	5	6	7	8	9	10	11	12
Advanced Emergency Medical Technician	0	0	0	0	0	2	0	0	0	0	0	0
Advanced Registered Nurse Practitioner	33	11	15	0	1	5	0	0	0	0	0	0
Animal Massage Practitioner	0	0	0	0	0	0	0	0	0	1	0	0
Athletic Trainer	0	0	0	0	0	0	0	0	0	0	0	0
Audiologist	0	0	0	0	0	0	0	0	0	1	0	0
Cardiovascular Invasive Specialist	0	0	0	0	1	0	0	0	0	0	0	0
Chemical Dependency Professional	2	1	3	6	0	2	2	2	5	3	9	0
Chemical Dependency Professional Trainee	10	4	6	3	0	7	4	9	14	4	27	1
Chiropractic X-Ray Technician	0	0	0	1	0	0	0	0	0	0	0	0
Chiropractor	0	2	0	9	1	35	0	147	0	42	0	0
Counselor, Agency Affiliated	1	1	3	4	0	2	0	3	4	1	5	0
Counselor, Certified	1	0	0	3	0	0	0	0	3	2	2	0
Counselor, Certified Advisor	0	0	0	0	1	0	0	0	0	0	0	0
Dental Anesthesia Assistant	0	0	0	0	1	0	0	0	0	0	0	0
Dental Assistant	2	0	1	10	0	0	0	0	0	9	6	0
Dental Hygienist	0	0	0	7	0	0	0	0	0	1	0	0
Dentist	1	0	1	49	0	0	4	0	1	53	3	0
Denturist	0	0	0	2	0	0	1	0	1	0	1	0
Dietitian/Nutritionist	0	0	0	0	1	0	0	0	0	0	0	0
Dispensing Optician	0	0	0	1	0	0	0	0	0	1	0	0
Dispensing Optician Apprentice	0	0	0	0	1	0	0	0	0	0	0	0
East Asian Medicine Practitioner	0	0	1	22	0	1	1	0	1	3	1	0
Emergency Medical Responder	0	0	0	0	1	0	0	0	0	0	0	0
Emergency Medical Technician	1	0	4	1	1	10	0	1	33	0	0	0
Expanded Function Dental Auxiliary	0	0	0	0	0	0	0	0	0	1	0	0
Genetic Counselor	0	0	0	0	1	0	0	0	0	0	0	0
Health Care Assistant	4	0	0	3	0	2	0	1	8	1	2	1
Hearing Instrument Fitter/Dispenser	0	0	0	0	1	0	0	0	0	0	0	0
Home Care Aide	4	2	0	2	4	4	1	5	8	0	0	3
Humane Society	0	0	0	0	0	0	0	0	1	0	0	0
Hypnotherapist	0	0	0	0	0	0	1	0	1	0	0	0
Licensed Practical Nurse	56	35	4	1	0	9	0	0	5	0	0	0
Marriage and Family Therapist	1	0	0	0	0	1	1	0	1	1	0	0
Marriage and Family Therapist Associate	0	0	0	1	0	0	0	0	0	0	0	0
Massage Practitioner	5	0	0	16	0	42	22	2	14	26	2	31
Medical Assistant	4	0	3	3	0	2	4	0	12	2	15	6
Mental Health Counselor	2	0	5	5	0	0	3	1	5	3	0	3
Mental Health Counselor Associate	1	0	0	0	0	0	0	0	1	1	0	0
Midwife	0	0	0	0	1	0	0	0	0	2	0	0

Profession	Staff Attorney											
	1	2	3	4	5	6	7	8	9	10	11	12
Naturopathic Physician	0	0	0	0	1	8	0	0	0	0	0	0
Nursing Assistant	104	21	4	66	3	35	24	28	228	2	1	37
Nursing Home Administrator	0	0	0	0	0	0	0	0	0	0	0	0
Nursing Pool Operator	0	0	0	0	1	0	0	0	0	0	0	0
Nursing Technician	0	0	0	0	1	0	0	0	0	0	0	0
Occupational Therapist	0	0	0	7	0	0	0	0	24	0	1	2
Occupational Therapy Assistant	0	0	0	3	0	0	0	0	9	0	0	0
Ocularist	0	0	0	0	1	0	0	0	0	0	0	0
Optometrist	0	0	0	1	0	1	0	0	0	0	0	0
Orthoist/Prosthetist	0	0	0	0	0	0	0	0	0	0	0	0
Osteopathic Physician	0	0	0	0	0	14	0	0	22	2	0	0
Osteopathic Physician Assistant	0	0	0	1	0	0	0	0	3	0	0	0
Paramedic	0	0	3	0	0	4	0	0	18	0	0	0
Pharmacies and Other Pharmaceutical Firms	0	0	0	0	0	0	5	39	0	36	0	0
Pharmacist	1	0	0	11	0	0	20	108	0	94	0	0
Pharmacist Intern	0	0	0	0	0	0	0	3	0	2	0	0
Pharmacy Assistant	0	0	0	0	0	1	6	28	0	21	0	0
Pharmacy Technician	0	0	0	0	0	0	6	52	0	27	0	0
Physical Therapist	0	0	0	7	0	0	0	0	45	0	3	4
Physical Therapist Assistant	0	0	0	11	0	0	0	0	21	0	5	1
Physician	0	0	0	3	0	1	0	0	1	6	0	0
Physician Assistant	0	0	0	0	1	0	0	0	0	0	0	0
Podiatric Physician	0	3	0	0	1	0	0	0	1	0	0	0
Psychologist	1	0	18	1	2	0	0	0	0	1	0	7
Radiological Technologist	0	0	0	0	0	0	0	1	1	0	0	0
Radiologist Assistant	0	0	0	0	1	0	0	0	0	0	0	0
Recreational Therapist	0	0	0	0	0	0	0	0	0	0	0	0
Reflexologist	0	0	0	0	0	1	1	0	0	0	0	0
Registered Nurse	248	121	50	0	5	36	0	0	8	3	0	0
Respiratory Care Practitioner	1	1	0	0	0	0	0	1	1	0	1	0
Retired Volunteer Medical Worker	0	0	0	0	1	0	0	0	0	0	0	0
Sex Offender Treatment Provider	0	0	1	2	0	0	0	0	0	1	0	0
Social Worker Advanced	0	0	0	0	1	0	0	0	0	0	0	0
Social Worker Associate Advanced	0	0	0	0	0	0	0	0	0	0	0	0
Social Worker Associate Independent	0	0	0	0	0	0	0	1	1	0	0	0
Social Worker Independent Clinical	0	2	0	2	0	0	0	0	0	0	1	2
Speech Language Pathologist	0	0	0	1	0	0	0	0	0	0	0	0
Surgical Technologist	0	0	0	0	0	0	1	0	2	0	0	0
Veterinarian	0	0	0	0	0	1	0	0	91	8	0	0
Veterinary Medication Clerk	0	0	0	0	0	0	0	0	0	0	0	0
Veterinary Technician	0	0	0	0	0	0	0	0	7	0	0	0
X-Ray Technician	0	0	0	1	0	1	0	0	1	1	3	2
Totals	484	206	125	270	40	233	114	440	611	372	99	112
Months Worked In Biennium	24	24	24	24	#N/A	24	24	24	24	24	24	24

Profession	13	14	15	16	17	18	19	20	21	22	23	24
Advanced Emergency Medical Technician	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Registered Nurse Practitioner	5	0	22	14	0	0	11	8	0	0	0	0
Animal Massage Practitioner	0	0	0	0	0	0	0	0	0	0	0	0
Athletic Trainer	1	0	0	0	0	0	0	1	0	0	0	0
Audiologist	0	0	1	0	0	0	1	0	0	0	0	5
Cardiovascular Invasive Specialist	0	0	0	0	0	1	0	0	0	0	0	0
Chemical Dependency Professional	3	7	4	5	0	45	7	4	4	0	7	12
Chemical Dependency Professional Trainee	6	18	8	6	0	29	14	8	10	1	9	10
Chiropractic X-Ray Technician	0	0	0	0	0	0	0	0	0	0	0	0
Chiropractor	0	28	0	1	0	0	1	0	10	0	0	18
Counselor, Agency Affiliated	4	3	6	3	0	17	15	3	3	2	9	9
Counselor, Certified	1	2	0	3	0	7	2	0	0	0	2	2
Counselor, Certified Advisor	0	0	0	0	0	1	0	0	0	0	0	0
Dental Anesthesia Assistant	0	0	0	0	0	1	0	0	0	0	0	0
Dental Assistant	0	15	0	1	0	0	0	0	5	14	0	10
Dental Hygienist	0	7	0	0	0	0	1	0	4	6	0	0
Dentist	0	77	0	1	0	1	0	0	21	121	0	20
Denturist	0	11	0	0	0	0	0	0	12	23	0	0
Dietitian/Nutritionist	0	0	0	0	0	1	0	0	0	0	0	0
Dispensing Optician	0	0	0	0	0	1	4	0	0	2	0	0
Dispensing Optician Apprentice	0	0	0	0	0	1	0	0	0	0	0	0
East Asian Medicine Practitioner	0	1	0	0	0	0	5	0	5	5	1	0
Emergency Medical Responder	0	0	0	0	0	1	0	0	0	0	0	0
Emergency Medical Technician	0	8	0	0	0	0	0	0	1	1	0	1
Expanded Function Dental Auxiliary	0	0	0	0	0	0	0	0	0	0	0	0
Genetic Counselor	0	0	0	0	0	1	0	0	0	0	0	0
Health Care Assistant	1	2	0	4	0	1	0	0	0	0	2	10
Hearing Instrument Fitter/Dispenser	0	0	0	0	0	1	0	0	0	0	0	0
Home Care Aide	6	13	1	1	0	1	2	0	15	0	2	2
Humane Society	0	0	0	0	0	0	0	0	0	0	0	0
Hypnotherapist	0	1	2	1	0	2	0	0	0	0	0	0
Licensed Practical Nurse	15	2	27	11	0	0	28	19	2	0	0	0
Marriage and Family Therapist	0	2	2	1	0	8	3	2	0	0	3	2
Marriage and Family Therapist Associate	0	0	1	3	0	1	1	1	2	0	0	0
Massage Practitioner	4	22	5	1	0	54	14	30	16	17	33	5
Medical Assistant	1	4	4	0	0	5	19	7	15	0	16	6
Mental Health Counselor	8	3	6	3	0	22	14	5	3	0	3	9
Mental Health Counselor Associate	0	0	2	1	0	2	1	0	0	0	1	5
Midwife	0	7	1	5	0	0	6	0	1	1	0	0
Naturopathic Physician	0	95	0	0	0	0	1	0	29	1	8	4
Nursing Assistant	95	107	7	41	0	6	3	0	196	1	2	7
Nursing Home Administrator	1	0	105	0	0	0	0	0	0	0	0	123

Profession	13	14	15	16	17	18	19	20	21	22	23	24
Nursing Pool Operator	0	0	0	0	0	1	0	0	0	0	0	0
Nursing Technician	0	0	0	0	0	1	0	0	0	0	0	0
Occupational Therapist	0	0	0	0	0	19	0	0	0	0	0	0
Occupational Therapy Assistant	0	0	0	0	0	7	0	0	0	0	0	0
Ocularist	0	0	0	0	0	1	0	0	0	0	0	0
Optometrist	0	2	0	0	0	0	38	0	0	3	0	0
Orthoist/Prosthetist	0	0	0	0	0	0	0	0	0	0	0	2
Osteopathic Physician	0	1	1	0	0	18	82	0	0	0	0	140
Osteopathic Physician Assistant	0	0	0	0	0	1	1	0	0	0	0	4
Paramedic	0	0	0	0	0	0	0	0	1	0	0	0
Pharmacies and Other Pharmaceutical Firms	20	1	17	2	0	0	0	0	0	0	0	0
Pharmacist	56	0	39	14	0	0	0	0	1	0	0	0
Pharmacist Intern	1	0	0	1	0	0	0	0	0	0	0	0
Pharmacy Assistant	10	1	17	3	0	0	0	0	1	0	0	0
Pharmacy Technician	16	0	14	2	0	0	0	0	0	0	0	0
Physical Therapist	0	0	0	0	0	20	0	0	0	0	0	0
Physical Therapist Assistant	0	1	0	0	0	5	0	0	1	1	0	0
Physician	0	2	0	2	0	2	1	1	2	4	3	2
Physician Assistant	0	0	0	0	0	1	0	0	0	0	0	0
Podiatric Physician	0	0	14	0	0	1	0	0	0	0	20	0
Psychologist	0	0	0	31	0	1	0	0	0	0	46	12
Radiological Technologist	1	0	0	0	0	0	0	0	1	0	1	1
Radiologist Assistant	0	0	0	0	0	1	0	0	0	0	0	0
Recreational Therapist	0	0	0	0	0	0	0	0	0	0	0	1
Reflexologist	0	0	0	0	0	1	0	1	0	0	0	0
Registered Nurse	60	8	138	30	0	0	63	54	13	0	0	0
Respiratory Care Practitioner	1	0	5	0	0	1	0	0	0	0	1	5
Retired Volunteer Medical Worker	0	0	0	0	0	1	0	0	0	0	0	0
Sex Offender Treatment Provider	0	0	1	0	0	1	0	0	0	0	2	1
Social Worker Advanced	0	0	0	0	0	1	0	0	0	0	0	0
Social Worker Associate Advanced	1	0	0	0	0	0	0	0	0	0	0	0
Social Worker Associate Independent	0	0	1	0	0	2	0	0	0	0	0	6
Social Worker Independent Clinical	4	0	0	1	0	17	2	0	1	0	1	12
Speech Language Pathologist	0	1	2	1	0	0	8	0	0	0	0	12
Surgical Technologist	0	0	0	1	0	2	2	0	0	0	5	1
Veterinarian	36	0	32	0	0	13	0	33	0	4	0	0
Veterinary Medication Clerk	0	0	1	0	0	1	0	2	1	0	0	0
Veterinary Technician	2	0	4	0	0	0	1	2	0	0	0	0
X-Ray Technician	0	0	0	0	0	0	2	0	0	0	2	3
Totals	372	466	505	210	17	347	372	201	397	229	202	486
Months Worked In Biennium	24	24	24	24	24	24	24	24	24	24	24	24

Appendix E: Distribution of Investigator Workload
2013-15 Biennium

Profession	Investigator														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Advanced Emergency Medical Technician															
Advanced Registered Nurse Practitioner					1						27				
Ambulance Service															
Ambulance Service Verified	1														
Animal Massage Practitioner															
Athletic Trainer															
Audiologist									1						
Chemical Dependency Professional	15	2	1	12		1			12			1			
Chemical Dependency Professional Trainee	2	2		1					3			1			
Chiropractic X-Ray Technician															
Chiropractor	8	1	6	3		9			13						
Counselor, Agency Affiliated	3		4	2					8			1			
Counselor, Certified		1		1		1									
Counselor, Certified Advisor															
Counselor, Registered															
Dental Assistant	1	7		1			1		1						
Dental Hygienist															
Dentist	2	25	6	2		3	2		20						
Denturist				1											
Dietitian/Nutritionist		2													
Dispensing Optician	6		1												
Dispensing Optician Apprentice															
East Asian Medicine Practitioner		1	1	2											
Emergency Medical Technician		3		1					1						
Genetic Counselor															
Health Care Assistant															
Hearing and Speech															
Home Care Aide	1	2		1					10						
Hypnotherapist							1		1						
Licensed Practical Nurse				1	15						23				
Marriage and Family Therapist	3		1	3											
Marriage and Family Therapist Associate				1					2						
Massage Practitioner	3	5	67	5			1		78			1			
Medical Assistant	8	7	2	6		1	1		12			2			
Mental Health Counselor	5	2	2			6			4						

Mental Health Counselor Associate					2		1								
Midwife															
Naturopathic Physician	18	1	1	2		2			4						
Nursing Assistant	13	27	20	37		8	1		104			7			
Nursing Home Administrator	1	1				2			3			1			
Occupational Therapist					1										
Occupational Therapy Assistant									1						
Optometrist	1					2			2						
Orthoist/Prosthetist															
Osteopathic Physician	8	1	3			5	1		5						
Osteopathic Physician Assistant									1						
Paramedic	4								4						
Pharmacies and other Pharmaceutical Firms		1				1			1			4	23		
Pharmacist												17	61		
Pharmacist Intern													1		
Pharmacy Assistant												5	8		
Pharmacy Technician							1					5	8		
Physical Therapist	1	1	2			1			3			2			
Physical Therapist Assistant															
Physician	4		1						1	33				104	
Physician Assistant									1	2				8	
Podiatric Physician	1	1				1			1						
Psychologist	3	3	1	1		9									
Radiological Technologist				2					1						
Reflexologist									2						
Registered Nurse	2		1	41		2				123					
Respiratory Care Practitioner									3						
Sex Offender Treatment Provider															
Social Worker Advanced															
Social Worker Associate Advanced															
Social Worker Associate Independent				2					3			1			
Social Worker Independent Clinical						1						1			
Speech Language Pathologist															
Surgical Technologist	2			1					1						
Veterinarian	5		5						5						
Veterinary Medication Clerk															
Veterinary Technician		1							4						
X-Ray Technician				1					3						
Grand Total	121	97	129	88	57	56	7	2	319	35	173	18	31	101	112
Months Worked	24	24	24	10	8	24	5	1	24	24	15	10	18		14

Profession	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Advanced Emergency Medical Technician															2
Advanced Registered Nurse Practitioner											4	23			
Ambulance Service										1					
Ambulance Service Verified										1					
Animal Massage Practitioner										1					
Athletic Trainer									1						1
Audiologist															
Chemical Dependency Professional	1			23	6			3	4	7				4	17
Chemical Dependency Professional Trainee				10	3				1	1					10
Chiropractic X-Ray Technician															
Chiropractor	4		7	1				4	3	5				5	11
Counselor, Agency Affiliated			11	3				3	3					3	2
Counselor, Certified			3	1					1						2
Counselor, Certified Advisor				1											
Counselor, Registered									1						
Dental Assistant					2				1	4					4
Dental Hygienist										2					
Dentist	9		15	6				7	11	22				8	20
Denturist	1			3				1	2	2				1	2
Dietitian/Nutritionist									1						
Dispensing Optician					1										
Dispensing Optician Apprentice															
East Asian Medicine Practitioner				3					2	1					4
Emergency Medical Technician					1					1				1	6
Genetic Counselor															
Health Care Assistant															
Hearing and Speech															
Home Care Aide	12		4	8				1	2	1				4	5
Hypnotherapist									2						
Licensed Practical Nurse											15	18			
Marriage and Family Therapist				12					1	2				1	
Marriage and Family Therapist Associate				1						4					
Massage Practitioner	4		3	12				3	2	4				3	7
Medical Assistant	7		1	10				8	3	3				4	9
Mental Health Counselor	1		33					3	13					1	11
Mental Health Counselor Associate			6						2						1
Midwife									9						2
Naturopathic Physician			1	1					7	5					3

Profession	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Nursing Assistant	164			24	62			35	58	26				40	49
Nursing Home Administrator				3	2			3	2	3				1	5
Occupational Therapist				1	4									2	3
Occupational Therapy Assistant					1									1	1
Optometrist				1	1									1	2
Orthoist/Prosthetist				2											
Osteopathic Physician	3			4	5			2	3						8
Osteopathic Physician Assistant															
Paramedic															1
Pharmacies and other Pharmaceutical Firms						41	1								
Pharmacist						37	15								
Pharmacist Intern							1								
Pharmacy Assistant						7	1								
Pharmacy Technician					1	3	1								
Physical Therapist	1							3						2	3
Physical Therapist Assistant				1				3							3
Physician		205	5					2					14		1
Physician Assistant		13	1										1		
Podiatric Physician					1			1	1					2	4
Psychologist				20	1			4	1					1	1
Radiological Technologist	1							1							
Reflexologist															
Registered Nurse										1	41	99			
Respiratory Care Practitioner	1				1			1							1
Sex Offender Treatment Provider				5											
Social Worker Advanced				1											1
Social Worker Associate Advanced															
Social Worker Associate Independent				4				1	1	1					4
Social Worker Independent Clinical				10				4	4	1					
Speech Language Pathologist															
Surgical Technologist								1		1					
Veterinarian	2			2	5			4	5	1				5	4
Veterinary Medication Clerk															
Veterinary Technician								1	1					2	
X-Ray Technician				1	1			1							
Grand Total	211	218	6	209	147	88	19	92	155	102	60	##	15	92	210
Months Worked	24	24	3	24	3	24	24	15	21	24	8	24	24	19	24

Profession	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
Advanced Emergency Medical Technician															
Advanced Registered Nurse Practitioner								19							
Ambulance Service															
Ambulance Service Verified						1		1							
Animal Massage Practitioner															
Athletic Trainer		1													
Audiologist									1		1				
Chemical Dependency Professional	6	9	2			2		2	1	9	10				6
Chemical Dependency Professional Trainee	3	6	3			3				4					1
Chiropractic X-Ray Technician															
Chiropractor	2	4	4			6		9	2	10	9				6
Counselor, Agency Affiliated	1	5	4					1		6	3				2
Counselor, Certified		1						1		2					
Counselor, Certified Advisor		1									1				
Counselor, Registered															
Dental Assistant						3			6	4	1				2
Dental Hygienist						1		1	1						
Dentist	2	21	4			11		12	12	29	6				4
Denturist		2	2					2	1	3					
Dietitian/Nutritionist															
Dispensing Optician															
Dispensing Optician Apprentice															
East Asian Medicine Practitioner		1	1			1				3	3				
Emergency Medical Technician		10	4			3		2	1	3	3				
Genetic Counselor															
Health Care Assistant	1					1		1							
Hearing and Speech															
Home Care Aide	1	6	9			9		6	4	7	7				3
Hypnotherapist		1	1												
Licensed Practical Nurse		1				1	25								
Marriage and Family Therapist		1									1				
Marriage and Family Therapist Associate								1							
Massage Practitioner	21	7	35			30		4	14	6	4				46
Medical Assistant	4	5	10			8		10	2	10	2				4
Mental Health Counselor	3	5	1			1		11	2	6	5				
Mental Health Counselor Associate	2	1									1				
Midwife	6	1						1							
Naturopathic Physician	1	3	1					1	1		2				
Nursing Assistant	18	42	61			83		39	51	66	55				33

Profession	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
Nursing Home Administrator	3		2			4			1	2	1				
Occupational Therapist								1		1					
Occupational Therapy Assistant								1							
Optometrist	1							1		1					
Orthoist/Prosthetist									4						
Osteopathic Physician	13	5	3			1		7	2	10				1	
Osteopathic Physician Assistant						1			1						
Paramedic		3						2		1				1	
Pharmacies and other Pharmaceutical Firms	1	1						1					7		6
Pharmacist												4	28		11
Pharmacist Intern															
Pharmacy Assistant												1	10		
Pharmacy Technician												3	14		1
Physical Therapist		2	2						1	4	4				
Physical Therapist Assistant			3			3		1		1					
Physician	3	2		219	70				1						2
Physician Assistant	1			8	2										
Podiatric Physician	4		1					1	1	2	1				
Psychologist	1	2	1			1				6					1
Radiological Technologist												1			
Reflexologist										2					1
Registered Nurse	2	1					116					1			
Respiratory Care Practitioner				4				2				4			
Sex Offender Treatment Provider		1													
Social Worker Advanced															
Social Worker Associate Advanced															
Social Worker Associate Independent										2					
Social Worker Independent Clinical		1	1							5	1				3
Speech Language Pathologist															
Surgical Technologist			4					1		1					
Veterinarian		2	4			1		3	2	2	1				5
Veterinary Medication Clerk		1													
Veterinary Technician									2		1				
X-Ray Technician						1									
Grand Total	100	155	167	227	72	176	160	126	114	208	129	8	59	121	18
Months Worked	24	24	16	24	12	24	24	24	24	24	24	4	24	24	24

Profession	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
Advanced Emergency Medical Technician			1												
Advanced Registered Nurse Practitioner				10				14					8	1	
Ambulance Service															
Ambulance Service Verified															
Animal Massage Practitioner												2			
Athletic Trainer															
Audiologist															
Chemical Dependency Professional			2						3	6		2		1	
Chemical Dependency Professional Trainee			2		1										
Chiropractic X-Ray Technician															
Chiropractor	2		7		8			9	11			10		1	
Counselor, Agency Affiliated			7		1			2				3			
Counselor, Certified			1		2			1				1			
Counselor, Certified Advisor															
Counselor, Registered															
Dental Assistant			1					4	6			1			
Dental Hygienist								3				3			
Dentist			25		14			47	27			27			
Denturist								1	3			2			
Dietitian/Nutritionist															
Dispensing Optician															
Dispensing Optician Apprentice															
East Asian Medicine Practitioner			1		2								1		
Emergency Medical Technician			5		1					1		1			
Genetic Counselor															
Health Care Assistant															
Hearing and Speech															
Home Care Aide			10		2			9	3			1		2	
Hypnotherapist					1					1					
Licensed Practical Nurse				28				27					16	1	
Marriage and Family Therapist									1						
Marriage and Family Therapist Associate															
Massage Practitioner	2		13		2			7	2						26
Medical Assistant			10		2			2	1			17			
Mental Health Counselor			5		3			1	4			1			
Mental Health Counselor Associate										3					
Midwife								3				2			
Naturopathic Physician					2					2					5
Nursing Assistant	1		89		27			23	4			20			9

Profession	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
Nursing Home Administrator			2		7				2					1	
Occupational Therapist					2					2					
Occupational Therapy Assistant									1						
Optometrist									2			1			
Orthoist/Prosthetist															
Osteopathic Physician			4		16				9			3			
Osteopathic Physician Assistant															
Paramedic			1						1						
Pharmacies and other Pharmaceutical Firms	1	2			1	7					47			1	
Pharmacist	2					9					33			1	
Pharmacist Intern						1					1				
Pharmacy Assistant						3					6			1	
Pharmacy Technician						5					7				
Physical Therapist			3						11						
Physical Therapist Assistant															
Physician				1	1		174					1		135	168
Physician Assistant							12					1		8	24
Podiatric Physician												2			
Psychologist			1									4		1	
Radiological Technologist											1				
Reflexologist															
Registered Nurse			1	93	1			118					93	1	1
Respiratory Care Practitioner					1										
Sex Offender Treatment Provider					3					1		1			
Social Worker Advanced														1	
Social Worker Associate Advanced			1												
Social Worker Associate Independent									1			1			
Social Worker Independent Clinical			2						3	1					
Speech Language Pathologist															
Surgical Technologist			1						2	1					
Veterinarian			5		15				5			6		1	
Veterinary Medication Clerk					2				1						
Veterinary Technician			1		1				1						
X-Ray Technician														1	
Grand Total	5	3	203	132	118	25	186	159	155	80	94	116	117	196	193
Months Worked	3	23	24	24	24	3	24	24	24	24	24	24	24	24	24

Profession	61	62	63	64	65	66	67	68	69	70	71	72	73	74
Advanced Emergency Medical Technician												1		
Advanced Registered Nurse Practitioner	14								1				3	
Ambulance Service														
Ambulance Service Verified												1		
Animal Massage Practitioner														
Athletic Trainer		2			1							1		
Audiologist							1							
Chemical Dependency Professional		13			5		7	8	4			9		
Chemical Dependency Professional Trainee		4			1		13	6	3			4		
Chiropractic X-Ray Technician								1						
Chiropractor		17			5		5	2	4		1	15		1
Counselor, Agency Affiliated		11			2		13	8	5			5		
Counselor, Certified		2			1			1	1			1		
Counselor, Certified Advisor														
Counselor, Registered														
Dental Assistant		4					7	2	1			4		
Dental Hygienist		1						1	2					
Dentist		27			3		17	9	6		1	33		1
Denturist		4					1		1					
Dietitian/Nutritionist														
Dispensing Optician		1										3		
Dispensing Optician Apprentice												1		
East Asian Medicine Practitioner					1		2	1				1		1
Emergency Medical Technician		2			9		1	1				2		
Genetic Counselor					1									
Health Care Assistant					1			1						1
Hearing and Speech												1		
Home Care Aide		3			3		11	4	14			6		
Hypnotherapist					1			1	1					
Licensed Practical Nurse	20								1					20
Marriage and Family Therapist		2						2	2			2		
Marriage and Family Therapist Associate		3						1	1			1		
Massage Practitioner		18			48		5	1	10			8		1
Medical Assistant		6			6		4	5	13			36		2
Mental Health Counselor		12			8		2	14				3		
Mental Health Counselor Associate		4					3	6	2			2		
Midwife		3										2		
Naturopathic Physician		6			2		1	3	9			6		6
Nursing Assistant		45			49		53	32	82		1	39		3

Profession	61	62	63	64	65	66	67	68	69	70	71	72	73	74
Nursing Home Administrator		8			4		1	1				6		
Occupational Therapist		2									1	1		
Occupational Therapy Assistant					1							2		
Optometrist		1			1							1		
Orthoist/Prosthetist														
Osteopathic Physician		10			3				2			7		
Osteopathic Physician Assistant									1			2		
Paramedic		1			6							4		
Pharmacies and other Pharmaceutical Firms			5						1	15		5		1
Pharmacist			20							37				
Pharmacist Intern										1				
Pharmacy Assistant			3		1					18		1		
Pharmacy Technician			1							17		2		
Physical Therapist		6			1			1	2			2		
Physical Therapist Assistant					1			1				3		
Physician		4		150	1	278						11		3
Physician Assistant				8		23								
Podiatric Physician		1			1		1	2	1					
Psychologist		12			1		3	5	1			6		
Radiological Technologist					7							1		
Reflexologist			1		2		1							
Registered Nurse	84								1				57	1
Respiratory Care Practitioner												1		
Sex Offender Treatment Provider		1							1			2		
Social Worker Advanced		1												
Social Worker Associate Advanced														
Social Worker Associate Independent		6			1		1	1				4		
Social Worker Independent Clinical		3			1		2	7	1			1		
Speech Language Pathologist		1						2				1		
Surgical Technologist							1							
Veterinarian		12			6		1		1			7		
Veterinary Medication Clerk														
Veterinary Technician					1									
X-Ray Technician					1				1					
Grand Total	118	260	29	158	187	301	157	130	176	88	4	257	80	21
Months Worked	24	24	24	24	24	24	24	24	24	24	24	24	22	24

Letter from the President

Letter from the President

POST-BOARD MEETING UPDATE

October 2015

Greetings Colleagues!

It is astounding to believe the autumn season is already here and that summer passed so quickly. As I witnessed the amazing “super blood moon” just after the autumnal equinox, it was almost overwhelming to realize people all over the world were collectively observing the same phenomenon. As boards of nursing we have another shared experience — we go about the work of protecting the public on a daily basis to have a collective impact beyond our individual jurisdictions.

Your NCSBN Board of Directors (BOD) met on Sept. 21–23, 2015, in Chicago. The following new board members were welcomed:

Suellyn Masek, WA	Area I Director
Adrain Guerrero, KS	Area II Director
Ellen Watson, VT	Area IV Director
Karen Scipio-Skinner, DC	Director-at-Large
Valerie Smith, AZ	Director-at-Large

They were engaged from the start, inquiring with candor and deliberating thoughtfully. In other words, they jumped right into the work! The first day was spent with Nancy R. Axelrod, founding president of BoardSource, who facilitated a day of governance and board member development. Highlights included the legal duties of the BOD and BOD members; characteristics that distinguish highly functioning boards; envisioning; and the right work of the BOD. BOD member development continued with a presentation on legal and fiduciary responsibilities by Tom Abram, legal counsel, and an introduction to nonprofit finance by Rob Clayborne, chief financial officer.

Treasurer and Finance Committee

Regretfully, the BOD accepted the resignation of Joe Baker, Jr., FL, as treasurer, effective Sept. 25, 2015. Changes within the division at the Florida Department of Health require his attention. The BOD acknowledged he had carried out his responsibilities as director-at-large and treasurer with consistent focus on the mission of NCSBN to provide services and products to the membership.

In accordance with NCSBN Bylaws, the BOD appointed Julie George, NC, to fulfill the responsibilities of treasurer. She will serve until August 2016 when a special election for treasurer will be held in conjunction with other elections at the Annual Meeting. Julie’s previous experience as treasurer will lend stability to the Finance Committee and the BOD.

In other financial matters, the BOD:

- Approved the financial statements for the period ending June 30, 2015.
- Approved the budget for fiscal year 2016.
- Approved the audit plan for financial statements and retirement plan.
- Passed a resolution related to the corporate depository of funds.

Committees and Appointments

The BOD approved revisions to the Standards Procedure Manual consistent with the direction for accreditation compliance by the American National Standards Institute and directed the Standards Development Committee to move forward with standards designation for the reporting of disciplinary actions by boards of nursing and verification of licensure through Nursys®

Some committee vacancies had occurred and individuals were appointed to the following committees:

National Standards Development Committee

Peggy Benson, AL
Tara Hulseley, WV-RN
Linda Kmetz, PA
Linda Young, SD

Institute of Regulatory Excellence

Mary Baroni, WA
Cynthia Gustafson, MT
Patricia Sharpnack, OH
Susan VanBeuge, NV

As a result of discussion and interest at the Annual Meeting, the BOD also determined to convene two new committees and developed their charges:

- Explore trends and issues regarding the regulatory oversight of nursing education programs.
- Explore current trends and issues regarding the use of medical cannabis and recreational marijuana and its relationship to nursing.

A call for committee volunteers will go out to the membership.

Additionally, the BOD appointed a subcommittee, comprised of Shirley Brekken, Kathy Thomas, Suellyn Masek and Gloria Damgaard to determine an approach to "explore development of a procedure and criteria for eligibility for full membership by a non-state or U.S. territory nursing regulatory body that uses a licensing examination developed by NCSBN," as directed by the Delegate Assembly.

Nurse Licensure (NLC) and APRN Compacts

The BOD received a report on which states are planning to pursue legislation to enact one or both of the compacts in the upcoming legislative session. The work of the Nurse Licensure Compact Legislative Strategy Team was acknowledged and is now transferred to the staff team providing support to member boards in the enactment and implementation of the enhanced NLC and APRN. Compact States can access the NLC Implementation Plan and Toolkit, which enumerates the

necessary steps for legislative introduction and implementation. As always, staff are available to provide subject matter expertise and welcome any and all questions at nursecompact@ncsbn.org.

Additionally, the BOD approved a proposal from the Council of State Governments to assist with the adoption of the enhanced NLC and APRN Compacts through a collaborative national education campaign, including the convening of a national legislative briefing, and on-site and remote technical assistance and testimony.

Additionally the BOD:

- Endorsed the National Patient Safety Foundation report on improving root cause analyses and actions to prevent harm (will be made available on the website).
- Approved an exception to the location of the 2018 Annual Meeting policy and directed staff to seek an alternative location (There is no room in the inn!).
- At the request of a member board, initiated discussion to provide assistance in licensure application processing and vetting of applicants, and directed staff to explore alternatives and provide further information (more to come).
- Initiated planning for the educational content for the 2016 Midyear Meeting (See you in Baltimore!).
- Reviewed and discussed the current status of member board compliance with the terms and conditions of NCSBN membership.

Again, on behalf of the BOD, thank you for the opportunity to serve you. We are honored and challenged to do the best we can. If you have any questions, comments and contributions please contact me at your convenience. We appreciate your wisdom and want to hear from you.

Regards,

Shirley A. Brekken

President

612.317.3012

shirley.brekken@state.mn.us



Washington State Department of
Health
Nursing Care Quality Assurance Commission (NCQAC)
Nursing Program Approval Panel (NPAP)
Panel B
August 6, 2015
10:00 AM to 12:00 AM
MINUTES

Commission Members: Teri Trillo, MSN, RN, CNE, Chair
Laurie Soine, PhD, ARNP

Pro Tem: Rhonda Taylor, MSN, RN
Lin Murphy, PhD, RN

DOH Staff: Mindy Schaffner, PhD, MSN-CNS, RN, Nursing Education Advisor
Barbara Gumprecht, Nursing Education Consultant
Kathy Moisio, Nursing Education Consultant
Tim Talkington, Staff Attorney (excused)
Miranda Bayne, Staff Attorney
Cable Wolverton, Nursing Education Support

10:00 AM Opening — Teri Trillo, Chair

- Call to order
- Approval of minutes July 2, 2015 - Minutes approved with changes.

1. Norwich University request practice for MN in Nursing Education follow up

Discussion: The panel reviewed the request for practice experience in Washington.

Decision: The panel approved Norwich University's request for MSN practice experiences for MSN nurse education, which includes 120 hours in clinical and classroom instruction.

2. Clover Park Complaint

Discussion: The panel reviewed an investigative report and decided the complaint was mostly resolved, and did not rise to a level that called for an open investigation.

Decision: The panel directed the Commission staff to send a letter expressing the following concerns:

- The Nursing Director or nursing representative is not a participant on the Tenure Tract Committee;
- The program must provide evidence of compliance with WAC 246-840-555 (7) (c) and (e);
- The nursing program must provide evidence of compliance with WAC 246-840-555 Standard II. Organization and administration for approved nursing education programs; and
- Provide evidence of due process in the schools complaint procedure; and submit a response to these requests by September 15, 2015.

3. Peninsula Community College review reports

Discussion: The panel decided the report was well prepared, faculty was qualified, and the process for providing information to students was acceptable.

Decision: The panel approved the report as written.

4. Bellevue College RN-BSN status report

Discussion: The panel reviewed the RN-BSN status report.

Decision: The panel directed the Commission staff to send a letter requesting a status report on faculty development for teaching at a BSN level, and a request for information regarding clinical placements and assignments for next year. The report is due by December 1, 2015.

5. Columbia Basin College RN-BSN application

Discussion: The panel discussed the RN-BSN application.

Decision: The panel approved the RN-MSN distance delivered application. The Commission staff will send a letter requesting information regarding the following:

- i. Does the program see any future changes for student services; and will they be available for BSN students?
- ii. The role of the Nursing Administrator in the evaluation of the faculty.

6. Seattle Pacific University response to CCNE faulty standard 2015

Decision: The panel decided to forward this topic to next month's meeting.

7. University of Washington response to Administrative structure

Discussion: The panel reviewed the response regarding the Administrative structure.

Decision: The panel requested additional clarification regarding the distinction between the Nursing Director's role and the role of the Chancellor. The requested report is due back within 30 days of the date of the letter.

8. Seattle Central College Substantive Change request

Discussion: The panel reviewed Seattle Central Colleges substantive change request.

Decision: The panel approved the substantive change for fall 2015 while deferring approval for winter 2016, pending evidence the program has enough faculty and clinical placements for the students.

9. West Virginia Wesleyan: request for waiver for one MSN/FNP student practice

Discussion: The panel discussed the request of a waiver for one MSN/FNP student practice.

Decision: The panel approved a waiver for one MSN/FNP student for practice experience.

10. Strategic Plan Discussion – All Members

Discussion: The panel discussed the NCQAC strategic plans.

Decision: The panel decided a priority was to focus on the development of faculty, and the possible creation of case studies for faculty to use in teaching.

11. Approval Procedure for Refresher Programs:

Discussion: The panel discussed the procedure for Refresher Programs.

Decision: The panel decided that Refresher Programs should only receive approval for up to 5 years. This procedure will be put into rule.

Adjournment: 12:13 p.m.



**Nursing Care Quality Assurance Commission (NCQAC)
Nursing Program Approval Panel (NPAP)**

Panel A

August 14, 2015

10:00 AM to 12:00 PM

MINUTES

Commission Members: Mary Baroni, PhD, RN, Chair
Lois Hoell, MS, MBA, RN

Pro Tem: Sue Woods, PhD, FAAN, RN
Karen Heys, MN, RN (Excused)

DOH Staff: Mindy Schaffner, Associate Director Education
Barbara Gumprecht, Nursing Education Consultant
Kathy Moisiso, Nursing Education Consultant
Tim Talkington, Staff Attorney
Miranda Bayne, Staff Attorney
Jean Wheat for Cable Wolverton, Nursing Education Support

10:00 AM Opening — Mary Baroni

- Call to order
- Approval of minutes from June 18, 2015 – Referred to NPAP B for final approval. Approved July 16, 2015 minutes.

1. St. Joseph's College: Request Approval for practice of MSN/Administration, MSN/Education, MSN/FNP, and RN-BSN programs

Discussion: The panel reviewed the request for approval of MSN/Administration, MSN/Education, MSN/FNP, and RN-BSN programs.

Decision: The panel approved the clinical sites as indicated. The panel would like clarification of the evaluation forms, clarification on Masters and BSN students, and clarification on the faculty evaluation forms.

2. Lower Columbia College (Report on SPINE program)

Discussion: The panel discussed the report on the SPINE program.

Decision: The panel approved the report as stated.

3. Seattle University: Response to Low Pass Rates

Discussion: The panel reviewed the report on the low passing rates.

Decision: The panel accepted the report as stated and commended the program on the rate increase for 2015. The panel recommended a plan of correction to include a better evaluation plan to short and long term strategies.

4. Tacoma Community College: Substantive Change Request/Moving to Concept Based Curriculum

Discussion: The panel discussed the request for substantive change to concept based curriculum.

Decision: The panel approved the request for the substantive change to a concept based curriculum.

5. **Walla Walla Community College: Substantive Change Request to Adopt DTA-MRP**

Discussion: The panel discussed the request for substantive change to adopt DTA-MRP.

Decision: The panel approved the request for substantive change of the DTA-MRP.

6. **A New Day Refresher Course: Program Response to Deficiencies Cited**

Discussion: The panel discussed the program response to deficiencies cited.

Decision: The panel accepted the program's response to deficiencies cited and the update on student progression. The panel requested clarification on Linda Rose's relationship and backup to Sandra, the program director.

7. **Strategic Plan Discussion**

Discussion: The panel discussed the 2015-2017 Strategic Plan.

Decision: The panel accepted the strategic plan as stated and plans to take to the Nursing Commission on September 11, 2015.

Adjournment at: 12:06 p.m.

Next Meetings: September 17, 2015 10:00 am to 12:00 pm
October 9, 2015 10:00 am to 12:00 pm

Conference call-in information: Problems connecting: Cable Wolverton 360-236-4711

Phone: 360-407-3780

PIN: 319493#



**Nursing Care Quality Assurance Commission (NCQAC)
Nursing Program Approval Panel (NPAP)
Panel B
September 3, 2015
10:00 AM to 12:00 AM
MINUTES**

Commission Members: Teri Trillo, MSN, RN, CNE, Chair
Laurie Soine, PhD, ARNP

Pro Tem: Rhonda Taylor, MSN, RN
Lin Murphy, PhD, RN

DOH Staff: Mindy Schaffner, PhD, MSN-CNS, RN, Associate Director of Nursing Education (Excused)
Barbara Gumprecht, Nursing Education Consultant
Kathy Moisio, Nursing Education Consultant
Tim Talkington, Staff Attorney
Miranda Bayne, Staff Attorney
Cable Wolverton, Nursing Education Support

10:00 AM Opening — Teri Trillo, Chair

- Call to order
- Approval of minutes August 6, 2015

1. Peninsula Community College review reports

Discussion: The panel reviewed Peninsula Community College's report.

Decision: The panel accepted the report as written. The Commission staff will request clarification of clinical hours as reported in the table. In addition, a recommendation will be made for the program to highlight new information that's provided in all subsequent reports.

2. Seattle Pacific University response to CCNE faulty standard 2015

Discussion: The panel reviewed the University's response to CCNE faculty standard.

Decision: The panel accepted the report as written. A request will be made for the CCNE response to the report once it's received by the program.

3. Excelsior request for clinical placement for RN-BSN and MSN programs

Discussion: The panel reviewed the request for clinical placement for RN-BSN and MSN programs.

Decision: The panel denied the request for clinical placement because the program's practicum courses do not meet Washington State requirements.

4. Washington State University- response to request more information on MSN and post-masters certificate in Nursing Education program

Discussion: The panel reviewed the response to the request for more information on MSN and post-Masters certificate in Nursing Education program.

Decision: The panel approved the nursing program's request pending clarification on how the master's students update their practice skills as stated in the AACN's "Essentials of Master's Education".

5. **Western Washington University RN-BSN response**

Discussion: The panel reviewed the Western Washington University's RN-BSN response.

Decision: Commission staff will request a spring 2016 report addressing the results from their stakeholder's meeting in regards to the organization structure and space issues.

6. **Seattle Central College: Substantive Change request follow up**

Discussion: The panel reviewed the follow up Substantive Change request.

Decision: The panel deferred approval pending the receipt and review of a detailed grid for the years 2015-2017 to include:

- i. Number of students
- ii. Clinical placements
- iii. Faculty assignments

7. **Plan of Correction for nursing programs template**

Discussion: The panel reviewed the nursing program's template.

Decision: The panel approved the POC template as constructed.

8. **Discussion on Education Session for Nursing Commission and Pro Tem members at November 13 NCQAC meeting.**

Discussion: Some of the suggested topics for the November 13 NCQAC meeting include the following:

- Current NAC programs not accredited
- Difference between panels and sub committees
- List the different types of programs we approve like MSN, RN-BSN, nursing assistant training programs, etc.
- How the Nursing Education unit has changed over the years
- Responsibilities of tech support
- How the Education Unit processes complaints
- Process involved in approval of out of state programs
- Where are we going in the future?
- Why some programs may not be approved
- Discuss the review and approval of out of state programs and requests for clinical placements
- List the number of out of state programs that receive approval to place students in practicum experience in Washington State

Adjournment: 11:33 a.m.



Nursing Care Quality Assurance Commission (NCQAC)
Nursing Program Approval Panel (NPAP)

Panel A

September 17, 2015
10:00 AM to 12:00 PM
MINUTES

Commission Members: Mary Baroni, PhD, RN, Chair
Lois Hoell, MS, MBA, RN

Pro Tem: Sue Woods, PhD, FAAN, RN
Karen Heys, MN, RN

DOH Staff: Mindy Schaffner, Associate Director Education
Barbara Gumprecht, Nursing Education Consultant
Tim Talkington, Staff Attorney
Cable Wolverton, Nursing Education Support
Kathy Moisio, Nursing Education Consultant

10:00 AM Opening — Mary Baroni

- Call to order
- Approval of minutes from August 14, 2015 – Accepted with minor changes.

1. Walla Walla University: ACEN Continued Accreditation/On-going Program Approval

Discussion: The panel reviewed the report from ACEN granting continued accreditation.

Decision: The panel accepted ACEN report and granted ongoing program approval. NCQAC will join with CCNE during visit to University in November 2015.

2. Lower Columbia College: DTA/MRP Substantive Change Request

Discussion: The panel reviewed the DTA/MRP Lower Columbia College's Substantive Change Request.

Decision: The panel deferred approval pending clarification of the LPN curriculum and the Personal Vocational Relationship course content.

3. Tacoma Community College ACEN response

Discussion: The panel reviewed the ACEN report.

Decision: The panel accepted the ACEN report as written.

4. Grays Harbor monthly report

Discussion: The panel reviewed the Grays Harbor College's monthly report.

Decision: The panel accepted the report while directing the commission staff to request:

- i. Information regarding faculty involvement in the systematic evaluation plan;
- ii. Process of faculty involvement with changes in curriculum;
- iii. Involvement of the Director in the faculty evaluation process;
- iv. Information regarding web site discrepancies; and
- v. Continued monthly reports.

5. **Green River CC LPN POC**

Discussion: The Panel reviewed and discussed the Green River College's LPN POC.

Decision: The Panel denied approval of the Green River College's LPN POC. In addition, the Commission will send a letter stating that WAC 246-840-555 and WAC 246-840-570 (4) were met while WAC 246-840-548 and WAC 246-840-560 and WAC 246-840-570 (7) require additional work.

6. **Lake Washington Technical College status report for ACEN visit and self-study**

Discussion: The panel reviewed the Lake Washington Technical College status report for ACEN visit and self-study.

Decision: Commission staff is to offer technical assistance prior to the program's October 2015 ACEN visit regarding systematic plan of evaluation and data for the ACEN visit.

7. **Plan of Correction: Review of template for nursing education**

Discussion: The panel reviewed the template for nursing education.

Decision: The panel approved the template while directing Commission staff to provide a follow-up assessment of the program's POC.

8. **Discussion on Education Session for Nursing Commission and Pro Tem members at November 13 NCQAC meeting.**

Discussion: The panel suggested several topics for the November 13, 2015 NCQAC meeting. The agreed upon most important topic is to identify how the panel's work protects the public.

Adjournment:



**Nursing Care Quality Assurance Commission (NCQAC)
Nursing Assistant Program Approval Panel (NAPAP)**

Minutes

August 10, 2015

Panel Members:

Tracy Rude, LPN, Chair
Margaret Kelly, LPN
Helen Myrick, Public Member
Margaret Mary Castle, RN, BSN
Judy Bungay, RN, BSN

DOH Staff:

Mindy Schaffner, Assistant Director of Nursing Education
Carole Knutzen, Nursing Education Assistant
Kathy Moio, Nursing Consultant
Cable Wolverton, Administrative Assistant
Tim Talkington, Staff Attorney (Excused)
Miranda Bayne, Staff Attorney

1. 2:30 PM Opening — Tracy Rude

- a. Call to Order 2:31**
- b. Review of July 13, 2015 Minutes – Approved with changes.**

2. Nursing Care Quality Assurance Commission Business Update

Discussion: The panel received a report that considerable revisions have been made to the Consistent Standard of Practice. In addition, a report was received on the status of the Nurse Licensure Compact.

3. Approved Programs:

- a. The following program has met the requirements found in WAC 246-841 for approval as a nursing assistant training program:**
 - i. Delta Rehab**

Discussion: The panel reviewed an application for Delta Rehab's nursing assistant training program.

Decision: The panel approved the program.

4. Plan of Correction (POC) Update

Discussion: The panel reviewed the status of all of the programs that were requested to submit POCs. The panel reviewed two programs that have not submitted POCs as requested.

Decision: Commission staff will send a letter reminding Firlane and the NW Indian College that their POCs have not been received as requested, and inquire regarding their intentions to continue operating or close, if either program is not currently operating.

5. Instructor Review:

- a. Health Resources**

Discussion: The panel reviewed the application of a proposed instructor.

Decision: The panel approved the applicant after much discussion.

b. Divine CNA

Discussion: The panel reviewed the application of a proposed instructor.

Decision: The deferred approval of the applicant pending

6. CNA of Longview Complaint Report

Discussion: The panel reviewed an investigative report regarding a complaint against CNA of Longview.

Decision: The panel issued a Statement of Deficiencies to the program and requested a Plan of Correction.

7. Excel CNA – Complaint

Discussion: The panel discussed a complaint against Excel CNA.

Decision: The panel decided to open an investigation.

8. NAPAP Policy

Discussion: The panel discussed how NAPAP, in collaboration with the Department of Social and Health Services, will determine and approve competencies for medication assistants.

Decision: The panel will send a clean version of the NAPAP policy to September's NCQAC business meeting.

9. Strategic Plan

Discussion: The panel discussed the different strategic plan topics. Some of the topics are as follows:

- i. Require BSN within 10 years for RN licensure;
- ii. Need to build capacity for nursing graduates;
- iii. Work aggressively with nursing assistant training programs with passing rates below 50%;
- iv. Develop online modules that provide training for directors and instructors;
- v. Develop legislative strategies to promote nursing issues;
- vi. Update and consolidate nursing assistant rules;
- vii. Analyze data that will assist NCQAC in making education decisions;
- viii. Complete nursing education rules; and
- ix. Develop a process to track nursing medication errors.

Decision: Commission staff will take the topics, work up a detailed strategic plan, provide timelines and designate staff and panel members to complete parts of the plan.

10. Work Plan

Discussion: The panel discussed updates.

Adjournment: 4:41 p.m.



**Nursing Care Quality Assurance Commission (NCQAC)
Nursing Assistant Program Approval Panel (NAPAP)**

MINUTES

September 16, 2015

Panel Members: Tracy Rude, LPN, Chair
Margaret Kelly, LPN
Helen, Public Member
Judy Bungay, RN, BSN

DOH Staff: Mindy Schaffner, Assistant Director Of Nursing Education
Carole Knutzen, Nursing Education Assistant
Kathy Moio, Nursing Consultant
Cable Wolverton, Administrative Assistant
Tim Talkington, Staff Attorney
Miranda Bayne, Staff Attorney

1. 2:30 PM Opening — Tracy Rude

- a. **Call to Order**
- b. **Review of August 10, 2015 Minutes** – Approved with minor corrections.

2. Nursing Care Quality Assurance Commission Business Update

Discussion: The panel received a report from the 9/8/15 business meeting to include:

- i. Date for computers to go live is 10/14/15;
- ii. Tutorial on Go to Meetings will be available before 1/7/16 Commission meeting;
- iii. The annual evaluation was included in the Commission packet;
- iv. Discussed the nominating committee;
- v. The budget was discussed;
- vi. Washington Health Professional Services will report directly to the Nursing Commission;
- vii. Report on out of state schools presented;
- viii. The Commission adapted the Medical Assistant Rules Change; and
- ix. Discussion strategic plans.

3. Approved Programs:

- a. **The following programs have met the requirements found in WAC 246-841 for approval as nursing assistant training programs:**

Discussion: The panel reviewed the applications for the following nursing assistant training programs:

- i. Odd Fellows Home
- ii. Pierce College IBEST
- iii. Henrietta Lacks Medical and BioScience High School

Decision: The panel approved all three nursing assistant programs.

4. Instructor Review

a. American Health Care

Discussion: The panel reviewed the application of a proposed instructor.

Decision: Deferred approval pending clarification of the proposed instructor's experience supervising nursing assistants.

5. NACES Complaint

Discussion: The panel discussed a complaint made against NACES.

Decision: The complaint was closed with no violation found.

6. Evaluation Results for August 12, 2015 Training

Discussion: The panel received the following report:

- i. Seventy two people attended the training;
- ii. Forty five evaluations were received;
- iii. The evaluations received were very positive;
- iv. Suggestions to have training on an annual basis were received;
- v. Interaction from the attendees were very good;
- vi. Only five schools with low pass rates did not attend; and
- vii. Low pass rates program Directors not in attendance will receive quiz.

Decision: The panel will direct the Commission staff to check next years pass rates to determine the effectiveness of the training.

7. Discussion: Follow up discussion about the conference call with Phil Dickison at NCSBN.

Discussion: The panel received a report regarding the conference call with Phil Dickison. In addition, the following actions and comments were noted:

- i. The panel expressed the need to clarify the Nursing Commission's authority with DSHS;
- ii. The panel members will assist the staff in comprising a list of issues for the Governess Committee;
- iii. Commission staff will review the MOU and a list of talking points that will be presented to the governess meeting in October; and
- iv. The list of talking points will be sent to the panel members for review by September 25, 2015.

8. Discussion on Education Session for Nursing Commission and Pro Tem members at November 13 NCQAC meeting. Please come prepared to discuss your thoughts on how we educate Commission Members about what NPAPs and NAPAP do. It would be great if some of you would volunteer to present at that meeting.

Discussion: The panel made several suggestions on the keys points the Education unit could present to at the November 13 NCQAC business meeting. Some of the suggestions are as follows:

- i. Part of what we are doing is assuring quality care to the patients we serve;
- ii. Continuity of service;
- iii. We want nursing students to know what they are doing;
- iv. We are here to assure the public safety; and
- v. After passing the licensing exams, we want the newly licensed credential holders to be competent.

9. Discussion about possible new Pro-Tem Members for NAPAP

Discussion: The panel discussed the upcoming expiration of a panel member's term, and whether it could function with 4 members as opposed to current 5 members.

Decision: The panel expressed a preference to continue with five members.

10. Complaint: The panel reviewed complaints against the following programs:

a. NAC Essential Prep

Decision: Open an investigation for possible unprofessional conduct.

b. St Patricks

Expand scope of investigation to determine if instructor had disclosed prior discipline.

11. Work Plan

Decision: The work plan discussion was deferred.

Adjournment: 11:17

**Nursing Care Quality Assurance Commission
July 1, 2015 – June 30, 2017 Strategic Plan**

COMMISSION

ID	GOAL	OBJECTIVES	RESPONSIBILITY	RESOURCES	DEADLINES	PROGRESS
C 1	Nurse Licensure Compact and AP Compact	1. Complete stakeholder work with interested parties	Task force members and Paula Meyer		10/31/15	√ ? X
		2. Summary of supporting and opposing organizations	Task force members and Paula Meyer		11/13/15	
		4. Determine if legislative action is possible in 2016 session	NCQAC		11/13/15	
		3. Inform Governor's office of organizations positions	Task force members and Paula Meyer		11/18/15	

ID	GOAL	OBJECTIVES	RESPONSIBILITY	RESOURCES	DEADLINES	PROGRESS
C 2	FBI Criminal Background Checks/RapBack	1. Meet with organizations opposing the bill: ACLU and WSNA	Catherine Woodard and Paula Meyer		12/31/15	√ ? X

		2. Meet with boards and commissions and ask for their position on the bill	Catherine Woodard and Paula Meyer		11/30/15	
		3. Meet with Washington State Patrol	Catherine Woodard and Paula Meyer		10/31/15	
		4. Meet with sponsoring legislators	Catherine Woodard and Paula Meyer		12/31/15	
		5. Present progress at NCQAC meeting	Catherine Woodard and Paula Meyer		11/13/15	On Agenda

ID	GOAL	OBJECTIVES	RESPONSIBILITY	RESOURCES	DEADLINES	PROGRESS
C 3	FBI Criminal Background Checks on all applicants	1. Review legal brief with chair, vice chair and secretary/treasurer	Paula Meyer		09/02/15	√ ? X
		2. Present issue, background, legal advice and recommendations to NCQAC at their November 13 meeting	Paula Meyer, Gail Yu		11/13/15	
		3. Determine next steps: rules, random audits, costs, decision package			11/13/15	

ID	GOAL	OBJECTIVES	RESPONSIBILITY	RESOURCES	DEADLINES	PROGRESS
C 4	ORBS	1. Meet with Nur Rajwany to determine assistance from NCSBN	Paula Meyer		08/21/15	√ ? X √
		2. Hire Associate Director, Licensing/Operations	Paula Meyer		09/30/15	√
		3. AD will be the person responsible for completing resource requirements and working with DOH IT Governance	Paula Meyer, ADN		09/30/15	√
		4. Joint meeting with NCSBN, DOH and NCQAC personnel to define project parameters and interface with DES	Paula Meyer, ADN		3/30/16	
		5. Develop project implementation plan	Paula Meyer, ADN		1/31/16	

ID	GOAL	OBJECTIVES	RESPONSIBILITY	RESOURCES	DEADLINES	PROGRESS
C 5	Orientation self learning modules	1. Review current orientation topics and content	Managers		9/30/15	√ ? X √

		2. Review work to date on self learning modules	Managers		1/31/16	
		3. Determine software needs to complete	Managers		5/31/16	
		4. Request NCQAC members to review modules	NCQAC volunteers		9/30/16	

ID	GOAL	OBJECTIVES	RESPONSIBILITY	RESOURCES	DEADLINES	PROGRESS
C 6	Substance Use Disorder Task Force	1. Complete procedure review and approve Alternative to Discipline Program	NCQAC	Task Force, staff	January 8, 2016	√ ? X
		2. Open rules related to substance use	NCQAC	Task force, staff	January 2016	
		3. Implement new procedures and performance measures	Washington Health Professional Services (WHPS) Program		January to February 2016	
		4. Post-implementation audit by Dr. Nancy Darbro	WHPS, Associate Director, Operations/		September 2016	

		six months after Approval of Alternative to Discipline Program	Licensing			
		5. Audit report to NCQAC	WHPS director, Associate Director, Operations/ Licensing, ED		November 2016	

**Nursing Care Quality Assurance Commission
July 1, 2015 – June 30, 2017 Strategic Plan
October, 2015**

DISCIPLINE

ID	GOAL	OBJECTIVES	RESPONSIBILITY	RESOURCES	DEADLINES	PROGRESS
D 1	Adopt best practices from the CORE Report that will benefit Washington	Staff to refine data from the CORE Report for the January subcommittee meeting. Identify best practices to add to the strategic plan.	Gene Pingle; Associate Director; Discipline Mgr; Legal Mgr	NCSBN; Assistant Attorney General	1/26/16 3/30/16	√ ? X

Education

ID	GOAL	OBJECTIVES	RESPONSIBILITY	RESOURCES	DEADLINES	PROGRESS
E 1	Complete nursing education rules and conduct training sessions for nursing programs, administration and faculty.	<ol style="list-style-type: none"> 1. Present draft rules to NCQAC at November 2015 business meeting. 2. File CR 102. 3. Rules Hearing at March, 2016 NCQAC meeting. 4. If no substantive changes, file CR 103 after hearing. 	Associate Director of Nursing Education	NPAP members and education staff.	<p>11/13/2015</p> <p>11/1/2015 3/11/2016</p> <p>3/31/2016</p>	√ ? X
E 2	Update and consolidate NA rules including <ul style="list-style-type: none"> • Education • Practice • Settings 	<ol style="list-style-type: none"> 1. Stakeholder meetings will be held. 2. Draft rules will be sent to stakeholders and presented to NCQAC. 3. CR 102. 4. Rules hearing. 	Associate Director of Nursing Education	Education Staff , Practice Staff, and NAPAP members	<p>5/2016-8/2016</p> <p>9/2016 – 12/2016</p> <p>3/2017 7/2017</p>	
E 3	Develop and implement a legislative plan and strategy to repeal 18.79.380.	<ol style="list-style-type: none"> 1 An organizational meeting will take place by NCQQC Task Force to begin work on legislative strategy. The committee will: <ol style="list-style-type: none"> a. Identify 	Associate Director of Nursing Education	Mary Baroni, chair, Charlotte Foster and Cass Tang		

		<p>stakeholders</p> <p>b. Establish timelines</p> <p>c. Identify communications plan and talking points for various stakeholders.</p> <p>2. Staff and task force members will meet with identified stakeholders.</p> <p>3. Staff and task force will prepare talking points for Governor's Office and DOH.</p> <p>4. Staff and members will prepare strategy for upcoming legislative session.</p> <p>5. Staff will obtain sponsors for legislation to repeal RCW 18.79.380.</p> <p>6. Staff will provide written testimony to task force members who will provide testimony during the session.</p>			<p>9/15/2015-5/31/2016</p> <p>6/1/2016</p> <p>8/15/2016</p> <p>1/15/2017</p> <p>1/15/2017</p>	
E 4	Increase capacity for BSN and graduate educational opportunities, including	1. NPAPs will identify at least three specific measures that	Associate Director of Nursing Education	NPAP members, education staff, APIN grant PI and staff, CCNA, and	11/15/2015	

	LPN to BSN/MSN options.	<p>NPAPs can implement to increase BSN and graduate nursing education capacity.</p> <p>2. NCQAC business meeting, NPAP will present a report and possible recommendations to the NCQAC.</p>		<p>NCSBN staff</p> <p>NPAP chairs and education staff.</p>	1/8/2016	
E 5	Provide on-line training modules for NA Program Directors, Nurse Education Administrators and faculty/instructors regarding regulatory responsibilities.	<p>1. NAPAP and NPAP will identify specific topics for the on-line modules.</p> <p>2. Identify possible venues for the on-line modules and consider costs and effectiveness in delivery.</p> <p>3. Nursing education staff present draft outline of on-line modules to the NAPAP and NPAP for review.</p>	Associate Director of Nursing Education	<p>Collective thinking of NAPAP and NPAP members and education staff.</p> <p>May need additional software and expertise of IT developer.</p>	<p>2/1/2017</p> <p>3/1/2017</p> <p>5/1/2017</p>	

		<p>4. First on-line module completed.</p> <p>5. Second on-line module will be completed.</p>			<p>10/1/2017</p> <p>3/1/2018</p>	
E 6	<p>Develop nursing education reporting system for student medication errors that result in harm or potential harm, and allegations of near misses.</p>	<p>1. Nursing Education Staff to assess existing reporting systems at NCQAC and DOH and determine the possibilities of utilizes these systems.</p> <p>2. Nursing Education Staff to determine cost effective and efficient method for reporting of student errors by January 2016 NPAP meetings.</p> <p>3. Establish regular data collection and review methods.</p> <p>4. Present annual reports to NPAP.</p>	<p>Associate Director of Nursing Education</p>	<p>Nursing Education Staff</p> <p>May need IT development work.</p>	<p>6/30/2016</p> <p>12/31/ 2016</p> <p>12/31/ 2016</p> <p>Annual Report</p>	
E. 7	<p>Identify NCQAC existing data and analyze data that will assist NCQAC in making informed and</p>	<p>Task force plan presented to NCQAC in July.</p>	<p>Associate Director of Nursing Education</p>	<p>Nurse Researcher and Policy Analyst.</p> <p>NCQAC members</p>	<p>7/15/16</p>	

	evidence based decisions.					
E. 8	Align Nursing Education website with Nursing Assistant layout.	<ol style="list-style-type: none"> 1. Education staff will develop web-site layout to be congruent with the NA website. 2. Education staff will post materials to nursing education web pages. 	Associate Director of Nursing Education	Nursing Education staff NPAPs	1/1/2016 4/31/2016	

DRAFT

**Nursing Care Quality Assurance Commission
July 1, 2015 – June 30, 2017 Strategic Plan
October, 2015**

LICENSING

ID	GOAL	OBJECTIVES	RESPONSIBILITY	RESOURCES	DEADLINES	PROGRESS
L 1	Implement national Minimum Data Sets and begin data analysis	<ol style="list-style-type: none"> 1. Complete legal analysis to require completion of MDS as part of renewal process. 2. Work with NCSBN on data collection tool. 3. Educate licensees on data collection. 4. Begin data collection. 	Licensing Manager Assistant Director of Education	ILRS Staff and online implementation committee NCSBN NCQAC staff	<p>12/31/15</p> <p>6/30/16</p> <p>12/31/16</p> <p>6/30/17</p>	
L 2	License renewal every 2 years – LPN, RN and ARNP (and continuing competency audit cycle).	<ol style="list-style-type: none"> 1. Stakeholder work has been done with continuing competency workshops. 2. Complete legal review and analysis 3. Develop plan including fee study 4. Rules process with workshops, drafting, review and approval 	Licensing Manager	NCQAC Staff, (revenue/budget review) HSQA rules staff ILRS, AAG office.	<p>06/30/16</p> <p>7/31/17</p>	
L 3	Create “retired active” category for ARNPs.	<ol style="list-style-type: none"> 1. Rules change required 	Licensing Manager	National Certifying bodies	Begin rules process 1/31/18	

			ARNP Consultant	NCQAC Staff, (revenue review) HSQA rules staff ILRS, AAG office		
L 4	WA nursing JP exam with relicensing.	Evaluate options to assure licensed nurses maintain currency with the RCW's and WAC's to include fiscal impact.		NCQAC members and staff, HSQA/OLS Revenue (costs to maintain on-line examination) LMS? AGG office?	12/31/16	

DRAFT

PRACTICE

ID	GOAL	OBJECTIVES	RESPONSIBILITY	RESOURCES	DEADLINES	PROGRESS
P 1	Align nursing and nursing assistant laws and rules with the National Council of State Boards of Nursing (NCSBN) Model Act, Model Rules, and Advanced Practice Registered Nurse (APRN) Consensus Model	<ol style="list-style-type: none"> 1. Develop a report that analyzes existing nursing law and rule comparing them with the NCSBN Model Act and Rule 2. Develop and implement a comprehensive project plan based on the analysis findings 3. Evaluate outcomes of project plan 	Associate Director of Nursing Practice ARNP Advisor	NCQAC staff and commission time	<ol style="list-style-type: none"> 1. 7-31-16 2. 9-30-16 3. 6-30-17 	✓ ? X
P 2	Inform consumers, licensees, nurses, and other stakeholders about the practice and regulation of the nursing profession	<ol style="list-style-type: none"> 1. Develop and implement a comprehensive project plan 2. Evaluate outcomes of project plan 3. Revise the Nursing Practice website 4. Prioritize and review/revise existing advisory opinions, or develop new interpretive statements, and policy statements 	Associate Director of Nursing Practice ARNP Advisor	NCQAC staff and commission time Educational program development costs including video production contract costs	<ol style="list-style-type: none"> 1. 12-31-15 2. 6-30-17 3. 6-30-17 1. 6-30-17 	

				IT and computer software/applications and training costs		
P 3	Obtain licensing and disciplining authority of nursing assistants, home care aides and medical assistants to the Nursing Commission	<ol style="list-style-type: none"> 1. Develop a comprehensive project plan 1. Evaluate outcomes of project plan 	Associate Director of Nursing Practice	NCQAC staff and commission time	<ol style="list-style-type: none"> 1. 12-31-16 2. 6-30-17 	

Washington State Nursing Care Quality Assurance Commission

Position Description

Legislative Panel

Purpose: To review and take positions on legislative bills on behalf of the Nursing Commission.

Membership:

Chairperson of Nursing Commission
Vice-Chairperson of the Nursing Commission
Other interested Commission members

Duties and Responsibilities:

1. Commission vice chair serves as the chair of the legislative panel
2. Meets weekly during the legislative session. Agendas will be posted within 48 hours of the meeting.
 - a. Opening
 - b. NCQAC Bill report
 - i. Review each bill
 - ii. Determine position and action on each bill
 - iii. Weekly report on actions
 - c. Conclusion
3. Presents Legislative issues to the Nursing Commission throughout Legislative session
4. Presents recommendations for legislative changes at every May meeting.

Staff:

Executive Director
Associate Director-Discipline
Associate Director-Nursing Practice
Legal Manager
Performance and Policy Consultant

Approved: 7/06, 7/08

Revised: 6/08, 03/11, 3/15



Health Systems Quality Assurance – Quarterly Dashboard Performance Measure Cases Processed – Intake/Assessment

2.1 Performance Measure: Percent of cases in which the intake and assessment steps are completed within 21 days.
Target: 77% within 21 days

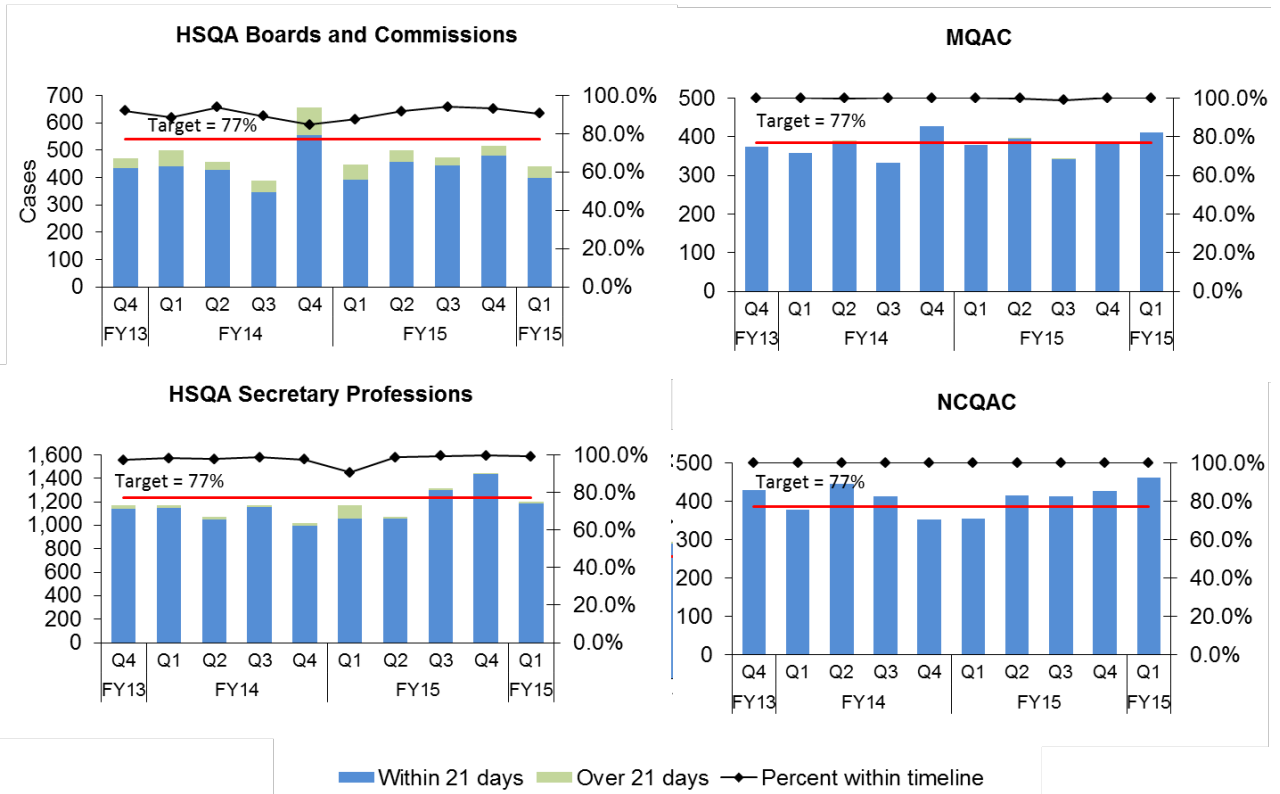
Analysis:

There were 2,511 complaints processed through intake/assessment during the quarter.

- 411 for HSQA boards and commissions.
- 1,197 for HSQA secretary professions.
- 412 for the Medical Commission.
- 461 for the Nursing Commission.

On average, 98% of complaints were processed within timeline in the first quarter

- 91% for HSQA boards and commissions.
- 99% for HSQA secretary professions.
- 100% for the Medical Commission.
- 100% for the Nursing Commission.



Health Systems Quality Assurance – Quarterly Dashboard Performance Measure Cases Processed - Investigation Steps

2.2 Performance Measure: Percent of cases in which the investigation step is completed within 170 days.
Target: 77% completed within 170 days.

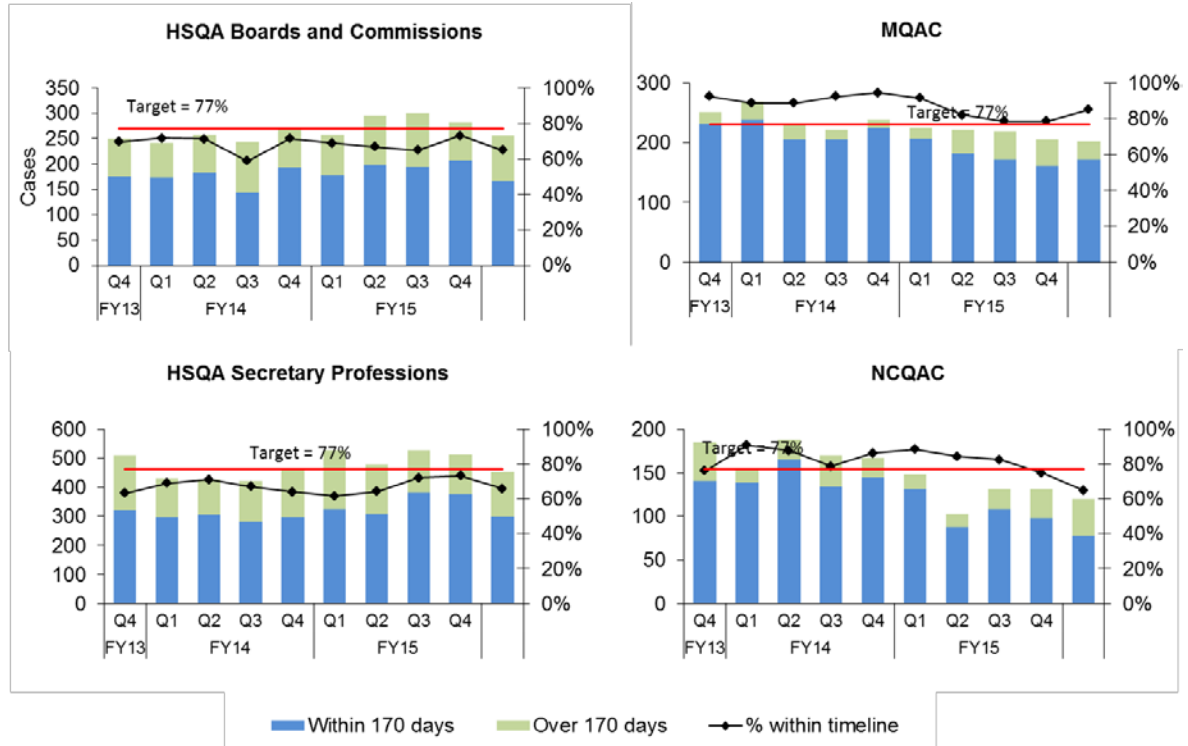
Analysis:

There were 1,032 cases processed through the investigation step during the quarter.

- 256 for HSQA boards and commissions.
- 454 for HSQA secretary professions.
- 202 for the Medical Commission.
- 120 for the Nursing Commission.

In total, 69% of investigations were completed within the target timeline.

- 65% for HSQA boards and commissions.
- 66% for HSQA secretary professions.
- 85% for the Medical Commission.
- 65% for the Nursing Commission.



Health Systems Quality Assurance – Quarterly Dashboard Performance Measure Cases Processed – Case Disposition

2.3 Performance Measure: Percent of cases in which the case disposition step is completed within 140 days.

Target: 77% completed within 140 days

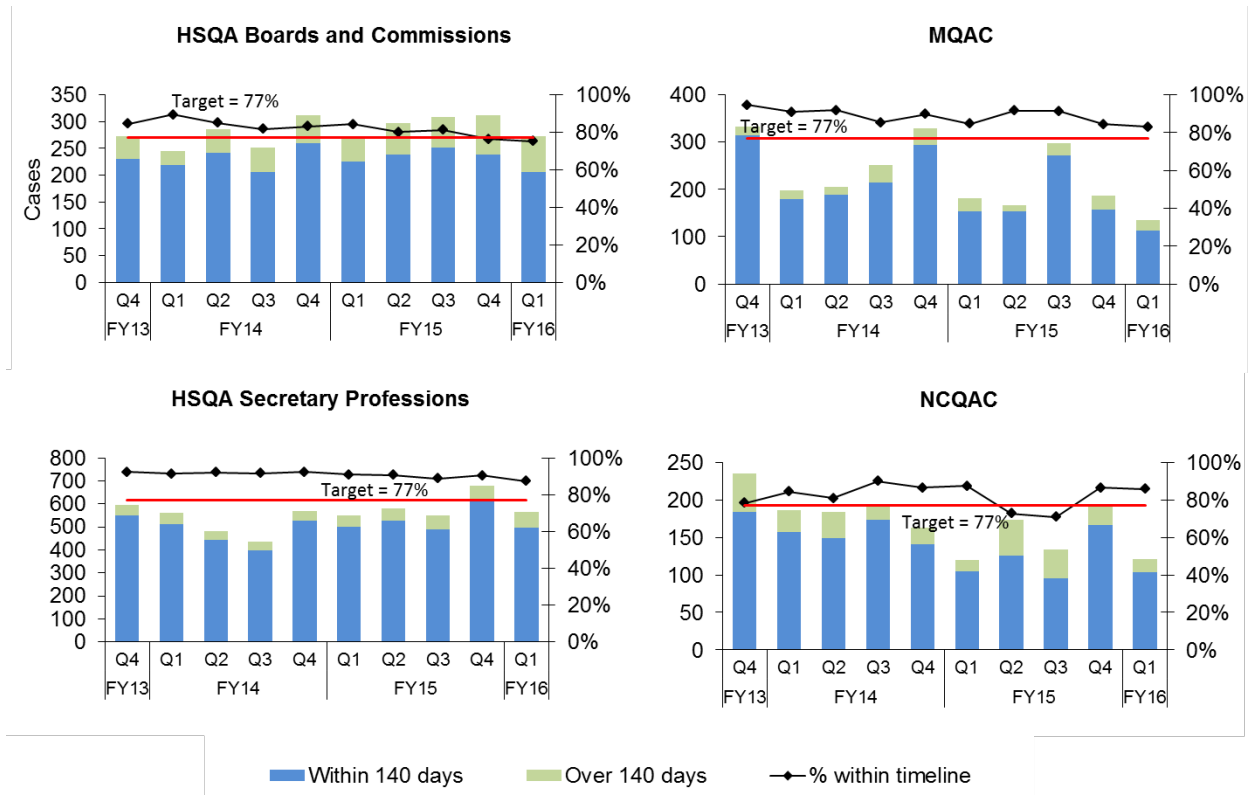
Analysis:

There were 1,095 cases processed through the case disposition step during quarter.

- 273 for HSQA boards and commissions.
- 566 for HSQA secretary professions.
- 135 for the Medical Commission.
- 121 for the Nursing Commission.

On average, 84% of cases were processed within timelines in the quarter.

- 75% for HSQA boards and commissions.
- 87% for HSQA secretary professions.
- 83% for the Medical Commission.
- 86% for the Nursing Commission.



Health Systems Quality Assurance – Quarterly Dashboard Performance Measure Cases in Investigation

2.4 Performance Measure: Percent of open cases currently in investigations step that are over 170 days.

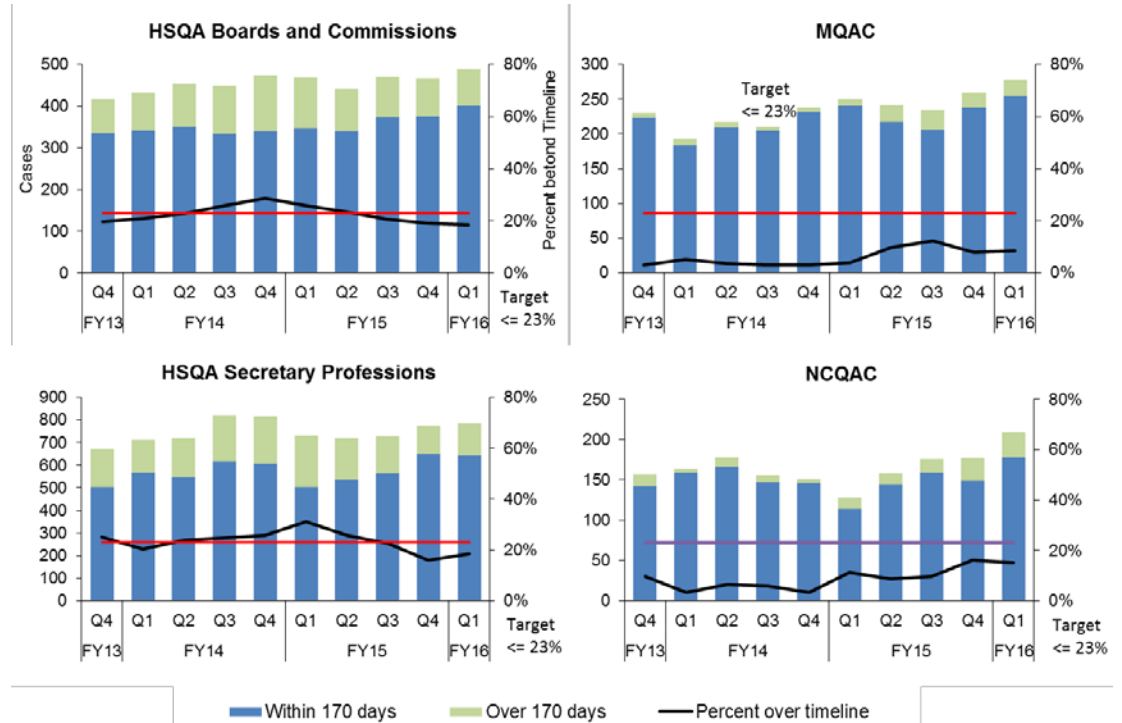
Target: No more than 23% over 170 days

There were 1,763 open investigations during the quarter.

- 490 for HSQA boards and commissions.
- 786 for HSQA secretary professions.
- 278 for the Medical Commission.
- 209 for the Nursing Commission.

In total, 16% of cases were over timeline in the quarter.

- 18% for HSQA boards and commissions.
- 19% for HSQA secretary professions.
- 8% for the Medical Commission.
- 15% for the Nursing Commission.



Health Systems Quality Assurance – Quarterly Dashboard Performance Measure Cases in Case Disposition

2.5 Performance Measure: Percent of open cases currently in the case disposition step that are over 140 days.

Target: No more than 23% over 140 days.

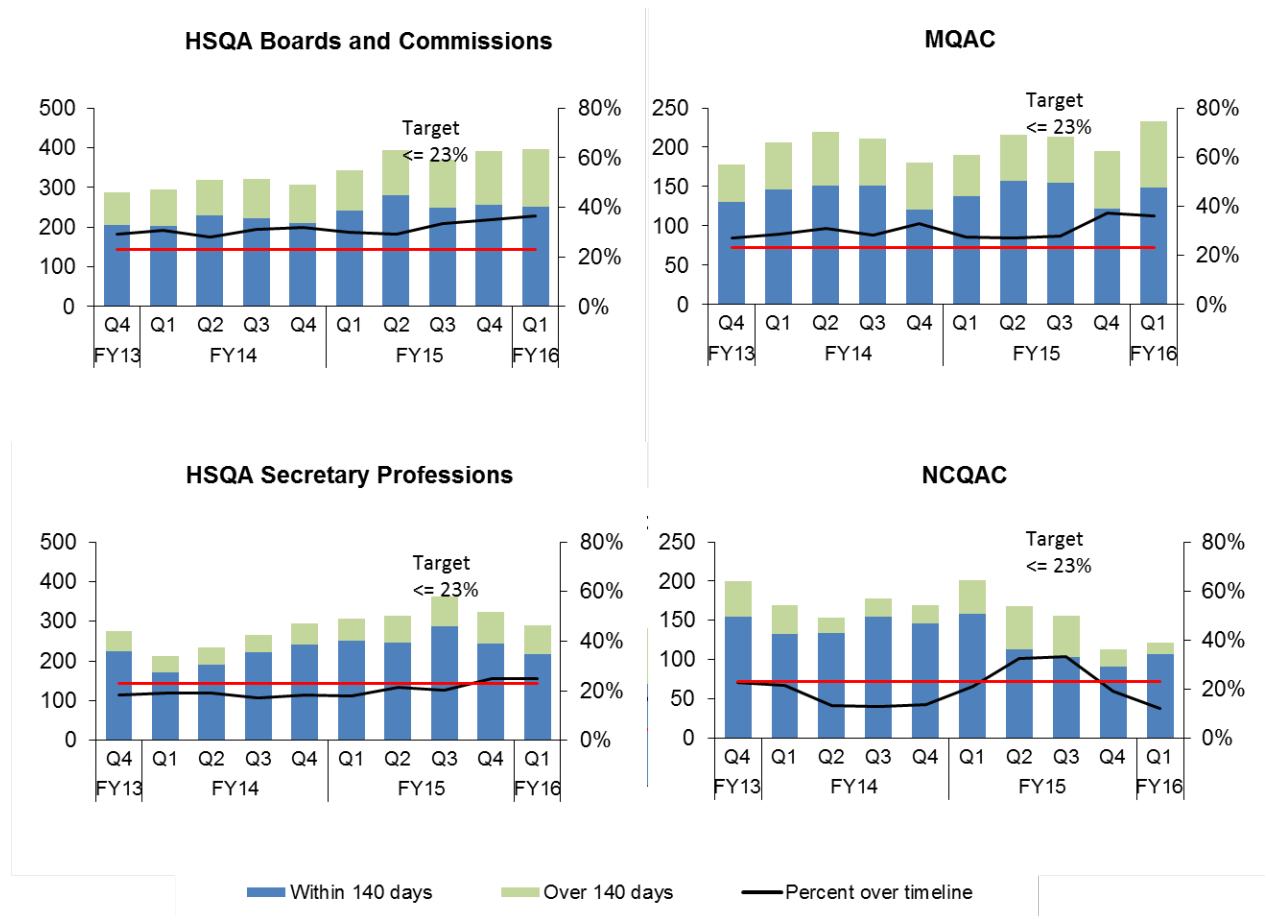
Analysis:

There was an average of 1,039 open investigations during the quarter.

- 395 for HSQA boards and commissions.
- 289 for HSQA secretary professions.
- 233 for the Medical Commission.
- 122 for the Nursing Commission.

On average, 30% of cases were over timeline in the quarter.

- 36% for HSQA boards and commissions.
- 25% for HSQA secretary professions.
- 36% for the Medical Commission.
- 12% for the Nursing Commission.





Health Systems Quality Assurance – Quarterly Dashboard Performance Measure Sanction Schedule

2.6 Performance Measure: Percent of Orders and STIDs that comply with the sanction schedule.

Target: 93%.

Analysis:

The Department of Health issued 194 final decisions in the quarter. These include:

- 26 for the Medical Commission.
- 47 for the Nursing Commission.
- 69 for HSQA boards and commissions.
- 52 for secretary professions.

Overall, 99% of these were within the sanction schedule in the quarter.

- 100% for the Medical Commission.
- 100% for the Nursing Commission.
- 100% for HSQA boards and commissions.
- 98% for secretary professions.



Health Systems Quality Assurance – Quarterly Dashboard Performance Measure Sexual Misconduct Cases Transferred within 14 days

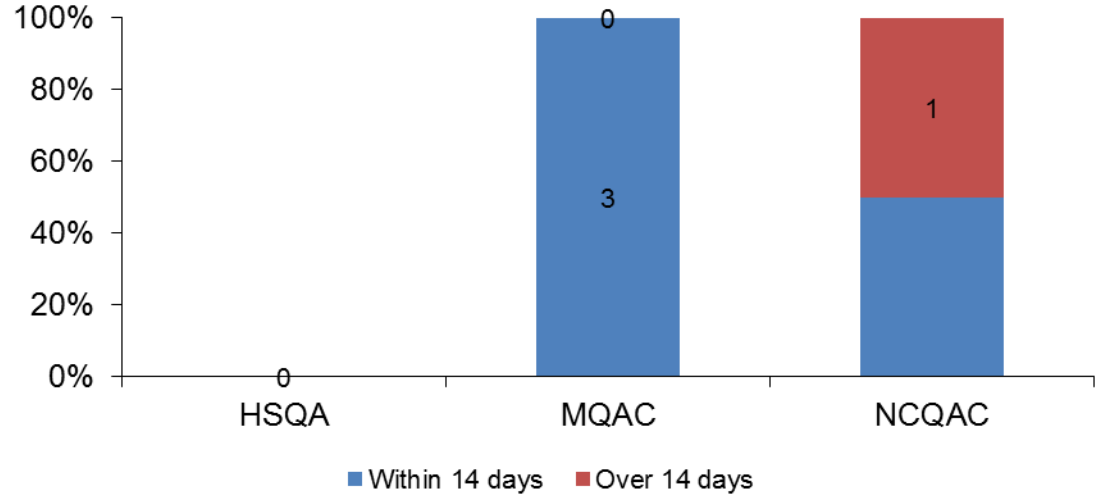
2.7 Performance Measure: Percent of cases involving sexual misconduct transferred to the Secretary within 14 days.

Target: 95% issued within 14 days

Analysis:

- A case is transferred to the secretary if a board or commission determines the case involves only sexual misconduct.

**Sexual Misconduct Cases Transferred within 14 Days
July- September 2015**





Health Systems Quality Assurance – Quarterly Dashboard Performance Measure Completed Investigations vs. Number of Investigators

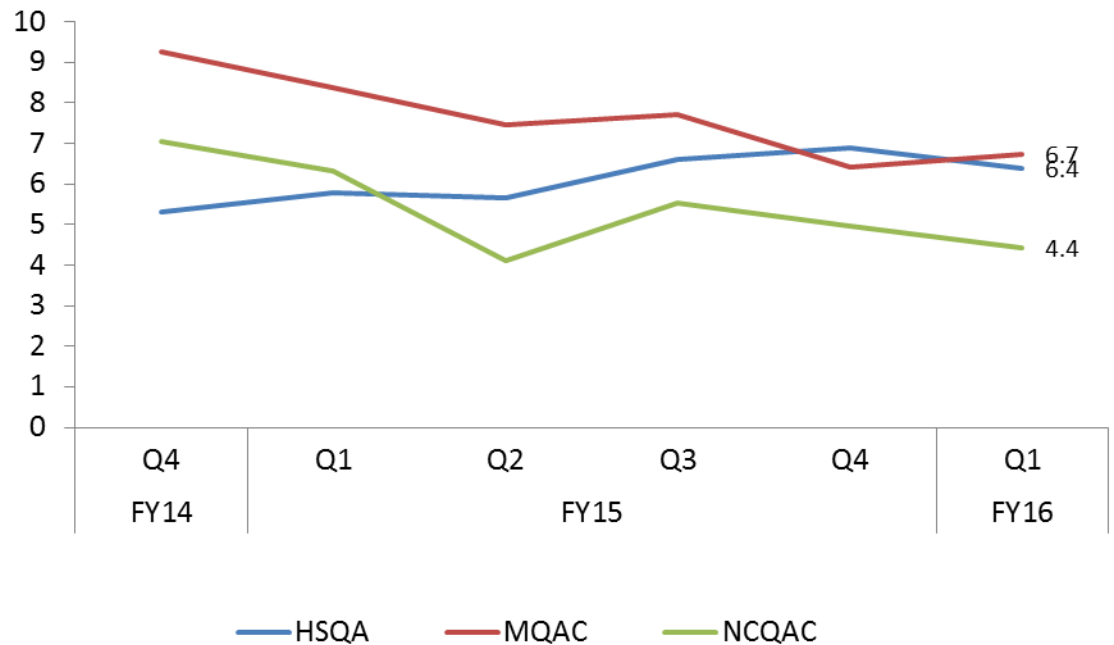
3.1 Performance Measure: Completed investigations vs. number of investigators.

Analysis:

During the recent quarter, investigators completed an average of 6 investigations per investigator each month.

- HSQA investigators completed an average of 242 investigations per month.
- MQAC investigators completed an average of 61 investigations per month.
- NCQAC investigators completed an average of 35 investigations per month.

1103 Measure 3.1 - Avg. Investigations Completed per Investigator





Health Systems Quality Assurance – Quarterly Dashboard Performance Measure Comparison of Legal Caseloads

3.2 Performance Measure: Number of completed investigations that are assigned to a staff attorney for legal review or production of documents v. number of staff attorneys.

Target: 65 cases per attorney

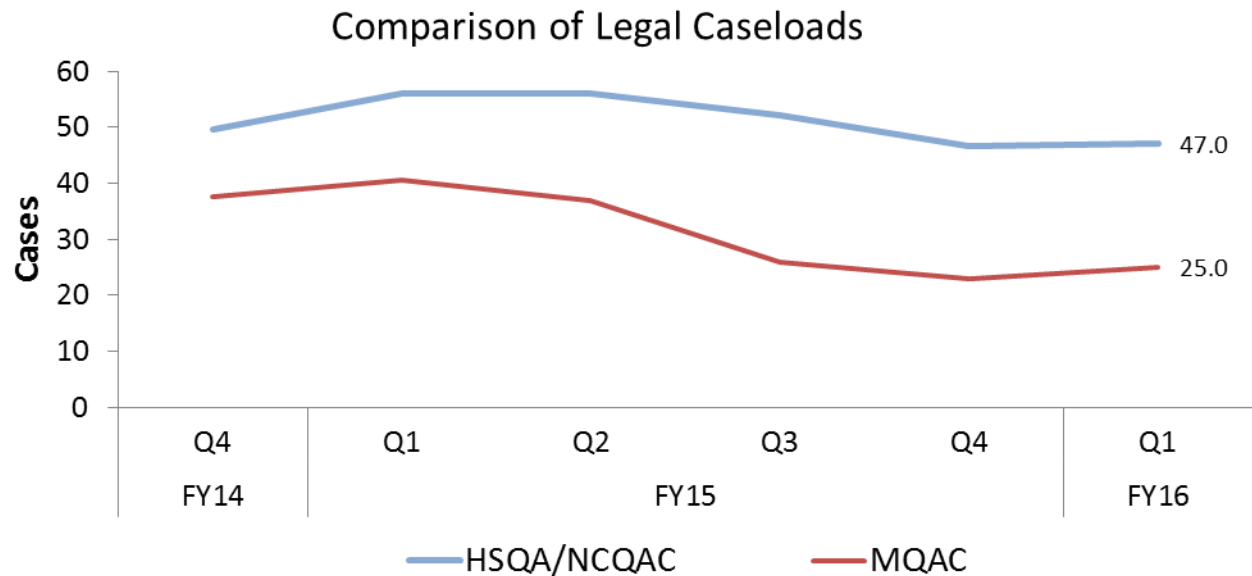
Analysis:

The caseload size for HSQA (including NCQAC) staff attorneys averaged 47 cases in the quarter.

- The average caseload size is up from 46.5 cases in the previous quarter.

The caseload size of MQAC staff attorneys averaged 25 cases in the quarter.

- The average caseload size is up from 23 cases in the previous quarter.



The caseload size for HSQA (excluding NCQAC) staff attorneys averaged 50 cases in the quarter.

The caseload size for NCQAC staff attorneys averaged 35 cases in the quarter.



Memo

To: Nursing Care Quality Assurance Commission

From: Catherine Woodard
Associate Director of Discipline

Date: October 30, 2015

Re: Investigative Performance Measures FY Quarter 1

We have identified a discrepancy in the HSQA performance measure 3.1 that we are addressing with personnel who create the HSQA report. The average number of investigations completed per month and average performance of investigators varies significantly from our statistics. The source of the discrepancy had not yet been identified and the HSQA report had not yet been updated at the time the business meeting packet was posted. The table below submitted to the Discipline Subcommittee covering the same time period more accurately reflects the Investigations Unit performance.

	Jul 15	Aug 15	Sep 15	3rd Quarter 2015
Reports Reviewed at CMT	142	142	158	147
UDA Investigations Opened at CMT	52	45	53	50
Investigations completed for UDA Report (PM 3.1)	36	47	41	41
Investigations Completed for Investigator (6.3 investigators)	6	7.5	6.5	6.6
Number of Open Investigations	196	197	214	202
Investigations Completed within timelines (Target 77%; PM 2.2)	57%	63%	73%	64%
Investigations Open Beyond 170 days (Target 23%; PM 2.4)	15%	14%	14%	14%
Investigations Open Beyond 365 days (Including Task Backs)	0	2	1	1
Cases in Early Remediation	2	11	5	6

**Nursing Care Quality Assurance Commission
 Legal Unit Performance Measures
 FY 2015 (Q1)
 Karl Hoehn, Legal Manager**

Type of Measure	Month	Baseline
Caseload/ Case volume	Average Caseload per Attorney	45.92
	Cases Assigned to Legal	41.33
	TOTAL Finalized Cases	56.33
Performance	Average of Finalized Cases per Attorney (Target 10 per month)	14.08
	Percentage of Legal Reviews Sent to RCM in 30 Days or less (Target 77%)	78.33%
	Document drafting time: Percentage of Drafts to AAG or SOA Served in 30 Days or less (Target 77%)	86.67%
Work Type/Complexity	Percentage of Cases involving an ARNP	6.00%
	Number of Cases forwarded to AAG	10.67
	Finalized with Legal Review only	21
	Finalized by Default or Final Order After Hearing	12
	Finalized by STID, AO or APUC (Settlements)	19
	Other (releases, reinstatements)	4.33

July	Aug.	Sept.	Q1 avg.
39	36	37.5	37.50
45	14	36	31.67
35	47	47	43.00
8.75	11.75	11.75	10.75
94%	86%	92%	91%
100%	40%	84%	75%
7%	7%	3%	6%
11	10	13	11.33
15	10	26	17
5	10	4	6
10	16	15	14
5	11	2	6

Nursing Care Quality Assurance Commission

Washington Health Professional Services (WHPS): Performance Measures Aug – Sept 2015

John Furman, Director

	Baseline*	August	September	Monthly Average
Program Participation Numbers	332	318	318	318
Average Days from Intake to Case Disposition	32	35	34	34.5
Average Days from Enrollment to Treatment Entry	1	0	0	0
Average Days Positive Drug Test Turn-Around Time	8	7	8	7.5
Positive Drug Tests Addressed Within Next Business Day	99%	26/26	32/32	100%
Average Days from Significant Contract Non-Compliance to Discipline Notification	3	2	2	2
Late Monthly Reports	22 (8%)	14	18	16(5%)
Employment rate	63%	73%	66%	69%
Case File Integrity**	96%	28/30	29/30	95%
Number of missed tests	--	0	3	1.5
Number of outreach activities*	--	4	4	4

*January- June 2015 numbers

**Review of 30 randomly selected files per month

***Presented to Seattle King County Health, Association of Professionals in Infection Control (APIC), Association of Occupational Health Nurses (AOHN), Summit Pacific Medical Center, Gonzaga University, Providence Everett, Clover Park Technical College, and Valley General Hospital.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Staff Assistance with Equipment Issues	Number: H13.01
Reference:		
Contact:	Chris Archuleta, Administrative Assistant Nursing Care Quality Assurance Commission (360) 236-4713	
Effective Date:	December 1, 2015	
Supersedes:		
Approved:	Paula R. Meyer, MSN, RN, FRE Executive Director Washington State Nursing Care Quality Assurance Commission	

PURPOSE: Administrative staff assists the Nursing Care Quality Assurance Commission (NCQAC) members with issues that arise with the operation and function of state issued NCQAC equipment.

PROCEDURE:

- I. NCQAC members contact Administrative Staff first when issue arises. Contact information below.**
 - A. Administrative Staff attempt to resolve the issue for NCQAC member.
 - B. If the issue cannot be resolved by the Administrative Staff, then Administrative Staff contact the HELP desk on behalf of the NCQAC member to resolve the issue.
 - C. Administrative Staff remains the primary point of contact resolving the issue. NCQAC members are not expected to interface with IT staff.
 - D. Administrative Staff response as follows:

1. Administrative Staff acknowledge receipt of request by email or phone within 4 hours.
2. Administrative Staff respond with resolution within 48 hours of initial inquiry.

ADDENDUM A:

Administrative Staff Contact List

1. Chris Archuleta	360-236-4713	Chris.archuleta@doh.wa.gov
2. Bobbi Allison	360-236-4741	Bobbi.allison@doh.wa.gov
3. Barbara Elsner	360-236-4763	Barbara.elsner@doh.wa.gov
4. Shari Kincy	360-236-4709	Shari.kincy@doh.wa.gov
5. Jean Wheat	360-236-4724	Jean.wheat@doh.wa.gov
6. Jennifer Anderson	360-236-4712	Jennifer.anderson@doh.wa.gov

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
OPERATIONAL PROCEDURE**

Title:	Review and Approval of International Educated Nurse Exam Applications	Number: B19.01
Reference:	RCW 18.79.190,18.79.160 WAC 246-840-045 (C)(i)(ii), 246-840-050, 246-840-575(2)	
Contact:	Licensing Manager, Teresa Corrado	
Effective Date:	November 13, 2015	
Approved:	Paula R. Meyer, MSN, RN, FRE Executive Director Washington State Nursing Care Quality Assurance Commission (NCQAC)	

PURPOSE:

This procedure establishes the process for review and approval of International Educated Nurse (IEN) license application and educational preparation for Washington State nurse licensure by examination. WAC 246-840-045 (1)(a) identifies the educational preparation of an IEN must be equivalent to the minimum standards prevalent for nursing education programs approved by the NCQAC. WAC 246-840-050(3) indicates only nurse applicants meet the education, experience and NCQAC determined application requirements shall be eligible to take the National Council Licensure Exam (NCLEX-RN or NCLEX-PN). WAC 246-840-045(5)(b)(1) and (c)(1) requires official transcripts must be sent directly to the NCQAC and for RNs that a commission approved credential evaluation service be completed. The approved credential evaluation service provides a course by course evaluation report to the NCQAC staff, determining if the applicant's education is equivalent to an RN program in the United States.

PROCEDURE:

Licensing Staff initially review applications of internationally educated RN and LPN applications to ensure a complete application. If there are deficiencies in the application file, the staff sends an email to the applicant requesting the missing requirements and copies the email in the notes field of the Integrated Licensing Regulatory System (ILRS). As licensing staff receive application requirements, they document the receipt in ILRS workflows. The licensing staff evaluates the requirements to determine eligibility to take the NCLEX. Licensing staff evaluate the following requirements to determine eligibility to take the National Council Licensing Exam. (NCLEX)

1.

2. Education evaluation:

Transcripts must be evaluated, course by course, by one of the following NCQAC approved education and licensure evaluation service providers:

Graduates of Foreign Trained Nursing Schools (CGFNS) www.cgfns.org

Education Records Evaluation Service (ERES) www.eres.com

International Education Research Foundation, Inc. (IERF) www.ierf.org

3. Education verification

After the applicant completes the nursing program, the school completes, signs, dates, and returns the Education Verification DOH form 669-325 to the NCQAC office.

4. Official Transcripts

If the evaluation service does not provide the NCQAC a copy of the applicant's transcripts, an official transcript with the degree listed must come directly from the school of nursing.

5. English Proficiency

WAC 246-840-045 requires all LPN and RN license applicants who received their nursing education out of the United States, except for Canada (Quebec requires the English Proficiency exam), United Kingdom, Ireland, Australia, New Zealand, Samoa, Guam, Mariana Islands, and Virgin Islands to complete an English proficiency test.

English proficiency exams approved by the NCQAC for both RN and LPN applicants:

- The Test of English as a Foreign Language (TOEFL) iBT®
 - TOEFL institution code: 7292
 - TOEFL website: www.toefl.com
 - Minimum pass rates for RN applicants: overall total score 84, 26 in speaking section.
 - Minimum pass rates for LPN applicants: overall total score of 79, 26 in the speaking.
 - The pass rates remain consistent with National Council of States of Board of Nursing (NCSBN) recommendations.
- The International English Language Testing System (IELTS). IELTS website: www.ielts.org,
 - Minimum pass rates for RN and LPN applicants: 6.5 overall and 6.0 in each additional section.
 - The pass rates remain consistent with National Council of States of Board of Nursing (NCSBN) recommendations.

Licensing staff forward the application to the education unit for review. Licensing staff documents in the notes field of ILRS the application was forwarded.

- The education unit reviews and evaluates the above listed documentation and determines academic eligibility to take the NCLEX. The Education unit staff returns an approved application to licensing staff to issue the license.
- Licensing or education staff notifies applicants deemed academically ineligible via email and documented in ILRS notes field, of the academic deficiency and provide resources for the applicant on how to meet requirements.

- If the applicant fails to complete the application process, licensing staff will close applications as incomplete following procedure B16.01.
- If the applicant submits further education documentation, licensing staff forwards the documentation and application to the education unit for another review.
- If the education unit determines the applicant completed a program from a non-approved or fraudulent nursing program, staff forwards the application to the appropriate discipline staff to start the Notice of Decision (NOD) process following procedure B30.01 NOD process.

6. NCLEX

Licensing staff use the www.pearsonvue.com website to make the applicant eligible to take the exam and documents authorization date in ILRS exam field.

- Review staff enters Passing NCLEX results in ILRS and forwards the completed file to approval staff to issue the license. The completion of the review process is confirmed through an ILRS workflow. Licensing staff place completed files in records retention boxes for records staff to process.
- Review staff enters failing NLCEX results in ILRS and places the file in the file cabinet to track re-takes of the exam.

7. Canada NCLEX

Applicants educated in Canada who have taken and passed the NCLEX, do not need to repeat the exam.

- The applicant must request their Canadian province complete a verification of licensure by NCLEX examination on DOH form 669-218 and submit the form directly to NCQAC office.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

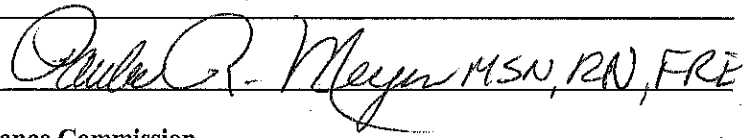
Title:	Commission Pay	Number:	H04.02
---------------	----------------	----------------	--------

Reference:	RCW 43.03.265, RCW 43.03-050 and RCW 43.03.060		
-------------------	--	--	--

Contact:	Nursing Care Quality Assurance Commission		
-----------------	---	--	--

Effective Date:	October 19, 2015		
------------------------	------------------	--	--

Supersedes:	March 8, 2013		
--------------------	---------------	--	--

Approved:	Paula R. Meyer, MSN, RN		MSN, RN, FRE
	Executive Director		
	Nursing Care Quality Assurance Commission		

PURPOSE STATEMENT:

Commission Members are compensated for performing duties consistent with their statutory responsibilities. This policy does not apply to travel reimbursement.

PROCEDURE

- 1. Commission worksheet/pay sheets are due to the Administrative Assistant 3, by the 10th of the following month. (Example: September is due by October 10th).**
This allows five (5) days for processing and forwarding to payroll by the 15th of each month.
- 2. Travel Expense Management (TEMS) are due by the 10th of the following month. (Example: September travel expenses are due October 10th).** This allows 10-days for processing and forwarding to accounting for processing by the 25th of each month. Accounting has 10-days to review, approve and forward to the Office of Financial Management for payout.
- 3. The maximum compensation per day is \$250.**

In accordance with statute, compensation will not exceed \$250 per day regardless of the length of time involved for that day, including travel time. All forms for commission compensation must be submitted to the Nursing Commission Office no later than the tenth of the month.

- 4. Less than eight hour days will be prorated.**

Commission members receive compensation at the prorated hourly rate of \$31.25 for less than eight hours in a single day.

- Legislative hearings
- New Commission Member orientation
- Reviewing journals or articles directly related to a disciplinary case

Commission Member out-of-state travel. Out-of-state travel requires approval from the full commission, or the Executive Director in consultation with the Chair, and is subject to approval to the travel reservations being completed.

- Travel time to and from the meeting will be compensated
- If the meeting is less than eight hours, compensation will be pro-rated according to the time posted on meeting agenda(s).

7. Not all activities are eligible for compensation.

Some activities should be done on the commission member's own time and will not be reimbursed. Members are encouraged to seek clarification from the executive director prior to engaging in activities not specifically stated in statute.

Examples:

- Continuing education courses
- Travel time to and from official business if the member, by choice, deviated from the most efficient method
- Performing duties on behalf of the commission without informing the executive director
- Performing duties on behalf of the commission that have, or appear to have, a conflict of interest with the commission's official duties
- Attendance at meetings of specific ad hoc committees if not officially appointed
- Study time involving reading journals or articles, not directly related to case reviews
- Pre-payment of anticipated costs or business to be performed at a future date

8. Pro-Tem Members are compensated according to their scope.

Programs will compensate pro-tem commission members for duties stated in their appointment letter. Duties outside of their appointment scope may not be compensated.

9. If a Commission Member is a state employee or an employee of a municipality, a choice of payer must be made.

A public official must be paid from a single payer source. Therefore, if a Commission Member is an elected official or an employee of a state agency, school or a municipal

Nursing Care Quality Assurance Commission

2016 Hearing Dates

DATE	LOCATION
January 4, 2016 (M)	Tumwater
January 29, 2016 (F)	Tumwater
February 9, 2016 (T)	Tumwater
February 25, 2016 (Th)	Tumwater
March 10, 2016 (Th)	Tumwater
March 25, 2016 (F)	Tumwater
April 4, 2016 (M)	Tumwater
April 21, 2016 (Th)	Tumwater
May 5, 2016 (Th)	Tumwater
May 19, 2016 (Th)	Tumwater
June 7, 2016 (T)	Tumwater
June 24, 2016 (F)	Tumwater
July 8, 2016 (F)	Tumwater
July 19, 2105 (T)	Tumwater
August 2, 2016 (T)	Tumwater
August 18, 2016 (Th)	Tumwater
September 8, 2016 (Th)	Tumwater
September 20, 2016 (T)	Tumwater
October 7, 2016 (F)	Tumwater
October 24, 2016 (M)	Tumwater
November 4, 2016 (F)	Tumwater
November 17, 2016 (Th)	Tumwater
December	No Hearings

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Request for Interpretive Statement, Consistent Standards of Practice Sub-Committee Responsibilities and Actions	Number:	F 03.02
Reference:	HSQA 1-1-06		
Contact:	Nursing Practice Advisor		
Effective Date:	May 11, 2012		
Supersedes:			
Approved:	Paula R. Meyer, Executive Director Washington State Nursing Care Quality Assurance Commission		

PURPOSE STATEMENT: The Nursing Care Quality Assurance Commission (NCQAC) regulates the practice of registered nurse, licensed practical nurse, advanced registered nurse practitioners, and nursing technicians. The NCQAC establishes, monitors, and enforces consistent standards of practice. The Consistent Standards of Practice sub-committee (CSPS) receives and reviews requests for Interpretive Statements. The CSPS uses Nursing Practice Advisory Groups to identify optimal practice in all practice settings across the state. The Nursing Practice Advisory Groups gather information and inform the members of the CSPS on current practice standards. The CSPS presents interpretive statements to the NCQAC for adoption.

PROCEDURE

1. A *Request for NCQAC Practice Review* may be submitted in writing by an individual or organization directly to the Nursing Practice Advisor. A *Request for NCQAC Practice Review* may be submitted to the NCQAC during the open microphone portion of a business meeting. See Attachment A.
2. The NCQAC assigns the Request to the CSPS. The CSPS determines the priority of the request. The CSPS scores each Request using the following Priority ranking: **High**, **Medium**, **Low**, or **No Review**.
3. The CSPS assigns Requests to the NPAG for further action. The NPAG completes the review of the literature and standards of practice. The NPAG forwards this information to the Nursing Practice Advisor
4. The Nurse Practice Advisor completes the draft interpretive statement using the documents gathered from the NPAG.
5. The CSPS accepts or revises the draft interpretive statement. The NPAG's work is referenced as addendums to support the interpretive statement.
6. The CSPS presents the draft interpretive statement to the NCQAC. The NCQAC may adopt, revise or reject the draft interpretive statement.

7. If adopted by the NCQAC, the Nursing Practice Advisor proceeds with the Secretary Review process according to HSQA Business Practice 1-1-06.
8. Once the interpretive statement is completed and filed with the Office of the Code Reviser, he CSPS communicates NCQAC's actions to the requester.



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

F03.02 Attachment A

Request for Nursing Care Quality Assurance Commission Practice Review

Nurses and other concerned citizens often have questions or concerns about nursing practice. Some questions require a formal response from the Nursing Care Quality Assurance Commission (NCQAC). Please complete this form to request a formal interpretive statement from the NCQAC.

Examples of issues are:

- Scope of practice concerns not addressed in current administrative rule or policy.
- Proposed changes to nursing statute or administrative rules.
- Other concerns you believe have nursing regulatory impact and you request a formal response from the NCQAC.

The Consistent Standards of Practice sub-committee of the NCQAC reviews requests. The sub-committee may prioritize requests based on urgency to public safety, relevance for large numbers of practicing nurses or client populations, and resources available to complete needed work. After completing a review, the NCQAC sends a written response to the request.

Please complete the following and submit your request to:

Nursing Care Quality Assurance Commission
PO Box 47864
Olympia WA 98504-7864
Attn: Nursing Practice Advisor

FAX: 360-236-4738, Attn: Nursing Practice Advisor

Please keep a copy of the request for your records.

1. Contact Information

First Name: Fujio _____ MI _____ Last Name: McPherson _____

Address 6501 Candace Court SE _____

City: Lacey _____ State: WA _____ Zip Code: 98513 _____

Phone Numbers Business (253) 968-3317 _____ Home (360) 413-1480 _____

Mobile: (360) 349-7882 _____ FAX _____

Email Address: fmdc82@comcast.net _____

I am licensed to practice nursing in Washington State: Yes No

Organization your represent, if applicable: **NW Consortium for Acupuncture and Integrative Medicine for Advanced Practice Clinicians** _____

2. Statement of the issue and requested action by the NCQAC. Please thoroughly explain the issue and the action you are requesting. Please provide evidence supportive of any requested changes.

3.

Issue: Inclusion of Acupuncture under the ARNP Scope of Practice

Requesting an Interpretive Statement/ Advisory opinion from the NCQAC supporting the inclusion of acupuncture under the ARNP scope of practice based on completion of formal 300 hour course in Traditional Chinese Medicine (TCM) accredited by the American Academy of Nurse Practitioners (AANP).

At this time there are two criteria being used to perform acupuncture in the State of Washington. The first applies to individuals with no prior experience or licensure in clinical practice and requires a Master's degree and completion of the NCCAOM boards. The second applies to physicians (MD, DO) and is based on 300 hour certification by the American Academy of Medical Acupuncture (AAMA). There are no courses specific to the needs of ARNPs.

At present in the USA, there are roughly 3500 physicians and 11-12,000 non physician acupuncturists that perform acupuncture. 40 acupuncture schools train non-physicians, and about 500-600 physicians are being trained yearly to AAMA standards, with sustained hospital privileges. <http://www.medicalacupuncture.org/Home.aspx>

Evidence Supporting a Change:

Traditional Chinese medicine (TCM) is one of the oldest healing systems on the planet. It has been documented as far back as 6,000 years. There have been numerous studies that support the efficacy and safety of acupuncture in the promotion of health and healing.

Originally founded in 1992 as the Office of Alternative Medicine (OAM), the NCCAM facilitates the research and evaluation of unconventional medical practices and disseminates this information to the public. The NCCAM established in 1998, supports 13 Centers, where researchers conduct studies on complementary and alternative medicine for specific health conditions and diseases. Scientists at several Centers are investigating acupuncture therapy.

Researchers at the NCCAM Center at the University of Maryland in Baltimore conducted a randomized controlled clinical trial and found that patients treated with acupuncture after dental surgery had less intense pain than patients who received a placebo.²⁰ Other scientists at the Center found that older people with osteoarthritis experienced significantly more pain relief after using conventional drugs and acupuncture together than those using conventional therapy alone.²⁹

Researchers at the Minneapolis Medical Research Foundation in Minnesota are studying the use of acupuncture to treat alcoholism and addiction to benzodiazepines, nicotine, and cocaine. Scientists at the Kessler Institute for Rehabilitation in New Jersey are studying acupuncture to treat a stroke related swallowing disorder and the pain associated with spinal cord injuries.

The OAM, now the NCCAM, also funded several individual researchers in 1993 and 1994 to conduct preliminary studies on acupuncture. In one small randomized controlled clinical trial, more than half of the women with a major depressive episode who were treated with acupuncture improved significantly.³⁰

In another controlled clinical trial, nearly half of the seven children with attention deficit hyperactivity disorder who underwent acupuncture treatment showed some improvement in their symptoms. Researchers concluded that acupuncture was a useful alternative to standard medication for some children with this condition.³¹

Moxibustion (Chinese: 灸; pinyin: jiǔ) is a traditional Chinese medicine **therapy** using moxa made from dried mugwort (*Artemisia argyi*).

In a third small controlled study, eight pregnant women were given moxibustion; to reduce the rate of breech births, in which the fetus is positioned for birth feet-first instead of the normal position of head-first (Vertex) . Researchers found the treatment to be safe, but they were uncertain whether it was effective. Then, researchers reporting in the November 11, 1998, issue of the Journal of the American Medical Association conducted a larger randomized controlled clinical trial using moxibustion. They found that moxibustion applied to 130 pregnant women presenting breech significantly increased the number of normal Vertex (head-first births.)

- Berman, B., Lao, L., Bergman, S., Langenberg, P, Wong, R., Loangenberg, P, and Hochberg, M. "Efficacy of Traditional Chinese Acupuncture in the Treatment of Osteoarthritis: A Pilot Study." *Osteoarthritis and Cartilage* 1995. (3):139-42.
- Allen, J.J.B. "An Acupuncture Treatment Study for Unipolar Depression." *Psychological Science*. 1998. 9:397-401.
- Sonklar, N. Acupuncture and Attention Deficit Hyperactivity Disorder. National Institutes of Health, Office of Alternative Medicine Research Grant *R21 RR09463. 1993.
- Milligan, R. Breech Version by Acumoxa. National Institutes of Health, Office of Alternative Medicine Research Grant #R21 RR09327. 1993.
- Cardini, F. and Weixin, H. "Moxibustion for Correction of Breech Presentation: A Randomized Controlled Trial..." *Journal of the American Medical Association*. 1998. 280:1580-

Requested NCQAC Action:

Requesting an Interpretive Statement/Advisory opinion from the NCQAC supporting the inclusion of acupuncture under the ARNP scope of practice based on the completion of 300 hour course in Traditional Chinese Medicine (TCM) accredited by the American Academy of Nurse Practitioners (AANP).

4. Explain how public safety will be enhanced by the action you request:

The inclusion of acupuncture into the ARNP scope of practice will not only improve clinical management options and outcomes but will provide a template for ARNP's to promote wellness and disease prevention.

Although acupuncture has shown efficacy in the treatment of many diseases, the tenants of Traditional Chinese Medicine focuses on therapies that enhance the healing potential of the body and support healthy lifestyle choices.

5. Please check which regulations or NCQAC policies are impacted:

Statutes [Chapter 18.79 RCW: Nursing care](#)

Rules [WAC 246-840](#)

Interpretive Statements / Advisory Opinion [Nursing Practice Statements](#)

Other – Please describe

Unknown

5. How does the issue impact you, your profession, or your organization?

This issue impacts me personally because I currently hold two licenses: ARNP, EAMP, and through my experience and educational preparation (to include high educational cost/debt) I have found that with the combination of TCM, nursing and medicine, I have been able to impact patient outcomes and healing with less dependency on medication, decreased side effects, improved patient compliance, better disease management and greater professional satisfaction. Yet when I examined the TCM educational requirements for non-clinicians I found much of the curriculum to be redundant and unnecessary for ARNP clinicians. This would provide a program specific to the needs of ARNPs.

The impact on the profession is clear. As there are no acupuncture training opportunities for ARNPs who wish to learn this form of medicine, except to return to school to get a Masters

Option open to non-clinicians. The Medical Acupuncture training does not train, nor is it receptive to ARNPS.

The NW Consortium is designed to not only provide 300 hours of training equivalent to the programs offered to physicians, but exceed the training by opening opportunities for continuing education options beyond course completion. NW Consortium encourages collaboration with and support of Licensed Acupuncturist and establishes training consistent with Traditional Chinese Medicine without the modifications that has been done with the Medical Acupuncture training programs.

6. How may the issue impact other organizations or the public?

Supporting this initiative would not only improve overall patient care, improve disease management and patient outcomes, but also increase access to these types of therapies. It may also facilitate the inclusion of EAMP within the established medical treatment facilities and encourage an integrative approach to care. Overall it will add a safe and effective option with a minimal side effect profile to promote the health and safety of the residents of Washington State.

7. Contact information for Affected Parties, if available.

A. First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Numbers Business _____ Home _____

Mobile _____ FAX _____

Email Address _____

B. First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Numbers Business _____ Home _____

Mobile _____ FAX _____

Email Address _____

C. First Name _____ MI _____ Last Name _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers Business _____ Home _____
Mobile _____ FAX _____
Email Address _____

D. First Name _____ MI _____ Last Name _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers Business _____ Home _____
Mobile _____ FAX _____
Email Address _____

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
POLICY**

Title:	Approval of Evaluators in Nurse Discipline Cases	Number:	A24. 09
Reference:	RCW 18.79; RCW 18.130		
Contact:	Paula R. Meyer, Executive Director		
Effective Date:	September 13, 2013 <u>November 13, 2015</u>		
Supersedes:	September 13, 2002; July 1, 2005; July 13, 2007; Nov 14, 2008; November 13, 2009; May 14, 2010; September 6, 2011, <u>September 13, 2013</u>		
Approved:	Suelyn Masek, MSN, RN, CNORM <u>Margaret Kelly, LPN, Chair</u> Washington State Nursing Care Quality Assurance Commission		

PURPOSE:

The NCQAC approves evaluators qualified to conduct mental and/or physical health, sexual deviancy, sexual or other misconduct, boundary violations, or any other applicable specialty evaluations on licensed nurses. Such evaluations may be required in Interim Orders, Agreed Orders and Final Orders. Nursing Care Quality Assurance Commission (NCQAC) staff may refer approved evaluators to licensees. The NCQAC reviews and revises the list of approved evaluators on a periodic basis. Additional approved evaluators may be added to the list.

PROCEDURE:

1. Requests to add or delete evaluators are forwarded to the Disciplinary Manager. Updates and deletions may be completed by the manager.
2. The Disciplinary Manager ensures all required documents are submitted. The Discipline Manager adds revision of the evaluator list to the agenda for the next Disciplinary Subcommittee meeting.
3. The Disciplinary Manager sends copies of the application documents to the subcommittee members, along with the current policy.
4. The subcommittee evaluates the documents and determines if the applicant meets the minimum standards.
5. The Disciplinary Manager updates the list.

Evaluator Minimum Standards:

1. Licensed in the State of Washington for at least two (2) years in one of following specialties: Board Certified Psychiatrist, Board Certified Physician, Psychologist with a PhD, Advanced Registered Nurse Practitioner holding national certification in the area of specialization, certification as a Sexual Offender Treatment Provider and/or certification as a Mental Health Evaluator;
2. No disciplinary action in any state;
3. Minimum of five (5) years of experience in assessment and treatment in area of specialization;
4. Present a current curriculum vitae reflecting formal education, work and research experience, professional activities and specialized training;
5. Knowledge of nursing practice and/or experience in evaluating nurses and other health professionals is desirable;
6. Agree to schedule a licensee for evaluation within a reasonable time period and to complete and submit the evaluation to meet the schedule of the Order; and
7. Submit a writing sample of a completed evaluation (names redacted).

Formatted: Indent: Left: 0", First line: 0"

*Certain exceptions to the evaluator minimum standards may be approved by the **Licensing and Discipline Subcommittee**.*

PROTOCOL FOR CONDUCTING A MENTAL/PHYSICAL HEALTH EVALUATION ON A LICENSED NURSE

I. The scope and content of a mental/physical health evaluation must include consideration of the following when rendering your professional opinion regarding the Respondent's ability to practice nursing with reasonable skill and safety.

A. A complete history of the Respondent, including physical, mental, social, developmental, medical, psychiatric or psychological factors. Review of Respondent's medical records, including physical and mental health records. Review of Respondent's medication history, especially use of mind-altering and/or psychotropic medications.

B. Appropriate and sufficient evaluation and testing to fully assess the Respondent's ~~physical and~~ mental condition, including but not limited to:

1. Cognitive ability: Nursing requires the ability to analyze and synthesize complex scientific, clinical, diagnostic, quantitative and qualitative data quickly and accurately. ~~Evaluation should include Respondent's critical thinking skills, judgment and problem solving ability, decision making, prioritization and organizational skills;~~
2. Mental acuity, alertness, memory; ~~Ability to be present and aware; to observe and rapidly assess a situation and develop a reasonable plan of action; divided attention skills. Ability to retain and recall essential and pertinent information;~~
3. Communication and Comprehension; ~~Ability to comprehend and communicate effectively, both verbally and in writing, including auditory comprehension and listening skills;~~
4. Ethics and moral character: Truthfulness, compassion, empathy, selflessness, ability to maintain professional boundaries;
5. ~~3.~~ Stress and management: Ability to manage stress and anger effectively;

~~6.4. Any diagnosed mental disorder that might prevent nursing with skill and safety. Physical ability: Physical strength and stamina, manual dexterity, mechanical ability;~~

~~7.5. Special Conditions for evaluation: _____~~

C. Review and evaluation of other physical and/or mental, psychiatric, psychological examinations deemed necessary by the evaluator, such as neuropsychological testing.

D. Review and comment on the material supplied by the ~~Department of Health~~ NCQAC upon which the Commission bases its belief that an evaluation of the Respondent is appropriate.

E. Review of any other physical, mental, psychiatric, psychological, sociological or other relevant information provided by the Respondent.

F. Report should include a full and detailed discussion of the following:

1. Respondent's condition or diagnosis;
2. Conclusions and prognosis;
3. Any of the foregoing above that you were not able to assess;
4. Recommendations regarding the need for ongoing care and treatment;
5. Professional opinion regarding Respondent's ability to practice nursing with reasonable skill and safety.

II. NCQAC members and staff may discuss the evaluation with the evaluators. The evaluation and written report are not privileged. Information may be shared between the staff and the evaluator. Respondent must sign an "Authorization to Release Confidential Records and Information" directed to the staff attorneys/NCQAC/Legal Services Unit.

Nurse Licensing

Washington State Department of Health
Nursing Commission

Overview

- * Licensing Process
- * Licensing Statistics
- * Endorsement Statistics

Licensing Process Overview

- * Step 1: Receipt of Application
- * Step 2: Application Intake
- * Step 3: Criminal Background Checks
 - * Washington State Patrol and NPDB
 - * FBI Fingerprint Background (Out of state applicants)
- * Step 4: Application Review
- * Step 5: Temporary Practice Permits
- * Step 6: Final Decision

Step 1: Receipt of Application

- * Applications and fees are delivered to DOH Revenue Department for fee processing
- * Application and Receipt of payment are brought to Nurse Licensing for intake of application



Completed Application Includes:

- * Application Fee
 - * \$88 for RN and LPN
 - * \$92 for ARNP
- * Demographic Information
 - * Social Security Number
 - * Mailing Address
 - * Email Address
- * Personal Data Questions
 - * If “yes” answer will need court documents and letter of explanation
- * Professional Education Information
- * AIDS/HIV Attestation
- * Applicant Attestation

Exam Applicant Responsibilities

- * Register to take the NCLEX exam and submit the \$200 fee to Pearson VUE
- * Submit Official transcripts with degree posted to Nurse Licensing after graduation
- * If Educated Outside of the US a commission approved education evaluation and English proficiency exam

Endorsement Applicant Responsibilities

- * License by Examination Verification
 - * NURSYS
 - * Non-NURSYS verification form
 - * Transcripts
- * If Educated Outside of the US a commission approved education evaluation and English proficiency exam

ARNP Applicant Responsibilities

- * Washington State RN License
- * Official Transcripts with Degree posted
- * National Certification Verification
- * Proof of 250 hours of employment
- * 30 Hours of Pharmacology Continuing Education

Step 2: Application Intake

- * All applications must be manually entered into ILRS (Integrated Licensing and Regulatory System) by the Nurse Licensing intake desk.
- * Information entered at intake:
 - * Demographic Information
 - * SSN
 - * Email Address (Main form of communication)
 - * Personal Data Questions
 - * Fee Information
- * If any fees or information are missing at the time of intake, a deficiency letter is mailed to the applicant

Step 3: Criminal Background Checks

- * A Washington State Patrol (WSP) criminal background check is conducted for all applicants.
- * Federal Practitioner Databank Search (NPDB)
- * FBI fingerprint background checks are conducted for applicants with an out-of-state address.
 - * DOH sends a fingerprint card with instructions to these applicants once an application has gone through intake and is pending in ILRS

Step 4: Application Review

Exam Application Review

1. Applications are filed alphabetically by school pending completion of nursing program
2. Washington State Nursing Commission receives the certificate of completion (COC) from school of nursing and makes applicants eligible to test
3. Pearson VUE sends authorization to test (ATT) via email

Exam Review Continued

4. Student schedules NCLEX exam
5. Application submitted to final approval once all licensing requirements have been met
 - ❖ Complete Application
 - ❖ Official Transcripts with Degree Posted
 - ❖ Passing NCLEX Score

Step 4: Application Review

Endorsement Application Review

1. Out of State Credential Verification pulled from NURSYS or Non-NURSYS verification is pulled and matched up to file
2. Education is verified through NURSYS or Official Transcripts
3. Application submitted to final approval once all licensing requirements have been met
 - ❖ Temporary Practice Permit if pending FBI background check
 - ❖ Permanent License if WA state resident

Step 5: Temporary Practice Permits

A six month temporary practice permit may be issued once the following license processes have been met:

Endorsement

- * Complete revenue process and correct fee is collected
- * Check each personal data question and ensure the application is complete
- * Verify license verification forms from other states
- * Verify NURSYS
- * NPDB and Washington State Patrol/Watch for criminal background checks
- * Reviewed by Discipline if exception application

Exam

- * Complete revenue process and correct fee is collected
- * Check each personal data question and ensure the application is complete
- * Pass the NCLEX exam
- * Transcripts with official degree posted
- * NPDB and Washington State Patrol/Watch for criminal background checks
- * Reviewed by Discipline if exception application

Step 6: Final Decision

Final Approval Desk reviews the application to see if all licensing requirements have been met.

- * Exception applications are forwarded to discipline staff for review and approval (“Yes” answers to PDQs, WATCH Hits, FBI Hits, etc.)

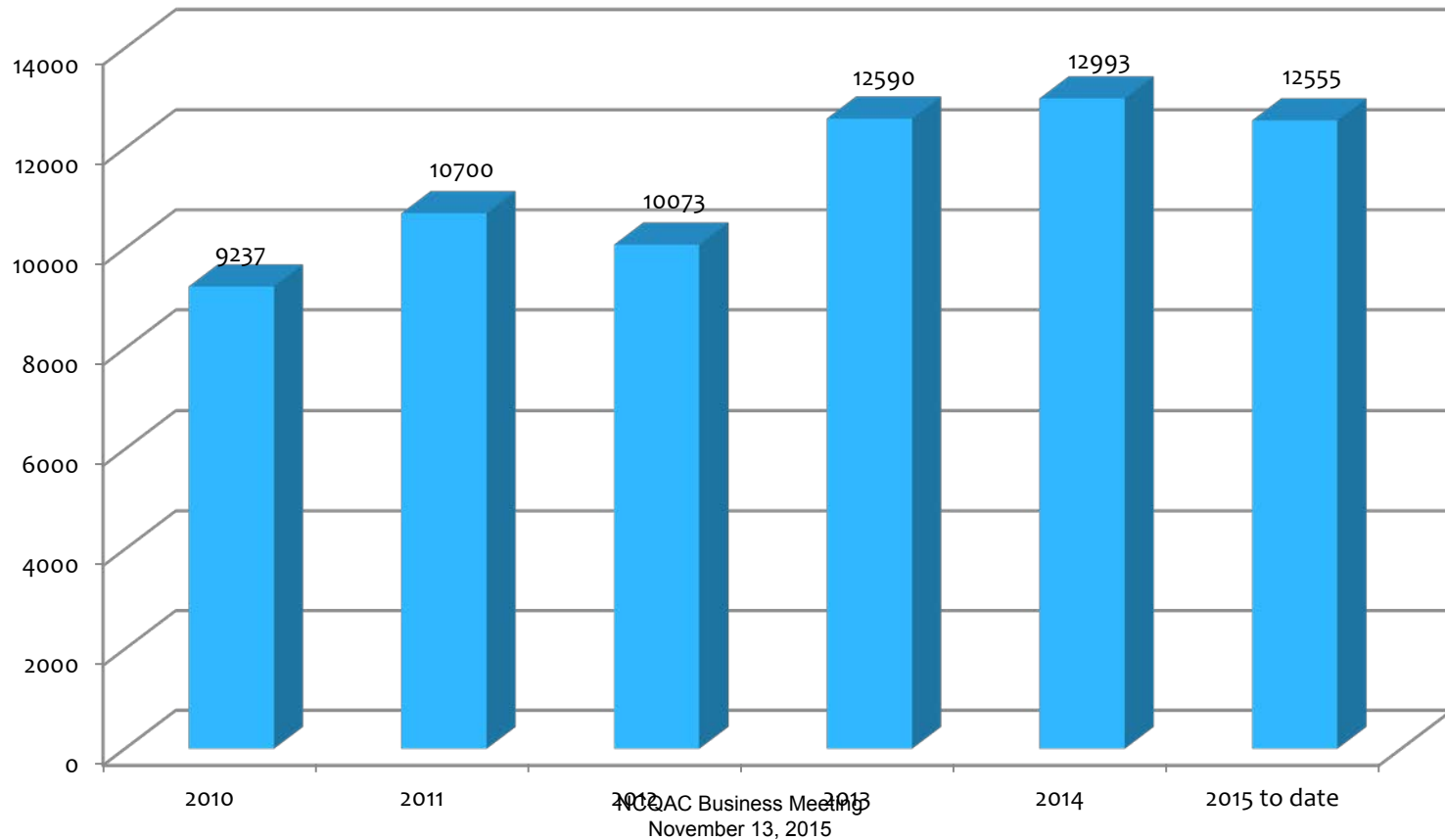
Final Decision Continued

After all requirements are met:

1. Application is approved through completion of ILRS workflow
2. Expiration date and CE due date are verified
3. License is printed and shows “active” online
4. Approval staff stamps the date on the front of the application
5. Application forwarded to records retention

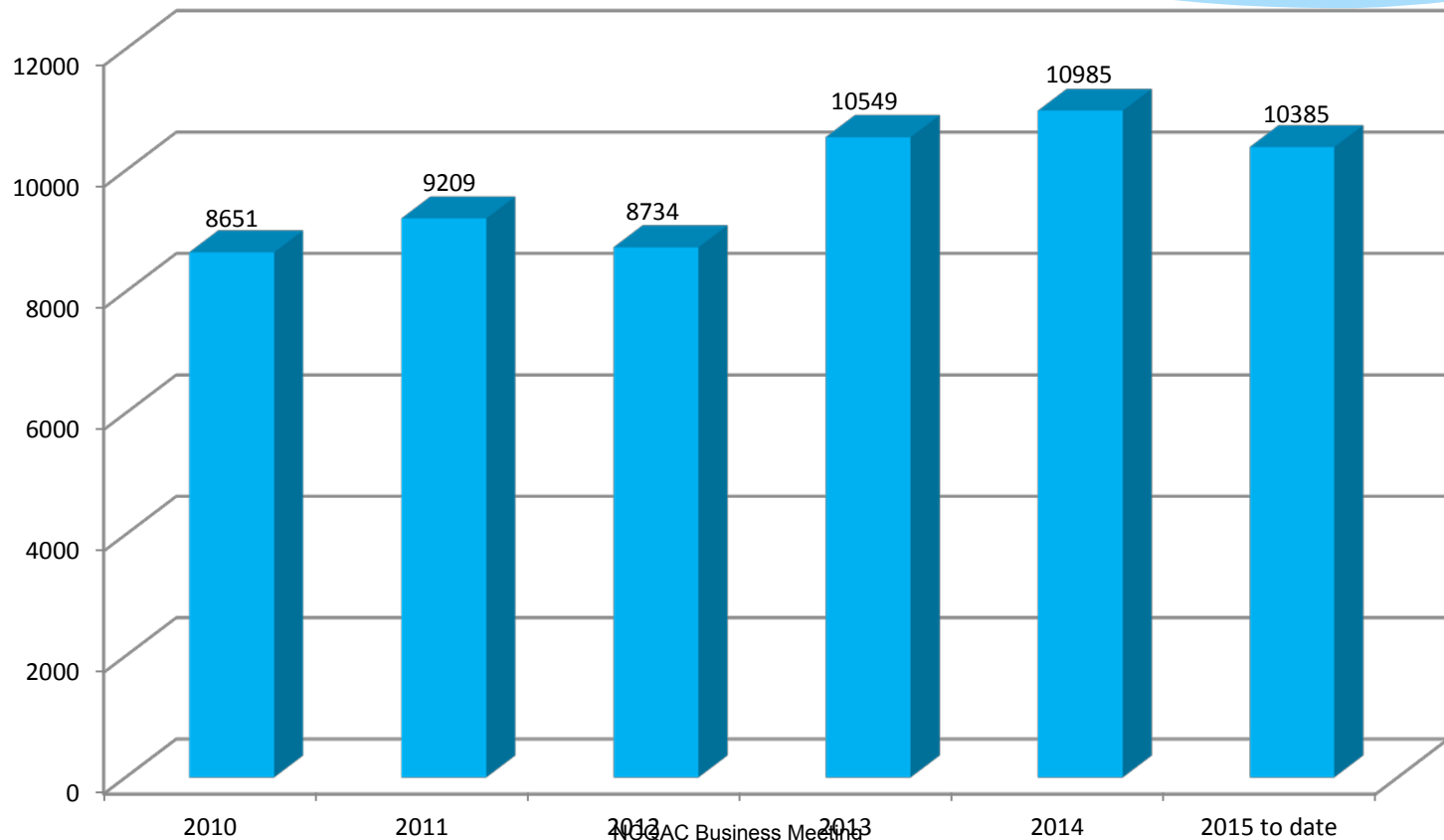
Nurse Licensing Statistics

Nursing Applications Received

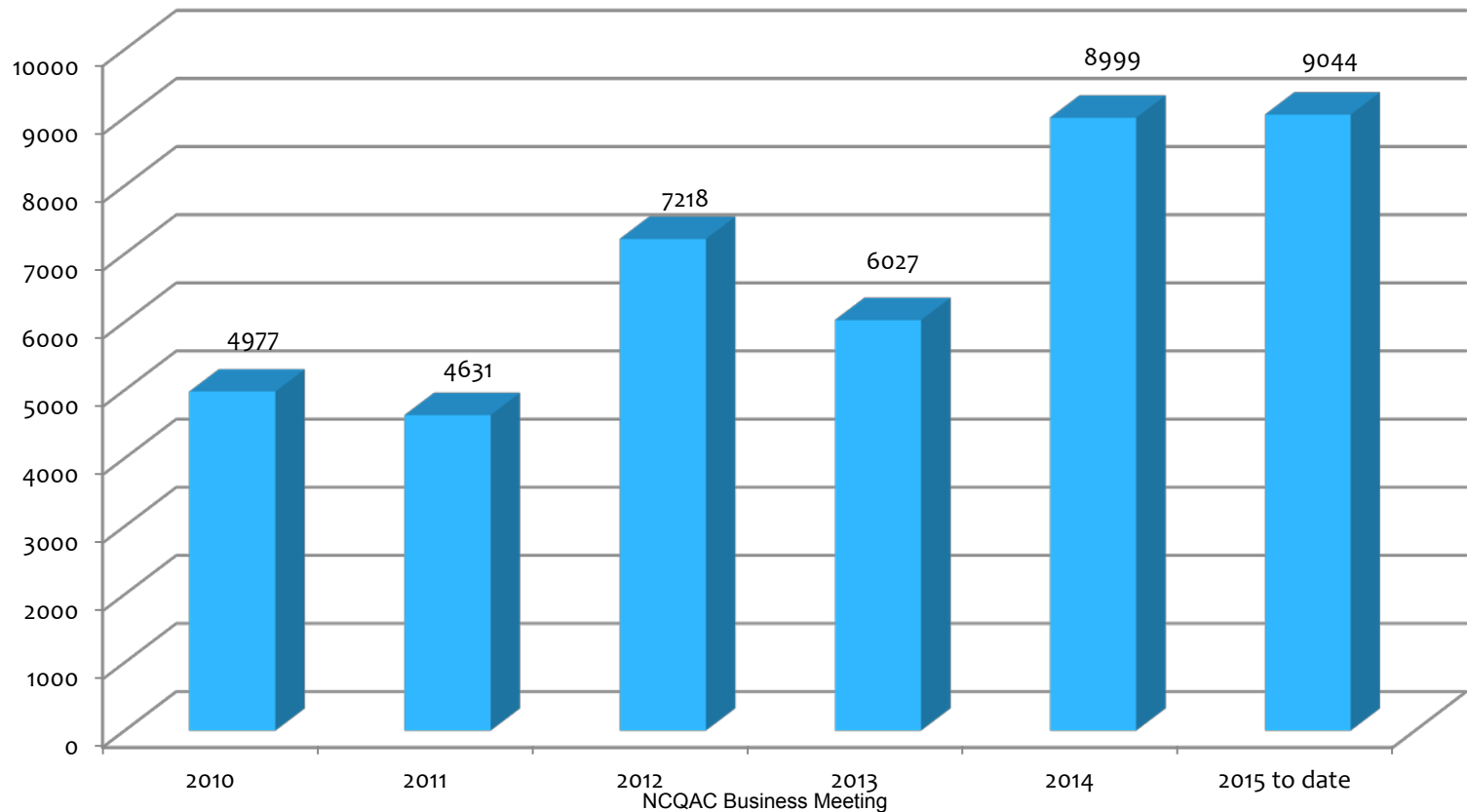


2012 AAC Business Meeting
November 13, 2015

Total Nursing Licenses Issued

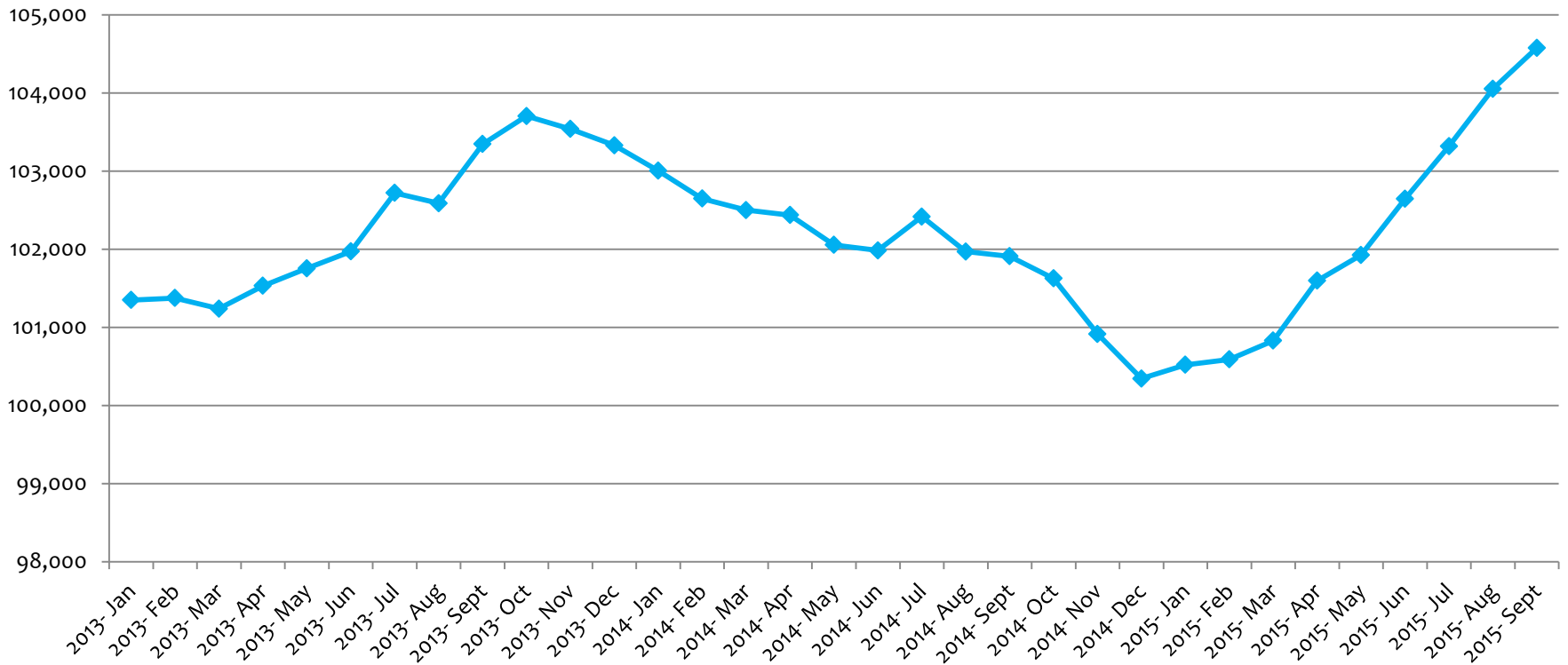


Temporary Practice Permits Issued

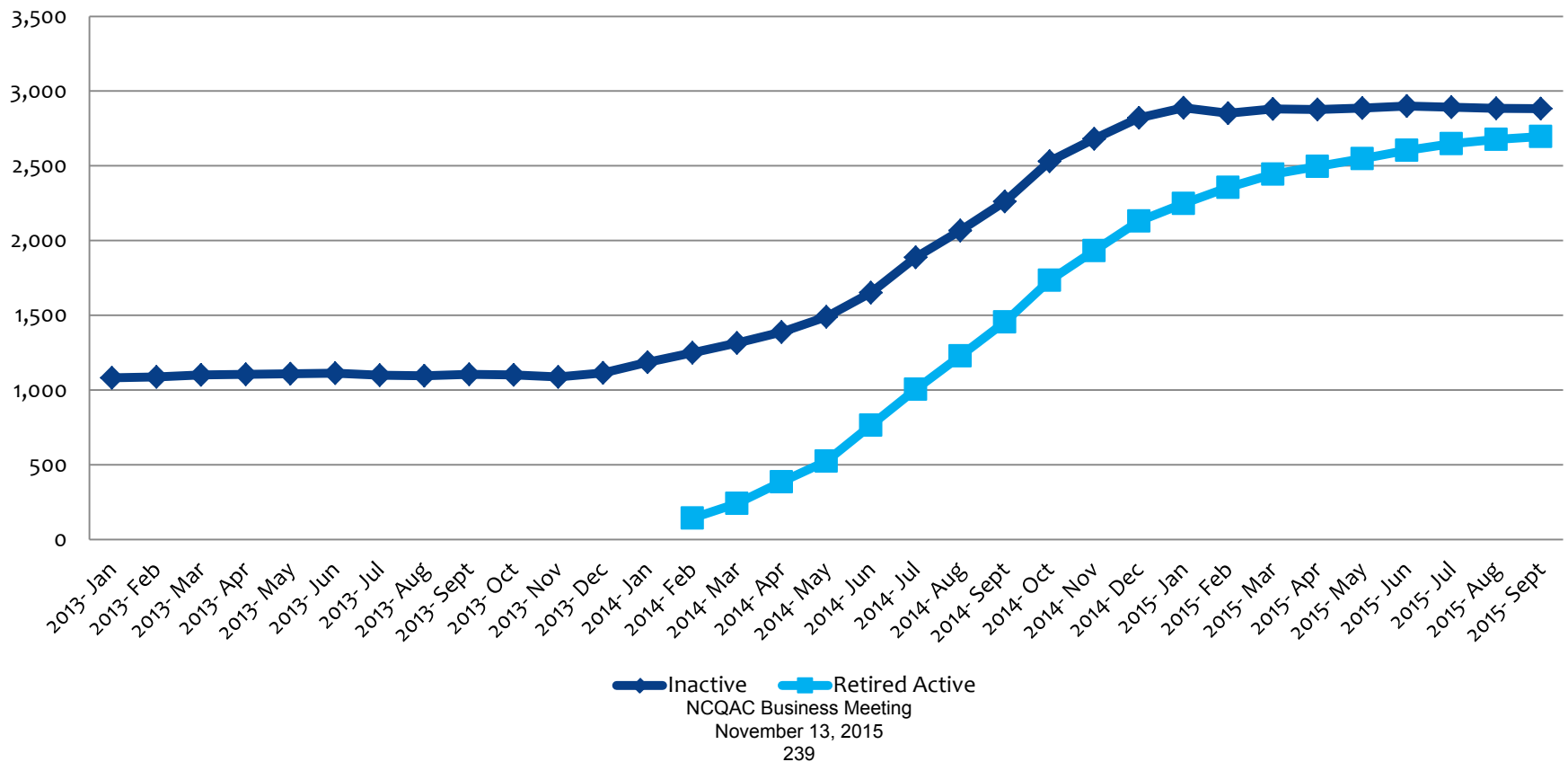


2013
NCQAC Business Meeting
November 13, 2015

Active Washington State Nurse License Trends

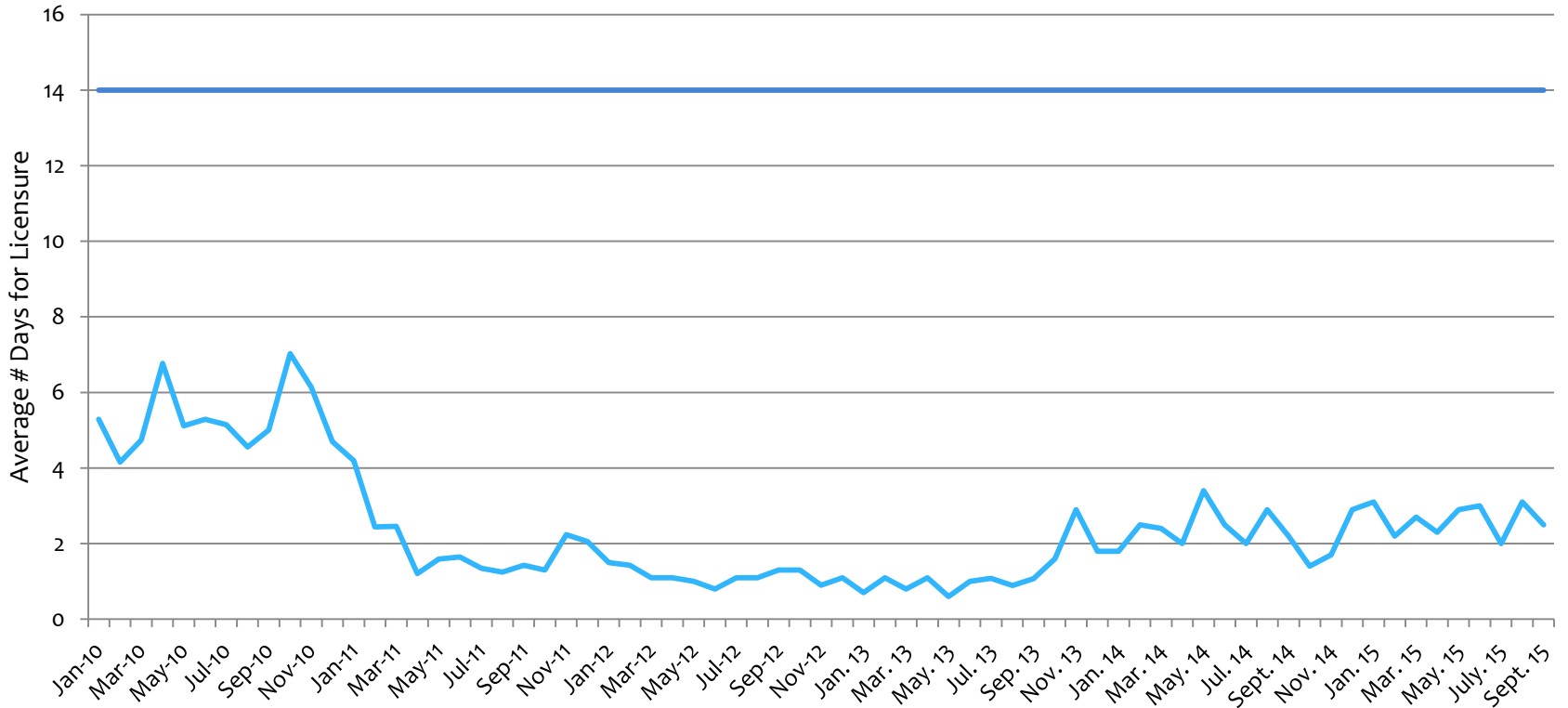


Inactive and Retired Active Nurse License Trends



Performance Measure:

License Issued within 14 days of last document received

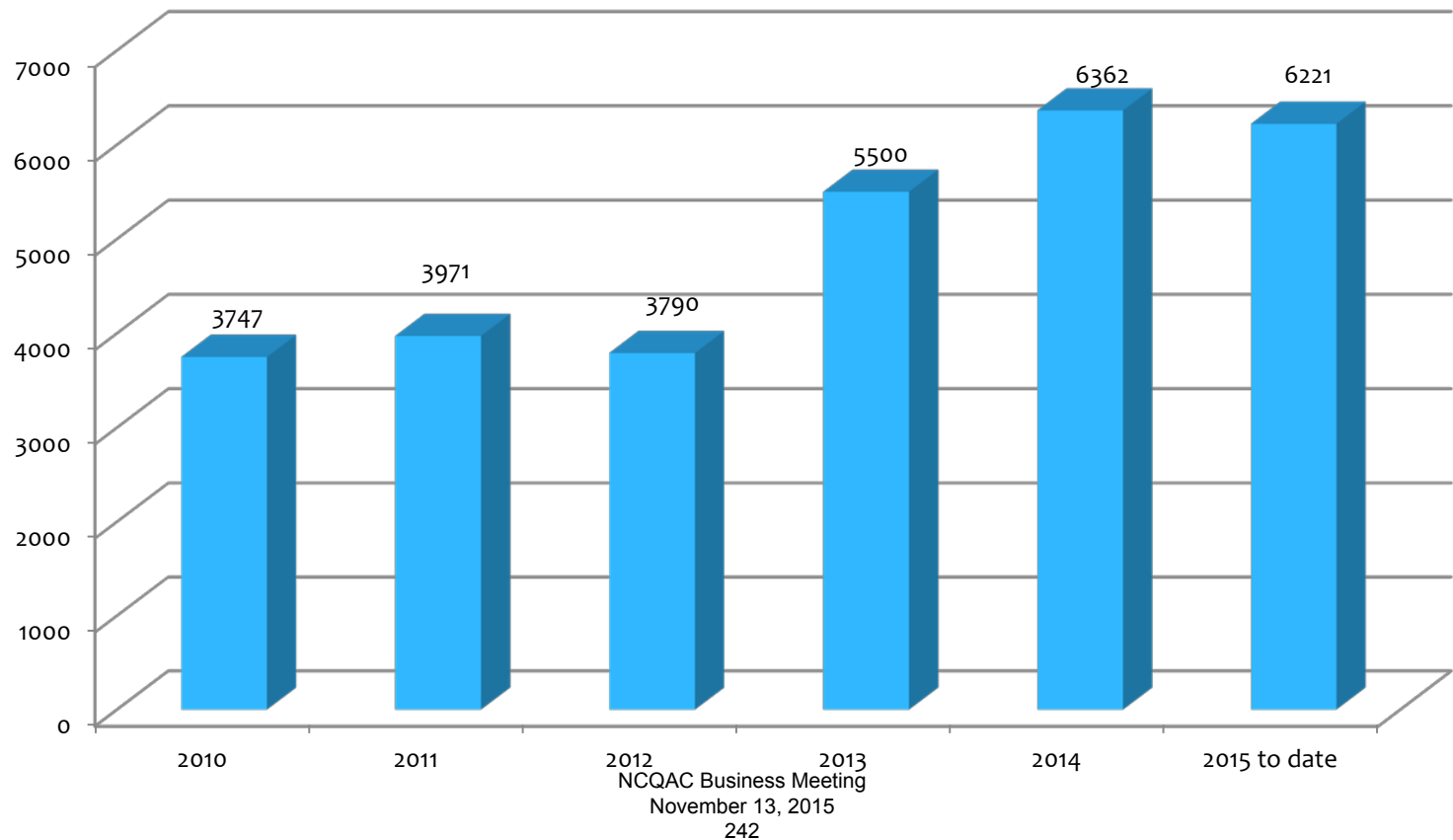


— NCQA Business Meeting Performance Measure

November 13, 2015

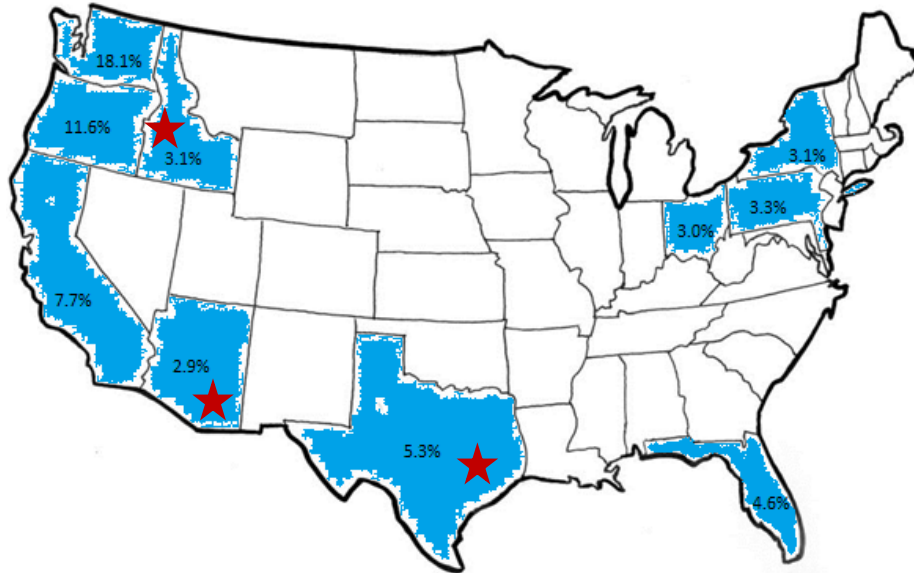
Endorsement Statistics

RN and LPN Endorsement Licenses Issued

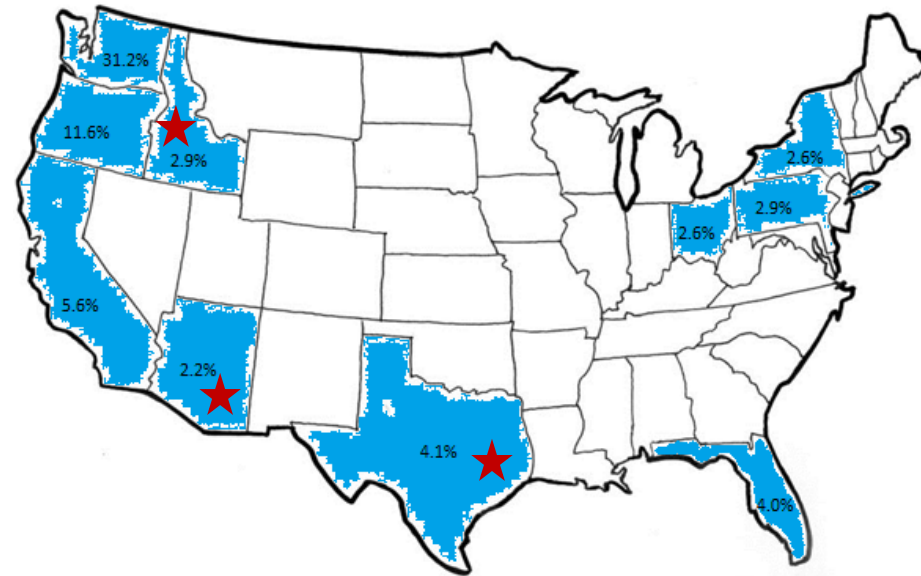


2013 Endorsements

Mailing Address at time of Initial Application



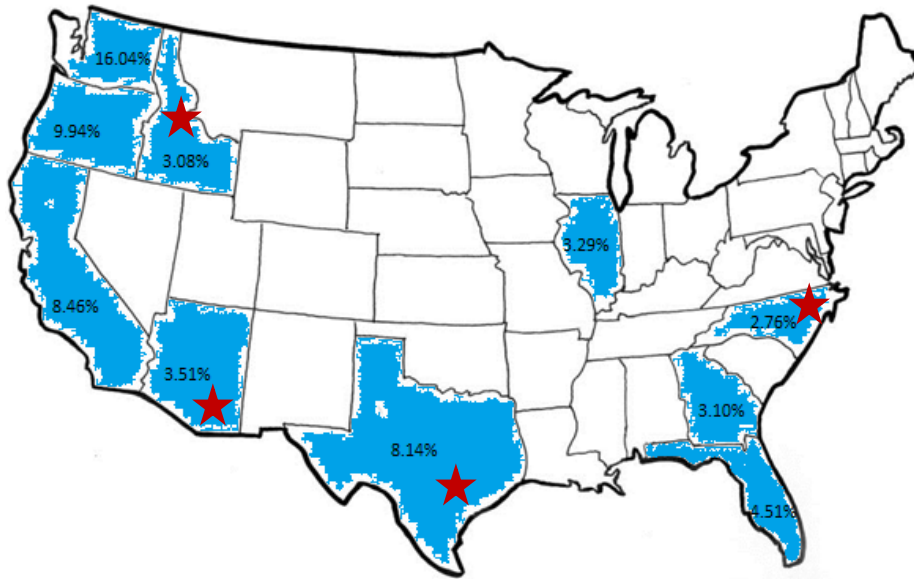
Current Mailing Address (Sept 2015)



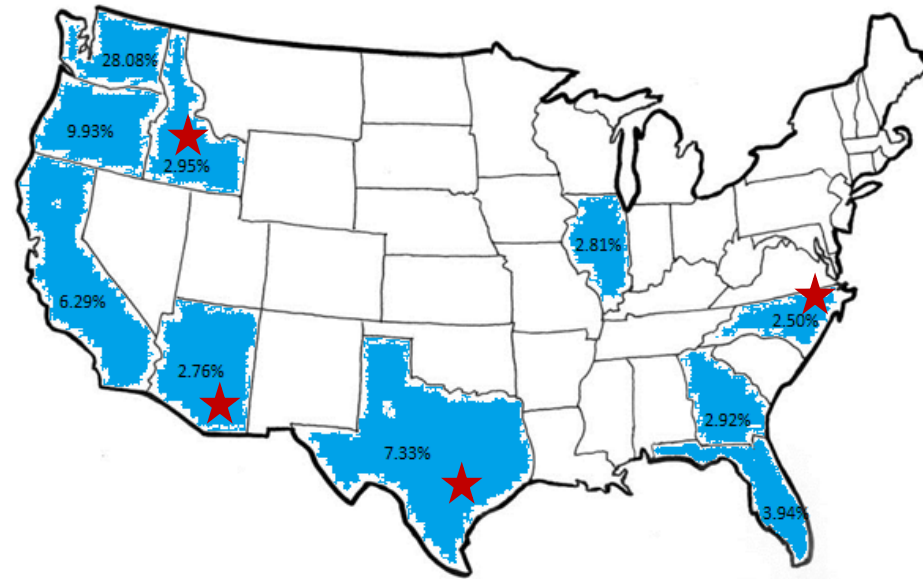
- * Calculations based on total endorsement applications for the 2013 calendar year
- * ONLY the top ten states are listed for each map. All other states are less than 3%.
- ★ States currently in the Nurse Licensure Compact (NLC)

2014 Endorsements

Mailing Address at Time of Initial Application



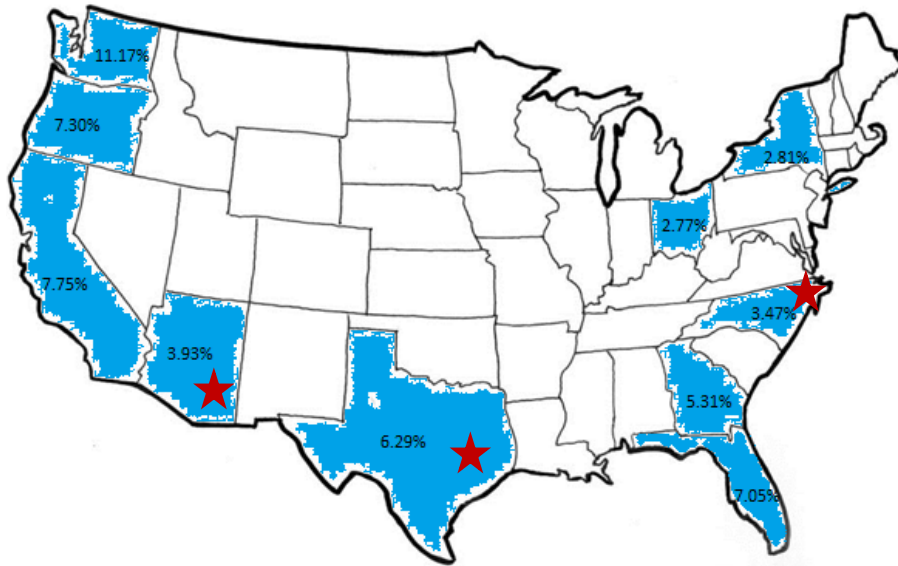
Current Mailing Address (Sept 2015)



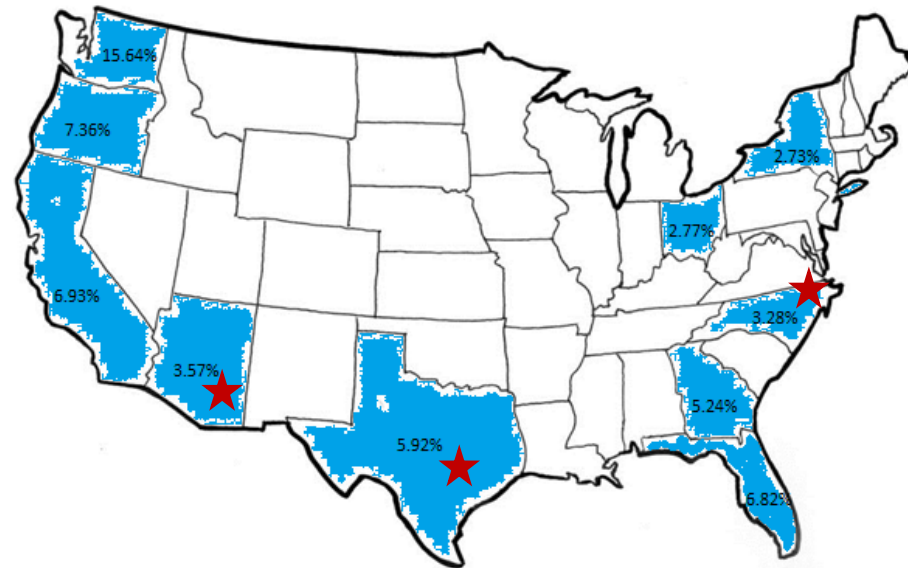
- * Calculations based on total endorsement applications for the 2014 calendar year
- * ONLY the top ten states are listed for each map. All other states are less than 3%.
- ★ States currently in the Nurse Licensure Compact (NLC)

2015 Endorsements

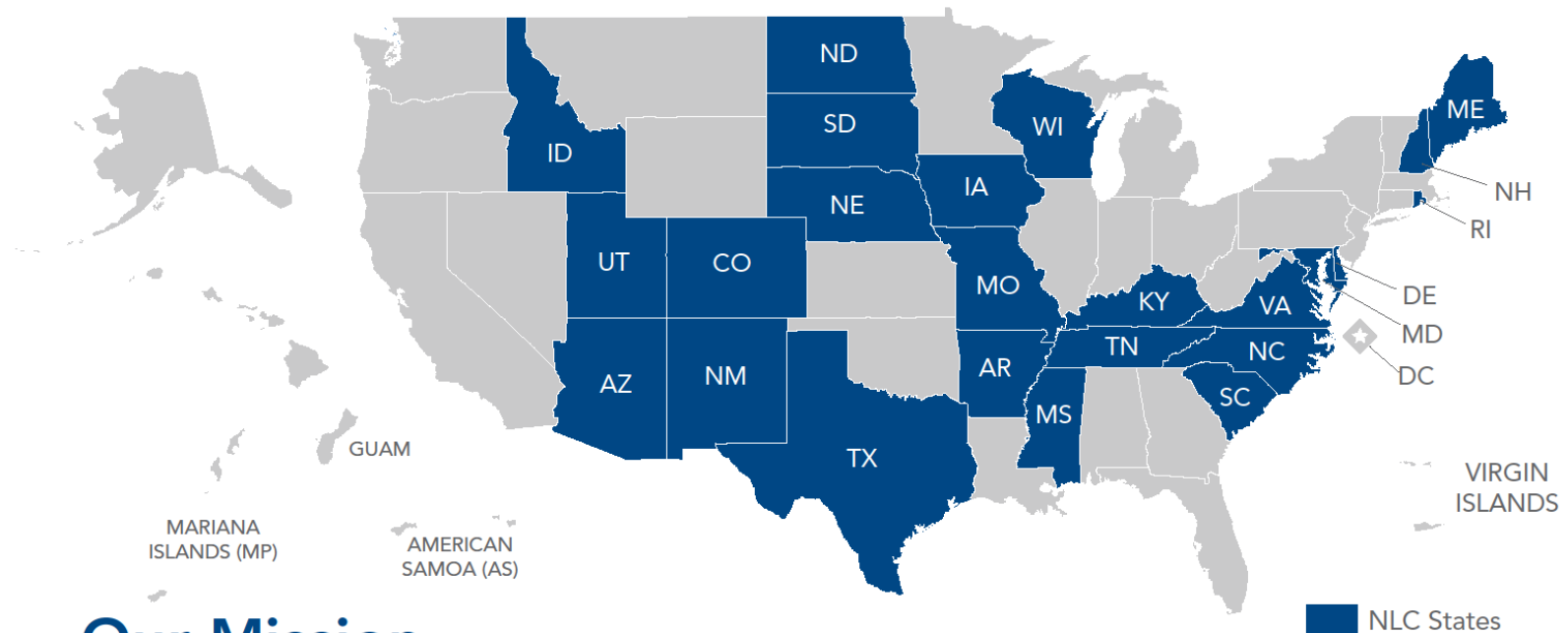
Mailing Address at Time of Initial Application



Current Mailing Address (Sept 2015)



- * Calculations based on total endorsement applications for the 2015 calendar year
- * ONLY the top ten states are listed for each map. All other states less than 2.7%
- ★ States currently in the Nurse Licensure Compact (NLC)



Our Mission

The Nurse Licensure Compact advances public protection and access to care through the mutual recognition of one state-based license that is enforced locally and recognized nationally.

Questions?



Department of Health
Nursing Care Quality Assurance Commission

Advisory Opinion

The Nursing Care Quality Assurance Commission (NCQAC) issues this advisory opinion in accordance with WAC 246-840-800. An advisory opinion adopted by the NCQAC is an official opinion about safe nursing practice. The opinion is not legally binding and does not have the force and effect of a duly promulgated regulation or a declaratory ruling by the NCQAC. Institutional policies may restrict practice further in their setting and/or require additional expectations to assure the safety of their patient and/or decrease risk.

<i>Title:</i>	Prevention and Treatment of Opioid-Related Overdoses	<i>Number:</i> NCAO 8.0
<i>References:</i>	RCW 18.79 Nursing Care WAC 246-840 Practical and Registered Nursing RCW 18.130.345 Washington State Uniform Disciplinary Act RCW 69.41 Legend Drugs-Prescription Drugs RCW 69.50 Uniform Controlled Substances Act RCW 4.24.300 Immunity from Liability for Certain Types of Medical Care Engrossed Substitute House Bill 1671 - Effective 7-24-2015	
<i>Contact:</i>	Deborah Carlson, MSN, RN, Associate Director of Nursing Practice	
<i>Phone:</i>	360-236-4725	
<i>Email:</i>	Debbie.carlson@doh.wa.gov	
<i>Effective Date:</i>	November 13, 2015	
<i>Supersedes:</i>	Not applicable	
<i>Approved By:</i>	Nursing Care Quality Assurance Commission	

Conclusion Statement

Advanced Registered Nurse Practitioners (ARNPs) with prescriptive authority may prescribe naloxone or other opioid antagonist to any one at risk for having or witnessing an opioid overdose. An ARNP may prescribe, dispense, distribute, and deliver an opioid overdose medication directly to any person who may be present at an opioid-related overdose, including individuals, law enforcement, emergency medical technicians, family members, or service providers. A pharmacist may enter into a collaborative drug therapy agreement (CDTA) with an ARNP with prescriptive authority to allow the pharmacist to prescribe naloxone directly to the public. This includes use of off-label intranasal naloxone.

An RN or LPN may dispense, distribute, and deliver opioid overdose medication following a standing order from an authorized provider (licensed physician and surgeon, dentist, osteopathic physician and surgeon, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, or ARNP, or a licensed midwife within his or her scope of practice) in any setting.

Administration of opioid antagonists is the best means of promoting prevention of opioid-related overdoses. Given the widespread and multifaceted reach of care delivery, nurses are uniquely positioned to combat the opioid overdose epidemic on many fronts.

Background and Analysis

In November 2014, the Nursing Commission, the Medical Commission, and the Board of Osteopathic Medicine received a request from the Washington Association of Sheriffs and Police Chiefs to answer the question as to whether a practitioner (local public health officer, emergency medical services program director, or other licensed practitioner) may provide naloxone to a law enforcement agency. At the time of the request, the law did not include language regarding law enforcement officers. [Engrossed Substitute House Bill 1671](#) effective July 24, 2015 expanded access to law enforcement officers.

Opioid Overdose Information

Prescription opioid use is becoming more prevalent in the United States. Many cases of opioid dependence begin with the treatment for pain. Chronic opioid use changes the functions of the brain leading to physical dependence and tolerance and may progress to opioid addiction. Since 2012, drug poisoning deaths in the United States have risen 6%, and deaths involving heroin increased 39%. Naloxone is safe, effective, and has no abuse potential. Community-based opioid overdose prevention programs began in the mid-1990s in the United States. Since 1996, an increasing number of community-based programs distribute naloxone to reverse potentially fatal overdoses.

Washington State

The following information is from the [Washington State Injury and Violence Prevention Guide, January 2013: Drug Poisoning and Overdose Chapter \(DOH 530-090\)](#). In 2010, Washington State's poisoning death rate 15 per 100,000, higher than the national death rate of 13 per 100,000. It is the leading cause of unintentional death in Washington State. Over 90% of poisoning deaths are due to drug overdoses. Rates between increased 370% between 1990 and 2010. Prescription opioid overdose deaths increased from 0.4 per 100,000 in 1995 to 7.4 per 100,000 in 2008. The rate dropped to 6.0 per 100,000 in 2010. The three opioids most involved include methadone (involved in most deaths), oxycodone, and hydrocodone.

The 2010 Health Youth Survey found that 4% (about 3,300 students) of 8th graders had used opioids to get high in the past 30 days. Of 10th and 12th graders, 8% (about 13,200 students) had used these drugs to get high. About 6% (about 342,000) of Washington residents 12 years and older use prescription pain drugs non-medically.

The state has the 4th highest rate of residents using prescription pain drugs in a non-medical way in the United States. The [\(ADAI\) Alcohol and Drug Abuse Institute -University of Washington](#) data for 2011 showed that heroin has remained a major drug of abuse and in recent years use has increased among young adults and spread beyond the largest cities. Prescription-type opiates appear to be a pathway to heroin use for many users, with 39% of heroin injectors in Seattle reporting being addicted to prescription-type opiates before trying heroin according to data in 2009. It is difficult to get a direct measurement of heroin use. Police evidence of positive tests for heroin shows that positive heroin use grew from 13.1% to 34.5% between 2001 and 2012. The rate of all opiate deaths (heroin and/or prescription opiates) has doubled in the past decade. First time treatment admissions show that heroin is the most common drug in 2012 among 18-29 year olds and the growth is primarily outside of the Seattle metro area (ADAI).

Naloxone

Naloxone is the most commonly used opioid antagonist given to reverse the effects of an opioid overdose by counteracting life-threatening depression of the central nervous and respiratory system. It is a legend drug, but not a controlled substance. Naloxone is the current standard of treatment for opioid overdose The Food and Drug Administration (FDA) approved administration by intravenous,

intramuscular, or subcutaneous routes. Clinicians may use professional judgment as to the use and administration of the drug if it is not described in the approved labeling from the FDA. The FDA recognizes that off-label use is a well-established principle that has allowed discovery of new and beneficial uses for previously approved drugs. Off-label use via intranasal administration of Naloxone is common because of ease of administration, storage, avoidance of needles, and literature supporting using naloxone by the intranasal route. The FDA has granted fast track designation to an intranasal naloxone investigational new drug application in July 2015. The FDA approved a new hand-held auto-injector ([Evzio®](#)) that can be used by patients, family members, or caregivers for intramuscular or subcutaneous injection.

Support of Opioid Prevention Programs

The [American Medical Association](#) and the [American Public Health Association](#) support availability of take-home naloxone. The United Nations Office on Drugs and Crime and the World Health Organization's report, [Community Management of Opioid Overdose \(2014\)](#) supports naloxone being available to first responders and people dependent on opioids, peers and family members who might be present when an overdose occurs. The [Washington State Interagency Guideline on Prescribing Opioids for Pain \(2015\)](#) recommends health care providers consider prescribing naloxone as a preventive rescue medication for patients with opioid use disorder and counseling of family member or other personal contacts in a position to assist the patient at risk of an overdose and supports take-home naloxone. The National Association of School Nurses position statement, [Naloxone Use in the School Setting: The Role of the School Nurse](#), states that, school nurses should facilitate access to naloxone for the management of opioid related overdoses in the school setting and implement its use as part of their school emergency response protocol. At least five states adopted laws on the use of naloxone in schools requiring it to be available. Some schools in other states teach students on how to get it at a pharmacy and use it. Federal, Tribal, state, and local law enforcement agencies are beginning to be trained and carry naloxone. Washington State has community-based naloxone programs in several counties.

Legal Analysis

The Uniform Controlled Substance Act or UCSA (RCW 69.50.315) previously allowed a person to get a prescription, possess naloxone, and administer naloxone to anyone who may be suffering from an apparent opiated-related overdose.

In 2015, the USCA was revised (RCW 69.410.040 and 69.50.315 and repeal of RCW 18.130.345), to increase access to opioid overdose medications by permitting health care practitioners (authorized to prescribe legend drugs) to administer, prescribe, and dispense opioid overdose medication to any person or entity who may be present at an overdose ([Engrossed Substitute House Bill 1671](#)). This includes law enforcement, emergency medical technicians, family members, or service providers. The issuance of a prescription or protocol must be for a legitimate medical purpose in the usual course of professional practice. It permits LPNs and RNs to dispense, possess, and administer opioid overdose medications prescribed by an authorized health care provider or following standing orders or protocols. The law defines a standing order or protocol as a “written or electronically recorded instructions, prepared by a prescriber, for distribution and administration of a drug by designated and trained staff or volunteers of an organization or entity, as well as other actions and interventions to be used upon the occurrence of clearly defined clinical events in order to improve patients’ timely access to treatment”.

The law requires when prescribing, dispensing, distributing or delivery of the medication, the ARNP (or the RN or LPN following standing orders) must inform the recipient that as soon as possible, after administration, the person at risk of experiencing an overdose, should be transported to a hospital, or a

first responder, should be summoned. CDTAs, standing orders, or protocols from an authorized practitioner may be used to prescribe, dispense, distribute, and deliver opioid overdose medication.

The law allows any person to lawfully possess, store, deliver, distribute, or administer the medication with a prescription or order issued by an authorized practitioner. Practitioners prescribing, dispensing, distributing, or delivering an opioid antagonist, acting in good faith and with reasonable care, are not subject to criminal or civil liability or disciplinary action. A person who possesses stores, distributes, or administers an opioid antagonist for prevention and treatment of an opioid overdose, acting in good faith, shall not be charged or prosecuted for possession of a controlled substance. A person acting in good faith who seeks medical assistance for someone experiencing a drug-related overdose or a person experiencing a drug-related overdose, shall not be charged or prosecuted if the evidence for the charge was obtained as a result of the person seeking medical assistance.

[RCW 18.79.250](#) defines the scope of practice for ARNPs with prescriptive authority to prescribe legend drugs. This would include naloxone or any other opioid antagonist. The Washington State Department Pharmacy Commission issued a statement in 2012 supporting and encouraging the use of CDTAs for naloxone. Pharmacists may prescribe naloxone directly to the public if a pharmacist has signed a CDTA with a legal prescriber, including an ARNP with prescriptive authority. ARNPs are not required to enter into a CDTA.

[RCW 4.24.300](#), commonly known as the “Good Samaritan” law, provides immunity from civil liability to anyone (including licensed health care providers) who provides emergency care, without compensation, unless there is gross negligence or misconduct.

Recommendations

The Nursing Commission encourages ARNPs and other health care providers to be knowledgeable and current about evidence-based practices for the use of opioid analgesics to manage pain, as well as specific steps to prevent and manage opioid overdose. The Nursing Commission recommends nurses incorporate overdose prevention into everyday nursing practice. ARNPs, RNs, and LPNs should be at the forefront to integrate overdose prevention messages and education into conversations with high-risk patients, their family members, and friends to recognize the signs and symptoms of an opioid overdose, and respond appropriately if someone is experiencing an overdose, including administering an opioid antagonist.

The Nursing Commission recommends nurses follow current evidence-based practices for the use of opioid analgesics to manage pain, as well as specific steps to prevent and manage opioid overdose. Nurses must have appropriate training and demonstrate competency appropriate to their licensure, specialty area or setting, and specific activities. Nurses must inform the recipient that as soon as possible after prescribing, dispensing, or delivering, the person at risk of experiencing an overdose should be transported to a hospital or a first responder should be summoned.

The commission suggests nurses receive training and use resources such as through the Alcohol and Drug Abuse Institute at the University of Washington and Washington State Division of Behavioral and Recovery (DBHR): [Center for Opioid Safety Education \(COSE\)](#).

ARNPs interested in entering into a CDTA with a pharmacist must submit the CDTA to the Pharmacy Quality Assurance Commission for review. The Nursing Commission recommends using a template

created by StopOverdose.org made available through the University of Washington Alcohol and Drug Abuse Institute.

The Nursing Commission recommends nurses follow the [Washington State Interagency Guideline on Prescribing Opioids for Pain \(2015\)](#). This includes using the [Washington State Prescription Monitoring Program or PMP](#) as a part of ongoing monitoring to prevent opioid misuse when prescribing controlled substances. The guidelines include recommendations to consider prescribing naloxone as a preventive rescue medication for patients with opioid use disorder and counseling of family member or other personal contacts in a position to assist the patient at risk of an overdose.

The Nursing Commission recommends institutions and agencies consider initiating and implementing formal opioid overdose prevention programs as a strategy to prevent and respond to opioid overdoses within their facilities and/or in the community. Nursing educators should include opioid overdose prevention training and opioid antagonist administration in the nursing education curriculum. Recommended resources include:

- British Columbia Centre for Disease Control:
 - [Dispensing Naloxone Kits to Clients at Risk of Opioid Overdose: Nursing Competencies- British Columbia Centre for Disease Control](#)
 - [Decision Support Tool](#)
 - [Training Manual: Overdose Prevention and Response](#)
- Stopoverdose.org
- [Community Management of Opioid Overdose - World Health Organization \(2014\)](#)
- [Opioid Overdose Toolkit - Substance Abuse and Mental Health Services Administration \(2013\)](#)
- [U.S. Department of Veterans Affairs - Veterans Health Administration Opioid Safety Initiative Toolkit](#)
- [Indian Health Services and U.S. Department of Justice Law Enforcement Naloxone Toolkit \(2014\)](#)
- [American Academy of Pain Medicine](#)
- [Search and Rescue Washington](#)

Conclusion

ARNPs with prescriptive authority may prescribe, dispense, distribute, and deliver opioid overdose medication to any person who may be at high-risk or present at an overdose, including law enforcement, emergency medical technicians, family members, or service providers. RNs and LPNs may follow standing orders or protocols from an authorized provider. ARNPs may enter into a CDTA with a pharmacist to prescribe, dispense, distribute, and deliver opioid overdose medication. This opinion is also intended to raise awareness about the benefits of using naloxone for individuals at high-risk of opioid overdose and those who are in a position to assist an individual who is experiencing an opioid-related overdose.

References

Alcohol and Drug Abuse Institute, University of Washington: <http://adai.uw.edu/wastate/HYS/2014%20Washington%20State.pdf>

American Academy of Pain Medicine: <http://www.painmed.org/SOPResources/ClinicalTools/tools-forms/>

Lagoy, A. American Journal of Nursing (October 2014). Heroin and Naloxone. Vol. 114, Issue 10, (12). http://journals.lww.com/ajnonline/Fulltext/2014/10000/Heroin_and_Naloxone.3.aspx

American Medical Association: <http://www.ama-assn.org/ama/pub/advocacy/topics/preventing-opioid-abuse/opioid-abuse-task-force.page>

American Public Health Association: <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/16/13/08/reducing-opioid-overdose-through-education-and-naloxone-distribution>

British Columbia Centre for Disease Control:

- Dispensing Naloxone Kits to Clients at Risk of Opioid Overdose: Nursing Competencies, British Columbia Centre for Disease Control: http://www.bccdc.ca/NR/rdonlyres/69B901A8-272D-49A4-B6B0-88BB095961EE/0/Naloxonecompetency_April14approved.pdf
- Decision Support Tool: <http://www.bccdc.ca/NR/rdonlyres/64310A80-0939-4F0B-BDBC-C101B7A2E4E2/0/NaloxoneDSTforNursesApril14approved.pdf>
- Training Manual: Overdose Prevention and Response: http://towardtheheart.com/assets/uploads/files/Training_ManualDocuments_2012.08.29.pdf

[College of Registered Nurses of British Columbia: Scope of Practice for Registered Nurses](#)

Community Management of Opioid Overdose – World Health Organization (2014): http://www.who.int/substance_abuse/publications/management_opioid_overdose/en/

Interagency Guideline on Prescribing Opioids for Pain (2015): <http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>

Indian Health Services and U.S Department of Justice Law Enforcement Naloxone Toolkit (2014): <https://www.bjatrainng.org/tools/naloxone/Naloxone-Background>

Legislative: Responding to the Fatal Opioid Overdose Epidemic: A Call to Nurses: Online Journal of Issues in Nursing: Clark, A. (2014). 19(3): <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-19-2014/No3-Sept-2014/Responding-to-Fatal-Opioid-Overdose-Epidemic.html>

MMWR Community-Based Opioid Overdose Prevention Programs Providing Naloxone-United States 2010: (2012) 61(06) 101-105: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6106a1.htm>

Naloxone Use in the School Setting: The Role of the School Nurse. National Association of School Nurses: <http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/854/Naloxone-Use-in-the-School-Setting-The-Role-of-the-School-Nurse-Adopted-June-2015>

National Institutes of Health Presentations (2012)

- [Populations at Risk for Opioid Overdose: Paluozzi, L.](#)
- [Public Health Interventions to Address Opioid Overdose: Reuter, N.](#)
- [Naloxone: Effects and Side Effects: Terman, G.W.](#)
- [Naloxone: Overview, Criminal Justice and other Special Settings: Binswanger, I.](#)
- [Bystander Overdose Education and Naloxone Distribution in Massachusetts: Walley, A.Y.](#)
- [Role of Naloxone in Opioid Overdose Fatality Prevention: El-Bassel, N.](#)
- [Naloxone for Outpatient Use: Data Required to Support an NDA: Hertz, S.](#)
- [Naloxone Expanded Access: OTC status Considerations for a Nonprescription Drug Development Program: Leonard-Segal, A.](#)
- [Considerations for Development and Marketing of Needleless Naloxone HCl Delivery Systems: Wermeling, D.](#)
- [Ethical and Regulatory Considerations in Drug Development for IN Naloxone: Nelson, R.](#)
- [Lessons Learned from Implementation: Zimet, G.](#)

Off-Label: Just what the Doctor Ordered. Tomaszewski, C.

(2006): <http://intranasal.net/Peer%20Reviewed%20literature/Tomaszewski,%20Off-label%20-%20Just%20what%20the%20doctor%20ordered,%20J%20Med%20Tox%202006.pdf>

Opioid Overdose Toolkit – Substance Abuse and Mental Health Services Administration (SAMHSA)

(2013): http://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf

Opioid Trends Across Washington State (April 2015), University of Washington Alcohol and Drug Abuse Institute: <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf>

Pain Management Resources Washington State Department of Health:

<http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PainManagement>

Pharmacy Collaborative Agreement

Template: http://www.wsha.org/files/257/Blank_Naloxone_CDTA_08092012_1.pdf

Safe and Effective Opioid Prescribing for Chronic Pain Continuing Education. Boston University School of Medicine, Substance Abuse and Mental Health Services Administration, Massachusetts Board of Registration in Medicine, Massachusetts Medical Society, Massachusetts Department of Public Health, and Massachusetts Hospital Association: <http://www.opioidprescribing.com/overview>

Search and Rescue Washington: <http://www.medicineabuseproject.org/search-rescue/wa>

Stopoverdose.org: <http://www.stopoverdose.org/>

Strategies for Preventing Heroin Overdose: Sparer, K.A. (2003). BMJ 326(7386), 442-444: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1125320/>

Substance Abuse Information - World Health Organization:

http://www.who.int/substance_abuse/information-sheet/en/

United Nations Office on Drugs and Crime: <http://www.unodc.org/>

U.S. Department of Veterans Affairs – Veterans Health Administration Opioid Safety Initiative
Toolkit: http://www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_Toolkit.asp

Washington State Injury and Violence Prevention Guide, January 2013: Drug Poisoning and Overdose
(DOH 530-090): <http://www.doh.wa.gov/portals/1/Documents/2900/DOH530090Poison.pdf>

Opioid Trends Across Washington State (April 2015), University of Washington Alcohol and Drug
Abuse Initiative: <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf>

DRAFT

Frequently Asked Questions (FAQs) for Nursing Professionals Prevention and Treatment of Opioid-Related Overdoses

These FAQs are intended for nursing professionals governed by the Nursing Care Quality Assurance Commission. They convey general information only and do not constitute legal advice. Contact your attorney to obtain advice with respect to any particular issue or problem.

Question

What is an opioid antagonist?

Answer

Opioid antagonists reverse the effects of an opioid overdose. [Naloxone](#) (Narcan®) is the current standard of treatment for opioid overdose. The Food and Drug Administration (FDA) approves administration by intravenous, intramuscular, or subcutaneous routes. The FDA recently approved a hand-held auto-injector ([Evzio](#)®) for intramuscular or subcutaneous injection. It is a legend drug, but not a controlled substance. Naloxone has not been shown to produce tolerance or cause physical or psychological pain. It will produce withdrawal symptoms. Severity and duration of the withdrawal relate to the dose of naloxone and the degree and type of opioid dependency.

Question

Naloxone is not approved by the FDA for intranasal administration (off-label use). Can an ARNP prescribe intranasal naloxone? Can nurses administer off-label drugs?

Answer

ARNPs may prescribe off-label medications and nurses may administer these medications. Off-label (lacking approval by the FDA) use of intranasal naloxone is not uncommon because of ease of administration, storage, avoidance of needles, and literature supporting using of intranasal naloxone. Off-label delivery methods may be legally prescribed by ARNPs and may be dispensed, distributed or administered by ARNPs, RNs, and LPNs. Clinicians are expected to use their professional judgment as to the use and administration of the drug if not described in the approved labeling. The Center for Drug Evaluation and Research and the FDA support this practice. Off-label use should be done with careful insight and understanding of the risks and benefits to the patient considering high-quality evidence supporting efficacy, effectiveness, and safety. More information about off-label use may be found at the [Therapeutic Intranasal Drug Delivery](#) website. In July 2015, The FDA has granted fast track designation to an intranasal naloxone investigational new drug application.

Question

I am an advanced registered nurse practitioner (ARNP). A law enforcement agency asked me if I would prescribe naloxone for their staff to have available as stock inventory in the event of a suspected opioid-related overdose. Is this within my scope of practice?

Answer

July 24, 2015, [Engrossed Substitute House Bill 1671](#) expanded access of opioid antagonists to law enforcement officers. The new law allows ARNPs, local public health officers, emergency medical services program directors, and other licensed health practitioners to prescribe, dispense, and distribute opioid overdose medications to any person or entity who may be present at an overdose. This includes a law enforcement agency.

Question

Can an ARNP have a collaborative drug therapy agreement (CDTA) with a pharmacist to prescribe, dispense, and distribute, opioid overdose medication?

Answer

The new law allows the ARNP to have a CDTA with a pharmacist to prescribe, dispense, and distribute opioid overdose medications to anyone who requests it.

Question

Are ARNPs required to prescribe naloxone for an opioid dependent person or require nurses to carry naloxone?

Answer

The law does not require health care providers to prescribe a naloxone for an opioid dependent person or nurses to carry naloxone.

Question

Can an ARNP prescribe naloxone to a third party, such as a family member, friend, or caregiver?

Answer

An ARNP with prescriptive authority may prescribe naloxone to a third party.

Question

I am an ARNP writing a prescription for a family member of someone who might need naloxone. Do I write the prescription for the person who requests it or for the family member?

Answer

The prescription must be written for the individual who requests it.

Question

I am an RN is working in the community with a high-risk population for opioid overdoses. Can I carry naloxone for emergent administration for a suspected overdose and can I administer naloxone even though I do not know the person?

Answer

RNs and LPNs may carry and administer naloxone for emergency use for suspected opioid overdose. This includes administering to an unknown individual. RNs and LPNs may dispense naloxone for a high-risk person, their family members, or friends following standing orders from an authorized practitioner (licensed physician and surgeon, dentist, osteopathic physician and surgeon, podiatric physician and surgeon, physician assistant, osteopathic physician assistant, or advanced registered nurse practitioner, or as directed by a licensed midwife within his or her scope of practice). Additional clinical interventions may also be included in the standing orders.

Question

Can school nurse carry and administer naloxone in a school setting to a student?

Answer

The law states that RNs or LPNs may administer naloxone to a student with a prescription. RNs and LPNs may possess, store, deliver, distribute, or administer the medication to any person in any setting following a standing order. RNs and LPNs may also have a prescription in their own name to self-carry and may administer to anyone who may be experiencing an opioid overdose. The school or school district should establish policies and procedures for the management of opioid related overdoses in the school setting as part of the school emergency response plan.

Question

I am a nurse working in addiction treatment setting. Can I administer naloxone to a patient without a patient-specific order when I am at work?

Answer

A nurse may administer naloxone following standing orders or a patient-specific order.

Question

Can a licensed RN or LPN get a prescription to carry and administer opioid overdose medications in a non-work setting?

Answer

A RN or LPN may have a prescription for naloxone in the nurse's name for use in the non-work setting. Nurses may carry and administer naloxone for emergency use for an individual suspected opioid overdose whether the person is family member, friend, or a stranger. They may get a prescription from their primary care provider or a pharmacist with a CDTA.

Question

Does the law require a nurse to have a specific training or special certification to prescribe, dispense, and administer opioid overdose medications?

Answer

Just as in all care a nurse provides, the nurse must have the training, knowledge, skill, and ability to perform the activity competently. An employer or institution may require a specific training or certification. The StopOverdose.org and COSE provide training information for nurses and other health

care professionals. The British Columbia Centre for Disease Control [nursing competencies](#), [decision support tool](#), and [training manual](#) are excellent resources.

Question

Where can I get information about developing and implementing a community opioid safety and overdose prevention program?

Answer

The [StopOverdose.org](#) provides many resources about prevention activities made available by the University of Washington Alcohol and Drug Abuse Institute funded by the Washington State Division of Behavioral Health and Recovery. The [Center for Opioid Safety Education \(COSE\)](#) offers education and technical assistance for individual and communities in Washington State who want to learn how to prevent and intervene in opioid addiction and overdose.

Resources

- British Columbia Centre for Disease Control:
- [Dispensing Naloxone Kits to Clients at Risk of Opioid Overdose: Nursing Competencies-British Columbia Centre for Disease Control](#)
- [Decision Support Tool](#)
- [Training Manual: Overdose Prevention and Response](#)
- [Stopoverdose.org](#)
- [Community Management of Opioid Overdose - World Health Organization \(2014\)](#)
- [Opioid Overdose Toolkit - Substance Abuse and Mental Health Services Administration \(2013\)](#)
- [U.S. Department of Veterans Affairs - Veterans Health Administration Opioid Safety Initiative Toolkit](#)
- [Indian Health Services and U.S. Department of Justice Law Enforcement Naloxone Toolkit \(2014\)](#)
- [American Academy of Pain Medicine](#)
- [Search and Rescue Washington](#)

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Nursing Assistant Training Program Approval	Number: E02.04
Reference:	RCW 18.88A.020, RCW 18.88A.060, RCW 18.88A.082, RCW 34.05, WAC 246-841-410 through WAC 246-841-510, WAC 246-841-530 through 246-841-575, and WAC 246-841-586 through 246-841-596	
Contact:	Paula R. Meyer, MSN, RN, Executive Director (360) 236-4713	
Effective Date:	November 13, 2015	
Supersedes:	E02.03	
Approved:	Margaret Kelley, LPN, Chair Washington State Nursing Care Quality Assurance Commission	

PURPOSE STATEMENT:

The Nursing Care Quality Assurance Commission (NCQAC) assures that nursing assistant training programs, alternative training programs, and medication assistant endorsement programs meet the state requirements. NCQAC protects and ensures public safety by approving, monitoring and reviewing nursing assistant training programs and medication assistant endorsement education programs. NCQAC ensures the competency of nursing assistants by requiring an approved competency exam and through ongoing continuing competency requirements. The NCQAC has delegated authority to the Nursing Assistant Program Approval Panel (NAPAP) to make decisions relevant to all nursing assistant and medication assistant training programs.

PROCEDURE:

1. NCQAC staff members review initial nursing assistant, alternative training, and medication assistant program applications for compliance with Revised Code of Washington and Washington Administrative Code Requirements.

2. The staff will conduct a site visit to a new program, to ensure that the program meets state requirements. If a program has previously been approved as a nursing assistant training program, a site visit may not be necessary.
3. If a nursing assistant training program does not appear to meet all requirements for approval or renewal, a staff member will email the program director and request the information needed to complete the process. A letter will be mailed to the program a week after the first request, if the program does not respond to the request for information. The letter will give the program 90 days to respond before the file is closed, unless it is applying for medication assistant program renewal. The renewal application for a medication assistant training program is due ninety days before the two-year anniversary of the date approval was originally granted [WAC 246-841-595(1)]. Staff will notify medication assistant programs via email six (6) months in advance of the due date for renewal. Staff will prepare a list of all medication assistant programs that fail to meet the renewal requirements for NAPAP review and action.
4. NCQAC staff will present a list to NAPAP of all nursing assistant training programs including medication assistant programs that meet all the requirements for panel approval of the programs.
5. The staff will email the testing company to request a program test number for the approved traditional and alternative programs. For medication assistant programs, the program number will be the credential number generated in the DOH database (ILRS).
6. The staff will send an email to the program notifying them of the approval. The email will provide the approval letters, the forms to notify the Department of Health that a student has successfully completed an approved course, and other information as appropriate.
7. NCQAC staff will update the list of approved training programs on the NCQAC website as appropriate.
8. All programs shall complete a renewal process every two years and NCQAC staff may conduct site visits within the two year renewal timeframe.
9. If the information submitted for approval, renewal, or substantive change requests does not or may not meet requirements, the NCQAC staff will present the information to NAPAP. The program will be notified of the panel's decision within 30 days after the NAPAP meeting.

10. The staff will present all complaints to NAPAP for review and action. NAPAP may request staff to conduct an investigation. The staff will present the results of the investigation to NAPAP. NAPAP will determine if there have been violations of the rules. Refer to E03 NCQAC procedure entitled *Complaints and Actions Related to Nursing Education and Nursing Assistant Programs*.
11. If a program is determined to have violated applicable rules in chapter 246-841 WAC, NAPAP may issue a statement of deficiencies and request that the program submit a plan of correction within 14 days.
12. If the NAPAP panel has reason to believe that the program has substantially violated applicable rules in chapter 246-841 WAC, NAPAP may decide to take further action as allowed by law, including the withdrawal of program approval.
13. When NAPAP takes legal action requiring a letter of determination, NCQAC legal staff prepares the letter. The letter of determination becomes a final order in 20 days if the program does not appeal the determination.
14. NAPAP considers a request for reinstatement of a nursing assistant training program as described in WAC 246-841-440 and WAC 246-841-593.
15. The program director must submit an application for review by NCQAC staff when a nursing assistant training program or medication assistant endorsement program obtains a new program director or instructor. If it is unclear that the applicant meets state requirements, the application will be reviewed by NAPAP. The program director will be notified of the panel's decision within 30 days after the NAPAP meeting.
16. As identified in RCW 18.88A.060(4) the NCQAC) duties are to “ Prepare, grade, and administer, or determine the nature of, and supervise the grading and administration of, the competency evaluation for applicants for nursing assistant certification...” The NCQAC and DOH entered into a Memorandum of Understanding with the Department of Social and Health Services in which NCQAC staff participate in a Governance Committee for the nursing assistant competency examination contract. The Governance Committee selects the vendor, monitors contract performance and makes changes as needed to the contract. NCQAC in collaboration with DOH credentialing determines and approves the competency test for medication assistants.
17. NAPAP annually reviews the National Nurse Aide Assessment Program (NNAAP) and the Medication Assistant Program Annual School Pass Rate Reports. The NAPAP may take action on a program for failure to maintain an average passing rate of eighty percent

of first time test takers as identified in WAC 246-841-430, WAC 246-841-560, and WAC 246-841-591.

18. NCQAC staff will notify the Office of Customer Service regarding changes in program approval, withdrawal of approval, or other relevant information. The information will be emailed to the manager in the nursing assistant credentialing unit.

DRAFT



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Nursing Care Quality Assurance Commission
P.O. Box 47864
Olympia, WA 98504-7864
June 5, 2015

Dr. John Wiesman
Secretary of Health
Washington State Department of Health
PO Box 47890
Olympia, WA 98504-7890

Dear Dr. Wiesman:

On May 8, 2015, the Nursing Care Quality Assurance Commission passed a motion to require FBI Criminal Background Checks on all applicants for licensure as registered nurses and licensed practical nurses beginning on January 1, 2016. The Nursing Commission believes that requiring national background checks on all applicants is a prudent and necessary measure to protect the public as authorized under RCW 18.130.064(2)(b).

RCW 18.130.064(2) states in pertinent part:

- (a) The secretary shall establish requirements for each applicant for an initial license to obtain a state background check through the state patrol prior to the issuance of any license. The background check may be fingerprint-based at the discretion of the department.
- (b) The secretary shall specify those situations where a background checks under (a) of this subsection is inadequate and an applicant for an initial license must obtain an electronic fingerprint-based national background check through the state patrol and federal bureau of investigation. . . .

National background checks on all nursing licensure applicants are necessary to protect the public because the number of nursing applicants is increasing. Currently, FBI Criminal Background Checks are completed on only those applicants who apply for nursing licenses using out-of-state addresses. There is no mechanism to conduct a national criminal background check on applicants with a Washington State address who may have spent long periods of time in other states. There is no requirement for a national background check for an applicant who may have only recently moved to Washington and who may have lived for many years in other states.

Table 1 in the enclosure demonstrates the increases in the number of applicants since 2008, when RCW 18.130.064 became law. As stated above, applicants with a current Washington State address may have lived significant periods of times in other states. The inability to conduct a national criminal background check leaves the public at potential risk. In the past year, the number of applicants seeking Washington licensure with an out of state address increased from a monthly average of 650 to 1080 - a 40% increase. In just the past three months, the Nursing Commission processed 3,241 applications from nurses with out of state addresses.

Washington State licenses a large population of nurses caring for our most vulnerable people. Gallop Polls consistently rate nurses as the most trusted profession in the United States. The Nursing Commission desires to maintain this public trust. By completing FBI Criminal Background Checks on all applicants, including those with Washington State addresses, the Nursing Commission feels they are taking an important step to improve public protection. The Nursing Commission also feels they are taking one more step to maintain the public's trust.

The Nursing Commission completed a fiscal analysis and also worked with the Health Systems Quality Assurance, Office of Customer Service, to identify impacts. The Nursing Commission commits to support the outlay of increased resources necessary to implement FBI Criminal Background Checks on all nursing applicants. The timing for this initiative aligns with the 2015-2017 biennial budget cycle.

The Nursing Commission proposes that national FBI Criminal Background Checks be completed on only registered nurse and licensed practice nurse applications. Applications for Advanced Registered Nurse licenses require an active registered nurse license. Therefore, requiring a FBI Criminal Background check for an Advanced Registered Nurse Practitioner would be duplicative.

If you have any questions, please contact me at paula.meyer@doh.wa.gov or by phone at 360-236-4713. Thank you for your commitment to further protect the people of Washington State.

Sincerely,

Paula R. Meyer, MSN, RN, FRE
Executive Director

Enc. Table 1
Cc: Martin Mueller
Sam Marshall
Bob McLellan

Table 1 Registered Nurse, Licensed Practical Nurse, and Advanced Practice Registered Nurse Applications by month

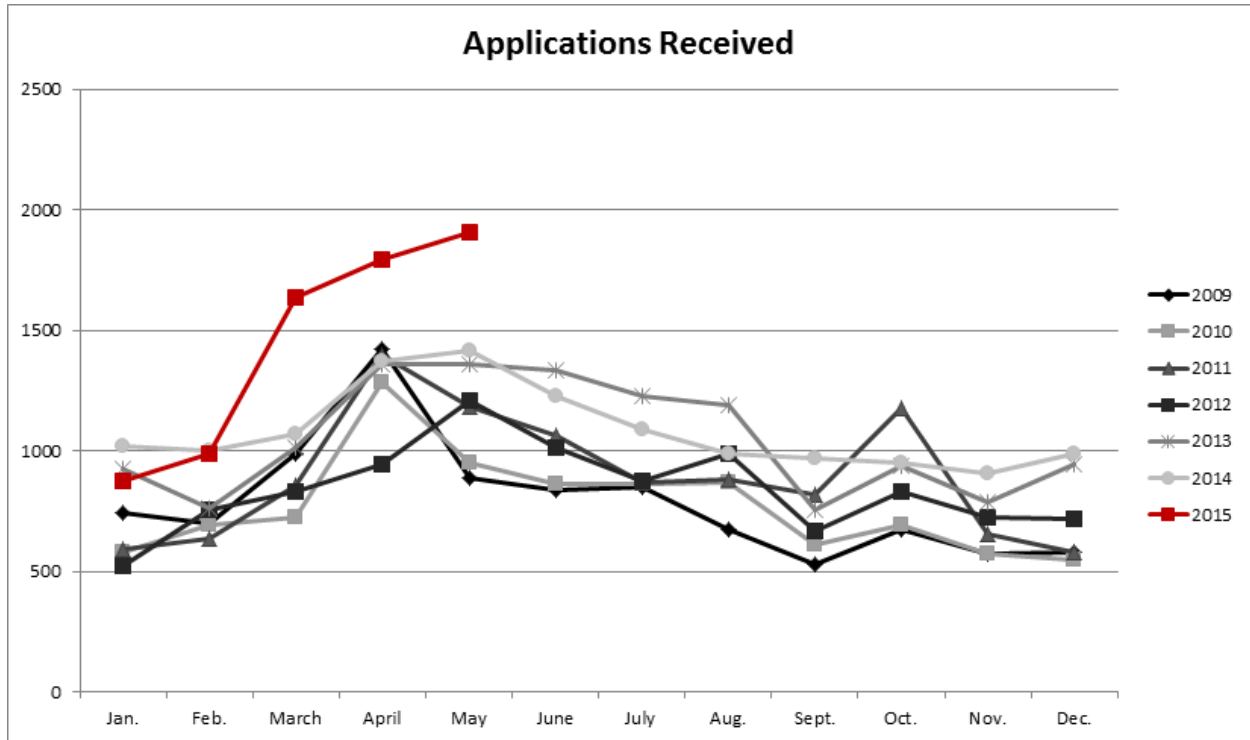


Table 2 Actions taken on out of state applicants related to Positive FBI Criminal Background Checks per year

Year	Positive FBI Background Checks on applicants with out of state addresses	Positive FBI Background Checks Investigated	Applicants Denied related to Positive FBI Background Checks	Application Granted with Conditions related to Positive FBI Background Checks
2009	152	1		
2010	196	0		
2011	223	2		
2012	236	1	1	
2013	329	10	1	
2014	547	5	1	2
2015	217	2		
TOTAL	1900	14	3	2

Most of the applicants with a positive FBI Criminal Background Check receive a Washington nursing license. Very few of the positive FBI Criminal Background Checks raise to the threshold causing an investigation. Even less proceed to conditional licenses or denial of an application.

RCW 18.130.064

Authority and duties — Secretary and disciplining authority — Background checks.

(1)(a) The secretary is authorized to receive criminal history record information that includes nonconviction data for any purpose associated with investigation or licensing and investigate the complete criminal history and pending charges of all applicants and license holders.

(b) Dissemination or use of nonconviction data for purposes other than that authorized in this section is prohibited. Disciplining authorities shall restrict the use of background check results in determining the individual's suitability for a license and in conducting disciplinary functions.

(2)(a) The secretary shall establish requirements for each applicant for an initial license to obtain a state background check through the state patrol prior to the issuance of any license. The background check may be fingerprint-based at the discretion of the department.

(b) The secretary shall specify those situations where a background check under (a) of this subsection is inadequate and an applicant for an initial license must obtain an electronic fingerprint-based national background check through the state patrol and federal bureau of investigation. Situations where a background check is inadequate may include instances where an applicant has recently lived out of state or where the applicant has a criminal record in Washington. The secretary shall issue a temporary practice permit to an applicant who must have a national background check conducted if the background check conducted under (a) of this subsection does not reveal a criminal record in Washington, and if the applicant meets the provisions of RCW [18.130.075](#).

(3) In addition to the background check required in subsection (2) of this section, an investigation may include an examination of state and national criminal identification data. The disciplining authority shall use the information for determining eligibility for licensure or renewal. The disciplining authority may also use the information when determining whether to proceed with an investigation of a report under RCW [18.130.080](#). For a national criminal history records check, the department shall require fingerprints be submitted to and searched through the Washington state patrol identification and criminal history section. The Washington state patrol shall forward the fingerprints to the federal bureau of investigation.

(4) The secretary shall adopt rules to require license holders to report to the disciplining authority any arrests, convictions, or other determinations or findings by a law enforcement agency occurring after June 12, 2008, for a criminal offense. The report must be made within fourteen days of the conviction.

(5) The secretary shall conduct an annual review of a representative sample of all license holders who have previously obtained a background check through the department. The selection of the license holders to be reviewed must be representative of all categories of license holders and geographic locations.

(6)(a) When deciding whether or not to issue an initial license, the disciplining authority shall consider the results of any background check conducted under subsection (2) of this section that

reveals a conviction for any criminal offense that constitutes unprofessional conduct under this chapter or the chapters specified in RCW [18.130.040\(2\)](#) or a series of arrests that when considered together demonstrate a pattern of behavior that, without investigation, may pose a risk to the safety of the license holder's patients.

(b) If the background check conducted under subsection (2) of this section reveals any information related to unprofessional conduct that has not been previously disclosed to the disciplining authority, the disciplining authority shall take appropriate disciplinary action against the license holder.

(7) The department shall:

(a) Require the applicant or license holder to submit full sets of fingerprints if necessary to complete the background check;

(b) Require the applicant to submit any information required by the state patrol; and

(c) Notify the applicant if their background check reveals a criminal record. Only when the background check reveals a criminal record will an applicant receive a notice. Upon receiving such a notice, the applicant may request and the department shall provide a copy of the record to the extent permitted under RCW [10.97.050](#), including making accessible to the applicant for their personal use and information any records of arrest, charges, or allegations of criminal conduct or other nonconviction data pursuant to RCW [10.97.050\(4\)](#).

(8) Criminal justice agencies shall provide the secretary with both conviction and nonconviction information that the secretary requests for investigations under this chapter.

(9) There is established a unit within the department for the purpose of detection, investigation, and prosecution of any act prohibited or declared unlawful under this chapter. The secretary will employ supervisory, legal, and investigative personnel for the unit who must be qualified by training and experience.

[2008 c 134 § 7.]

Notes:

Finding -- Intent--Severability--2008 c 134: See notes following RCW [18.130.020](#).

HOUSE BILL 2080

State of Washington

64th Legislature

2015 Regular Session

By Representatives Stanford, Goodman, and S. Hunt; by request of Nursing Care Quality Assurance Commission

Read first time 02/11/15. Referred to Committee on Public Safety.

1 AN ACT Relating to fingerprint-based background checks for health
2 professionals; and amending RCW 43.43.700, 43.43.705, 43.43.742, and
3 18.130.064.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 **Sec. 1.** RCW 43.43.700 and 2006 c 294 s 1 are each amended to
6 read as follows:

7 (1) There is hereby established within the Washington state
8 patrol a section on identification and criminal history hereafter
9 referred to as the section.

10 (2) In order to aid the administration of justice the section
11 shall install systems for the identification of individuals,
12 including the fingerprint system and such other systems as the chief
13 deems necessary. The section shall keep a complete record and index
14 of all information received in convenient form for consultation and
15 comparison.

16 (3) The section shall obtain from whatever source available and
17 file for record the fingerprints, palmprints, photographs, or such
18 other identification data as it deems necessary, of persons who have
19 been or shall hereafter be lawfully arrested and charged with, or
20 convicted of any criminal offense. The section may obtain like

1 information concerning persons arrested for or convicted of crimes
2 under the laws of another state or government.

3 (4) The section may:

4 (a) Retain the fingerprints submitted by a statutorily authorized
5 agency;

6 (b) Allow a search by criminal justice agencies of arrest
7 fingerprint submissions and unsolved crime files against the
8 fingerprints submitted for noncriminal justice purposes;

9 (c) Notify a statutorily authorized agency of a change in
10 criminal history record information that is identified against
11 retained fingerprints. The section must ensure that arrest
12 information is provided only to the statutorily authorized agency
13 from which the fingerprints originated.

14 (5) A statutorily authorized agency must notify license
15 applicants, applicants for employment, and applicants for other
16 noncriminal justice purposes subject to a criminal history background
17 check that their fingerprints may be retained by the section and the
18 federal bureau of investigation. A statutorily authorized agency must
19 also provide notification to license applicants, applicants for
20 employment, and applicants for other noncriminal justice purposes
21 that:

22 (a) Arrests and unsolved crime files may be searched against
23 their retained fingerprints; and

24 (b) Notification of any changes to criminal history record
25 information may be made to the statutorily authorized agency that
26 submitted the fingerprints to the section.

27 **Sec. 2.** RCW 43.43.705 and 2006 c 294 s 2 are each amended to
28 read as follows:

29 Upon the receipt of identification data from criminal justice
30 agencies within this state, the section shall immediately cause the
31 files to be examined and upon request shall promptly return to the
32 contributor of such data a transcript of the record of previous
33 arrests and dispositions of the persons described in the data
34 submitted.

35 Upon application, the section shall furnish to criminal justice
36 agencies a transcript of the criminal history record information
37 available pertaining to any person of whom the section has a record.

38 For the purposes of RCW 43.43.700 through 43.43.785 the following
39 words and phrases shall have the following meanings:

1 "Criminal history record information" includes, and shall be
2 restricted to identifying data and information recorded as the result
3 of an arrest or other initiation of criminal proceedings and the
4 consequent proceedings related thereto. "Criminal history record
5 information" shall not include intelligence, analytical, or
6 investigative reports and files.

7 "Criminal justice agencies" are those public agencies within or
8 outside the state which perform, as a principal function, activities
9 directly relating to the apprehension, prosecution, adjudication or
10 rehabilitation of criminal offenders.

11 "Statutorily authorized agency" means a public agency that has
12 statutory authority under state, federal, or local law to conduct a
13 state and federal criminal history background check for license
14 applicants, applicants for employment, or other noncriminal justice
15 purposes.

16 The section may refuse to furnish any information pertaining to
17 the identification or history of any person or persons of whom it has
18 a record, or other information in its files and records, to any
19 applicant if the chief determines that the applicant has previously
20 misused information furnished to such applicant by the section or the
21 chief believes that the applicant will not use the information
22 requested solely for the purpose of due administration of the
23 criminal laws or for the purposes enumerated in RCW 43.43.760(4). The
24 applicant may appeal such determination by notifying the chief in
25 writing within thirty days. The hearing shall be before an
26 administrative law judge appointed under chapter 34.12 RCW and in
27 accordance with procedures for adjudicative proceedings under chapter
28 34.05 RCW.

29 **Sec. 3.** RCW 43.43.742 and 1987 c 450 s 4 are each amended to
30 read as follows:

31 (1) The Washington state patrol shall adopt rules concerning
32 submission of fingerprints taken by local agencies ((after July 26,
33 1987,)) from persons for license application or other noncriminal
34 purposes.

35 (2) The Washington state patrol must adopt rules concerning the
36 participation of statutorily authorized agencies in receiving
37 notifications of any changes to criminal history records information
38 after the submission of fingerprints taken by local agencies for
39 noncriminal purposes.

1 (3) The Washington state patrol may charge fees for submission of
2 fingerprints which will cover as nearly as practicable the direct and
3 indirect costs to the Washington state patrol of processing such
4 submission or notifying a statutorily authorized agency of a change
5 in criminal history record information as provided in RCW 43.43.700.

6 **Sec. 4.** RCW 18.130.064 and 2008 c 134 s 7 are each amended to
7 read as follows:

8 (1)(a) The secretary is authorized to receive criminal history
9 record information that includes nonconviction data for any purpose
10 associated with investigation or licensing and investigate the
11 complete criminal history and pending charges of all applicants and
12 license holders.

13 (b) Dissemination or use of nonconviction data for purposes other
14 than that authorized in this section is prohibited. Disciplining
15 authorities shall restrict the use of background check results in
16 determining the individual's suitability for a license and in
17 conducting disciplinary functions.

18 (2)(a) The secretary shall establish requirements for each
19 applicant for an initial license to obtain a state background check
20 through the state patrol prior to the issuance of any license. (~~The~~
21 ~~background check may be fingerprint based at the discretion of the~~
22 ~~department.~~)

23 (b) Except pursuant to (c) of this subsection, the secretary has
24 the discretion to require a fingerprint-based background check. The
25 secretary shall specify those situations where a background check
26 under (a) of this subsection is inadequate and an applicant for an
27 initial license must obtain (~~an electronic~~) a fingerprint-based
28 national background check through the state patrol and federal bureau
29 of investigation. Situations where a background check is inadequate
30 may include instances where an applicant has recently lived out of
31 state or where the applicant has a criminal record in Washington. The
32 secretary shall issue a temporary practice permit to an applicant who
33 must have a national background check conducted if the background
34 check conducted under (a) of this subsection does not reveal a
35 criminal record in Washington, and if the applicant meets the
36 provisions of RCW 18.130.075.

37 (c) If a disciplining authority adopts rules authorizing such
38 activities for applicants and licensees in the professions it
39 regulates under RCW 18.130.040, the secretary shall obtain

1 fingerprint-based national background checks through the state patrol
2 and federal bureau of investigation for criminal history on all
3 applicants seeking licensure or license renewal. The secretary may
4 receive notifications of any changes to criminal history records
5 information on all applicants seeking licensure or license renewal
6 based on the retained fingerprints. The rules adopted by the
7 disciplining authority must establish requirements for:

8 (i) Setting fees associated with fingerprint-based national and
9 state background checks; and

10 (ii) Notifying all applicants and licensees that:

11 (A) Their fingerprints may be retained by the state patrol and
12 federal bureau of investigation;

13 (B) Arrests and unsolved crimes files may be searched against
14 their retained fingerprints; and

15 (C) Their criminal history record information will be
16 periodically updated and any changes reported to the secretary by the
17 state patrol pursuant to RCW 43.43.700.

18 (3) In addition to the background check required in subsection
19 (2) of this section, an investigation may include an examination of
20 state and national criminal identification data. The disciplining
21 authority shall use the information for determining eligibility for
22 licensure or renewal. The disciplining authority may also use the
23 information when determining whether to proceed with an investigation
24 of a report under RCW 18.130.080. For a national criminal history
25 records check, the department shall require fingerprints be submitted
26 to and searched through the Washington state patrol identification
27 and criminal history section. The Washington state patrol shall
28 forward the fingerprints to the federal bureau of investigation.

29 (4) The secretary shall adopt rules to require license holders to
30 report to the disciplining authority any arrests, convictions, or
31 other determinations or findings by a law enforcement agency
32 occurring after June 12, 2008, for a criminal offense. The report
33 must be made within fourteen days of the conviction.

34 (5) The secretary shall conduct an annual review of a
35 representative sample of all license holders who have previously
36 obtained a background check through the department. The selection of
37 the license holders to be reviewed must be representative of all
38 categories of license holders and geographic locations.

39 (6)(a) When deciding whether or not to issue an initial license,
40 the disciplining authority shall consider the results of any

1 background check conducted under subsection (2) of this section that
2 reveals a conviction for any criminal offense that constitutes
3 unprofessional conduct under this chapter or the chapters specified
4 in RCW 18.130.040(2) or a series of arrests that when considered
5 together demonstrate a pattern of behavior that, without
6 investigation, may pose a risk to the safety of the license holder's
7 patients.

8 (b) If the background check conducted under subsection (2) of
9 this section reveals any information related to unprofessional
10 conduct that has not been previously disclosed to the disciplining
11 authority, the disciplining authority shall take appropriate
12 disciplinary action against the license holder.

13 (7) The department shall:

14 (a) Require the applicant or license holder to submit full sets
15 of fingerprints if necessary to complete the background check;

16 (b) Require the applicant to submit any information required by
17 the state patrol; and

18 (c) Notify the applicant if their background check reveals a
19 criminal record. Only when the background check reveals a criminal
20 record will an applicant receive a notice. Upon receiving such a
21 notice, the applicant may request and the department shall provide a
22 copy of the record to the extent permitted under RCW 10.97.050,
23 including making accessible to the applicant for their personal use
24 and information any records of arrest, charges, or allegations of
25 criminal conduct or other nonconviction data pursuant to RCW
26 10.97.050(4).

27 (8) Criminal justice agencies shall provide the secretary with
28 both conviction and nonconviction information that the secretary
29 requests for investigations under this chapter.

30 (9) There is established a unit within the department for the
31 purpose of detection, investigation, and prosecution of any act
32 prohibited or declared unlawful under this chapter. The secretary
33 will employ supervisory, legal, and investigative personnel for the
34 unit who must be qualified by training and experience.

--- END ---

FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants*

I. Introduction

States craft regulatory policy through a variety of actors, including state legislatures, courts, agencies, and regulatory boards. While most regulatory actions taken by state actors will not implicate antitrust concerns, some will. Notably, states have created a large number of regulatory boards with the authority to determine who may engage in an occupation (*e.g.*, by issuing or withholding a license), and also to set the rules and regulations governing that occupation. Licensing, once limited to a few learned professions such as doctors and lawyers, is now required for over 800 occupations including (in some states) locksmiths, beekeepers, auctioneers, interior designers, fortune tellers, tour guides, and shampooers.¹

In general, a state may avoid all conflict with the federal antitrust laws by creating regulatory boards that serve only in an advisory capacity, or by staffing a regulatory board exclusively with persons who have no financial interest in the occupation that is being regulated. However, across the United States, “licensing boards are largely dominated by active members of their respective industries . . .”² That is, doctors commonly regulate doctors, beekeepers commonly regulate beekeepers, and tour guides commonly regulate tour guides.

Earlier this year, the U.S. Supreme Court upheld the Federal Trade Commission’s determination that the North Carolina State Board of Dental Examiners (“NC Board”) violated the federal antitrust laws by preventing non-dentists from providing teeth whitening services in competition with the state’s licensed dentists. *N.C. State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101 (2015). NC Board is a state agency established under North Carolina law and charged with administering and enforcing a licensing system for dentists. A majority of the members of this state agency are themselves practicing dentists, and thus they have a private incentive to limit

* This document sets out the views of the Staff of the Bureau of Competition. The Federal Trade Commission is not bound by this Staff guidance and reserves the right to rescind it at a later date. In addition, FTC Staff reserves the right to reconsider the views expressed herein, and to modify, rescind, or revoke this Staff guidance if such action would be in the public interest.

¹ Aaron Edlin & Rebecca Haw, *Cartels By Another Name: Should Licensed Occupations Face Antitrust Scrutiny*, 162 U. PA. L. REV. 1093, 1096 (2014).

² *Id.* at 1095.

competition from non-dentist providers of teeth whitening services. NC Board argued that, because it is a state agency, it is exempt from liability under the federal antitrust laws. That is, the NC Board sought to invoke what is commonly referred to as the “state action exemption” or the “state action defense.” The Supreme Court rejected this contention and affirmed the FTC’s finding of antitrust liability.

In this decision, the Supreme Court clarified the applicability of the antitrust state action defense to state regulatory boards controlled by market participants:

“The Court holds today that a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal’s* [*Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980)] active supervision requirement in order to invoke state-action antitrust immunity.” *N.C. Dental*, 135 S. Ct. at 1114.

In the wake of this Supreme Court decision, state officials have requested advice from the Federal Trade Commission regarding antitrust compliance for state boards responsible for regulating occupations. This outline provides FTC Staff guidance on two questions. *First*, when does a state regulatory board require active supervision in order to invoke the state action defense? *Second*, what factors are relevant to determining whether the active supervision requirement is satisfied?

Our answers to these questions come with the following caveats.

- Vigorous competition among sellers in an open marketplace generally provides consumers with important benefits, including lower prices, higher quality services, greater access to services, and increased innovation. For this reason, a state legislature should empower a regulatory board to restrict competition only when necessary to protect against a credible risk of harm, such as health and safety risks to consumers. The Federal Trade Commission and its staff have frequently advocated that states avoid unneeded and burdensome regulation of service providers.³
- Federal antitrust law does not require that a state legislature provide for active supervision of any state regulatory board. A state legislature may, and generally should, prefer that a regulatory board be subject to the requirements of the federal antitrust

³ See, e.g., Fed. Trade Comm’n Staff Policy Paper, *Policy Perspectives: Competition and the Regulation of Advanced Practice Registered Nurses* (Mar. 2014), <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf>; Fed. Trade Comm’n & U.S. Dept. of Justice, Comment before the South Carolina Supreme Court Concerning Proposed Guidelines for Residential and Commercial Real Estate Closings (Apr. 2008), <https://www.ftc.gov/news-events/press-releases/2008/04/ftcdoj-submit-letter-supreme-court-south-carolina-proposed>.

laws. If the state legislature determines that a regulatory board should be subject to antitrust oversight, then the state legislature need not provide for active supervision.

- Antitrust analysis – including the applicability of the state action defense – is fact-specific and context-dependent. The purpose of this document is to identify certain overarching legal principles governing when and how a state may provide active supervision for a regulatory board. We are not suggesting a mandatory or one-size-fits-all approach to active supervision. Instead, we urge each state regulatory board to consult with the Office of the Attorney General for its state for customized advice on how best to comply with the antitrust laws.
- This FTC Staff guidance addresses only the active supervision prong of the state action defense. In order successfully to invoke the state action defense, a state regulatory board controlled by market participants must also satisfy the clear articulation prong, as described briefly in Section II. below.
- This document contains guidance developed by the staff of the Federal Trade Commission. Deviation from this guidance does not necessarily mean that the state action defense is inapplicable, or that a violation of the antitrust laws has occurred.

II. Overview of the Antitrust State Action Defense

“Federal antitrust law is a central safeguard for the Nation’s free market structures The antitrust laws declare a considered and decisive prohibition by the Federal Government of cartels, price fixing, and other combinations or practices that undermine the free market.” *N.C. Dental*, 135 S. Ct. at 1109.

Under principles of federalism, “the States possess a significant measure of sovereignty.” *N.C. Dental*, 135 S. Ct. at 1110 (*quoting Community Communications Co. v. Boulder*, 455 U.S. 40, 53 (1982)). In enacting the antitrust laws, Congress did not intend to prevent the States from limiting competition in order to promote other goals that are valued by their citizens. Thus, the Supreme Court has concluded that the federal antitrust laws do not reach anticompetitive conduct engaged in by a State that is acting in its sovereign capacity. *Parker v. Brown*, 317 U.S. 341, 351-52 (1943). For example, a state legislature may “impose restrictions on occupations, confer exclusive or shared rights to dominate a market, or otherwise limit competition to achieve public objectives.” *N.C. Dental*, 135 S. Ct. at 1109.

Are the actions of a state regulatory board, like the actions of a state legislature, exempt from the application of the federal antitrust laws? In *North Carolina State Board of Dental Examiners*, the Supreme Court reaffirmed that a state regulatory board is not the sovereign. Accordingly, a state regulatory board is not necessarily exempt from federal antitrust liability.

More specifically, the Court determined that “a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates” may invoke the state action defense only when two requirements are satisfied: first, the challenged restraint must be clearly articulated and affirmatively expressed as state policy; and second, the policy must be actively supervised by a state official (or state agency) that is not a participant in the market that is being regulated. *N.C. Dental*, 135 S. Ct. at 1114.

- The Supreme Court addressed the clear articulation requirement most recently in *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003 (2013). The clear articulation requirement is satisfied “where the displacement of competition [is] the inherent, logical, or ordinary result of the exercise of authority delegated by the state legislature. In that scenario, the State must have foreseen and implicitly endorsed the anticompetitive effects as consistent with its policy goals.” *Id.* at 1013.
- The State’s clear articulation of the intent to displace competition is not alone sufficient to trigger the state action exemption. The state legislature’s clearly-articulated delegation of authority to a state regulatory board to displace competition may be “defined at so high a level of generality as to leave open critical questions about how

and to what extent the market should be regulated.” There is then a danger that this delegated discretion will be used by active market participants to pursue private interests in restraining trade, in lieu of implementing the State’s policy goals. *N.C. Dental*, 135 S. Ct. at 1112.

➤ The active supervision requirement “seeks to avoid this harm by requiring the State to review and approve interstitial policies made by the entity claiming [antitrust] immunity.” *Id.*

Where the state action defense does not apply, the actions of a state regulatory board controlled by active market participants may be subject to antitrust scrutiny. Antitrust issues may arise where an unsupervised board takes actions that restrict market entry or restrain rivalry. The following are some scenarios that have raised antitrust concerns:

- A regulatory board controlled by dentists excludes non-dentists from competing with dentists in the provision of teeth whitening services. *Cf. N.C. Dental*, 135 S. Ct. 1101.
- A regulatory board controlled by accountants determines that only a small and fixed number of new licenses to practice the profession shall be issued by the state each year. *Cf. Hoover v. Ronwin*, 466 U.S. 558 (1984).
- A regulatory board controlled by attorneys adopts a regulation (or a code of ethics) that prohibits attorney advertising, or that deters attorneys from engaging in price competition. *Cf. Bates v. State Bar of Ariz.*, 433 U.S. 350 (1977); *Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975).

III. Scope of FTC Staff Guidance

- A. This Staff guidance addresses the applicability of the state action defense under the federal antitrust laws. Concluding that the state action defense is inapplicable does not mean that the conduct of the regulatory board necessarily violates the federal antitrust laws. A regulatory board may assert defenses ordinarily available to an antitrust defendant.

1. Reasonable restraints on competition do not violate the antitrust laws, even where the economic interests of a competitor have been injured.

Example 1: A regulatory board may prohibit members of the occupation from engaging in fraudulent business practices without raising antitrust concerns. A regulatory board also may prohibit members of the occupation from engaging in untruthful or deceptive advertising. *Cf. Cal. Dental Ass'n v. FTC*, 526 U.S. 756 (1999).

Example 2: Suppose a market with several hundred licensed electricians. If a regulatory board suspends the license of one electrician for substandard work, such action likely does not unreasonably harm competition. *Cf. Oksanen v. Page Mem'l Hosp.*, 945 F.2d 696 (4th Cir. 1991) (en banc).

2. The ministerial (non-discretionary) acts of a regulatory board engaged in good faith implementation of an anticompetitive statutory regime do not give rise to antitrust liability. See 324 Liquor Corp. v. Duffy, 479 U.S. 335, 344 n. 6 (1987).

Example 3: A state statute requires that an applicant for a chauffeur's license submit to the regulatory board, among other things, a copy of the applicant's diploma and a certified check for \$500. An applicant fails to submit the required materials. If for this reason the regulatory board declines to issue a chauffeur's license to the applicant, such action would not be considered an unreasonable restraint. In the circumstances described, the denial of a license is a ministerial or non-discretionary act of the regulatory board.

3. In general, the initiation and prosecution of a lawsuit by a regulatory board does not give rise to antitrust liability unless it falls within the "sham exception." Professional Real Estate Investors v. Columbia Pictures Industries, 508 U.S. 49 (1993); California Motor Transport Co. v. Trucking Unlimited, 404 U.S. 508 (1972).

Example 4: A state statute authorizes the state's dental board to maintain an action in state court to enjoin an unlicensed person from practicing dentistry. The members of the dental board have a basis to believe that a particular individual is practicing dentistry but does not hold a valid license. If the dental board files a lawsuit against that individual, such action would not constitute a violation of the federal antitrust laws.

- B. Below, FTC Staff describes when active supervision of a state regulatory board is required in order successfully to invoke the state action defense, and what factors are relevant to determining whether the active supervision requirement has been satisfied.

1. When is active state supervision of a state regulatory board required in order to invoke the state action defense?

General Standard: “[A] state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*’s active supervision requirement in order to invoke state-action antitrust immunity.” *N.C. Dental*, 135 S. Ct. at 1114.

Active Market Participants: A member of a state regulatory board will be considered to be an active market participant in the occupation the board regulates if such person (i) is licensed by the board or (ii) provides any service that is subject to the regulatory authority of the board.

- If a board member participates in any professional or occupational sub-specialty that is regulated by the board, then that board member is an active market participant for purposes of evaluating the active supervision requirement.
- It is no defense to antitrust scrutiny, therefore, that the board members themselves are not directly or personally affected by the challenged restraint. For example, even if the members of the NC Dental Board were orthodontists who do not perform teeth whitening services (as a matter of law or fact or tradition), their control of the dental board would nevertheless trigger the requirement for active state supervision. This is because these orthodontists are licensed by, and their services regulated by, the NC Dental Board.
- A person who temporarily suspends her active participation in an occupation for the purpose of serving on a state board that regulates her former (and intended future) occupation will be considered to be an active market participant.

Method of Selection: The method by which a person is selected to serve on a state regulatory board is not determinative of whether that person is an active market participant in the occupation that the board regulates. For example, a licensed dentist is deemed to be an active market participant regardless of whether the dentist (i) is appointed to the state dental board by the governor or (ii) is elected to the state dental board by the state’s licensed dentists.

A Controlling Number, Not Necessarily a Majority, of Actual Decisionmakers:

- Active market participants need not constitute a numerical majority of the members of a state regulatory board in order to trigger the requirement of active supervision. A decision that is controlled, either as a matter of law, procedure, or fact, by active participants in the regulated market (*e.g.*, through veto power, tradition, or practice) must be actively supervised to be eligible for the state action defense.
- Whether a particular restraint has been imposed by a “controlling number of decisionmakers [who] are active market participants” is a fact-bound inquiry that must be made on a case-by-case basis. FTC Staff will evaluate a number of factors, including:
 - ✓ The structure of the regulatory board (including the number of board members who are/are not active market participants) and the rules governing the exercise of the board’s authority.
 - ✓ Whether the board members who are active market participants have veto power over the board’s regulatory decisions.

Example 5: The state board of electricians consists of four non-electrician members and three practicing electricians. Under state law, new regulations require the approval of five board members. Thus, no regulation may become effective without the assent of at least one electrician member of the board. In this scenario, the active market participants effectively have veto power over the board’s regulatory authority. The active supervision requirement is therefore applicable.

- ✓ The level of participation, engagement, and authority of the non-market participant members in the business of the board – generally and with regard to the particular restraint at issue.
- ✓ Whether the participation, engagement, and authority of the non-market participant board members in the business of the board differs from that of board members who are active market participants – generally and with regard to the particular restraint at issue.
- ✓ Whether the active market participants have in fact exercised, controlled, or usurped the decisionmaking power of the board.

Example 6: The state board of electricians consists of four non-electrician members and three practicing electricians. Under state law, new regulations require the approval of a majority of board members. When voting on proposed regulations, the non-electrician members routinely defer to the preferences of the electrician members. Minutes of

board meetings show that the non-electrician members generally are not informed or knowledgeable concerning board business – and that they were not well informed concerning the particular restraint at issue. In this scenario, FTC Staff may determine that the active market participants have exercised the decisionmaking power of the board, and that the active supervision requirement is applicable.

Example 7: The state board of electricians consists of four non-electrician members and three practicing electricians. Documents show that the electrician members frequently meet and discuss board business separately from the non-electrician members. On one such occasion, the electrician members arranged for the issuance by the board of written orders to six construction contractors, directing such individuals to cease and desist from providing certain services. The non-electrician members of the board were not aware of the issuance of these orders and did not approve the issuance of these orders. In this scenario, FTC Staff may determine that the active market participants have exercised the decisionmaking power of the board, and that the active supervision requirement is applicable.

2. What constitutes active supervision?

FTC Staff will be guided by the following principles:

- “[T]he purpose of the active supervision inquiry . . . is to determine whether the State has exercised sufficient independent judgment and control” such that the details of the regulatory scheme “have been established as a product of deliberate state intervention” and not simply by agreement among the members of the state board. “Much as in causation inquiries, the analysis asks whether the State has played a substantial role in determining the specifics of the economic policy.” The State is not obliged to “[meet] some normative standard, such as efficiency, in its regulatory practices.” *Ticor*, 504 U.S. at 634-35. “The question is not how well state regulation works but whether the anticompetitive scheme is the State’s own.” *Id.* at 635.
- It is necessary “to ensure the States accept political accountability for anticompetitive conduct they permit and control.” *N.C. Dental*, 135 S. Ct. at 1111. *See also Ticor*, 504 U.S. at 636.
- “The Court has identified only a few constant requirements of active supervision: The supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it; the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy; and the ‘mere potential for state supervision is not an adequate substitute for a decision by the State.’ Further, the state supervisor may not itself be an active market participant.” *N.C. Dental*, 135 S. Ct. at 1116–17 (citations omitted).

- The active supervision must precede implementation of the allegedly anticompetitive restraint.
- “[T]he inquiry regarding active supervision is flexible and context-dependent.” “[T]he adequacy of supervision . . . will depend on all the circumstances of a case.” *N.C. Dental*, 135 S. Ct. at 1116–17. Accordingly, FTC Staff will evaluate each case in light of its own facts, and will apply the applicable case law and the principles embodied in this guidance reasonably and flexibly.

3. What factors are relevant to determining whether the active supervision requirement has been satisfied?

FTC Staff will consider the presence or absence of the following factors in determining whether the active supervision prong of the state action defense is satisfied.

- The supervisor has obtained the information necessary for a proper evaluation of the action recommended by the regulatory board. As applicable, the supervisor has ascertained relevant facts, collected data, conducted public hearings, invited and received public comments, investigated market conditions, conducted studies, and reviewed documentary evidence.
 - ✓ The information-gathering obligations of the supervisor depend in part upon the scope of inquiry previously conducted by the regulatory board. For example, if the regulatory board has conducted a suitable public hearing and collected the relevant information and data, then it may be unnecessary for the supervisor to repeat these tasks. Instead, the supervisor may utilize the materials assembled by the regulatory board.
- The supervisor has evaluated the substantive merits of the recommended action and assessed whether the recommended action comports with the standards established by the state legislature.
- The supervisor has issued a written decision approving, modifying, or disapproving the recommended action, and explaining the reasons and rationale for such decision.
 - ✓ A written decision serves an evidentiary function, demonstrating that the supervisor has undertaken the required meaningful review of the merits of the state board’s action.
 - ✓ A written decision is also a means by which the State accepts political accountability for the restraint being authorized.

Scenario 1: Example of satisfactory active supervision of a state board regulation designating teeth whitening as a service that may be provided only by a licensed dentist, where state policy is to protect the health and welfare of citizens and to promote competition.

- The state legislature designated an executive agency to review regulations recommended by the state regulatory board. Recommended regulations become effective only following the approval of the agency.
- The agency provided notice of (i) the recommended regulation and (ii) an opportunity to be heard, to dentists, to non-dentist providers of teeth whitening, to the public (in a newspaper of general circulation in the affected areas), and to other interested and affected persons, including persons that have previously identified themselves to the agency as interested in, or affected by, dentist scope of practice issues.
- The agency took the steps necessary for a proper evaluation of the recommended regulation. The agency:
 - ✓ Obtained the recommendation of the state regulatory board and supporting materials, including the identity of any interested parties and the full evidentiary record compiled by the regulatory board.
 - ✓ Solicited and accepted written submissions from sources other than the regulatory board.
 - ✓ Obtained published studies addressing (i) the health and safety risks relating to teeth whitening and (ii) the training, skill, knowledge, and equipment reasonably required in order to safely and responsibly provide teeth whitening services (if not contained in submission from the regulatory board).
 - ✓ Obtained information concerning the historic and current cost, price, and availability of teeth whitening services from dentists and non-dentists (if not contained in submission from the regulatory board). Such information was verified (or audited) by the Agency as appropriate.
 - ✓ Held public hearing(s) that included testimony from interested persons (including dentists and non-dentists). The public hearing provided the agency with an opportunity (i) to hear from and to question providers, affected customers, and experts and (ii) to supplement the evidentiary record compiled by the state board. (As noted above, if the state regulatory board has previously conducted a suitable public hearing, then it may be unnecessary for the supervising agency to repeat this procedure.)
- The agency assessed all of the information to determine whether the recommended regulation comports with the State's goal to protect the health and

welfare of citizens and to promote competition.

- The agency issued a written decision accepting, rejecting, or modifying the scope of practice regulation recommended by the state regulatory board, and explaining the rationale for the agency's action.

Scenario 2: Example of satisfactory active supervision of a state regulatory board administering a disciplinary process.

A common function of state regulatory boards is to administer a disciplinary process for members of a regulated occupation. For example, the state regulatory board may adjudicate whether a licensee has violated standards of ethics, competency, conduct, or performance established by the state legislature.

Suppose that, acting in its adjudicatory capacity, a regulatory board controlled by active market participants determines that a licensee has violated a lawful and valid standard of ethics, competency, conduct, or performance, and for this reason, the regulatory board proposes that the licensee's license to practice in the state be revoked or suspended. In order to invoke the state action defense, the regulatory board would need to show both clear articulation and active supervision.

- In this context, active supervision may be provided by the administrator who oversees the regulatory board (*e.g.*, the secretary of health), the state attorney general, or another state official who is not an active market participant. The active supervision requirement of the state action defense will be satisfied if the supervisor: (i) reviews the evidentiary record created by the regulatory board; (ii) supplements this evidentiary record if and as appropriate; (iii) undertakes a *de novo* review of the substantive merits of the proposed disciplinary action, assessing whether the proposed disciplinary action comports with the policies and standards established by the state legislature; and (iv) issues a written decision that approves, modifies, or disapproves the disciplinary action proposed by the regulatory board.

Note that a disciplinary action taken by a regulatory board affecting a single licensee will typically have only a *de minimis* effect on competition. A pattern or program of disciplinary actions by a regulatory board affecting multiple licensees may have a substantial effect on competition.

The following do not constitute active supervision of a state regulatory board that is controlled by active market participants:

- The entity responsible for supervising the regulatory board is itself controlled by active market participants in the occupation that the board regulates. *See N.C. Dental*, 135 S. Ct. at 1113-14.
- A state official monitors the actions of the regulatory board and participates in deliberations, but lacks the authority to disapprove anticompetitive acts that fail to accord with state policy. *See Patrick v. Burget*, 486 U.S. 94, 101 (1988).
- A state official (*e.g.*, the secretary of health) serves *ex officio* as a member of the regulatory board with full voting rights. However, this state official is one of several members of the regulatory board and lacks the authority to disapprove anticompetitive acts that fail to accord with state policy.
- The state attorney general or another state official provides advice to the regulatory board on an ongoing basis.
- An independent state agency is staffed, funded, and empowered by law to evaluate, and then to veto or modify, particular recommendations of the regulatory board. However, in practice such recommendations are subject to only cursory review by the independent state agency. The independent state agency perfunctorily approves the recommendations of the regulatory board. *See Ticor*, 504 U.S. at 638.
- An independent state agency reviews the actions of the regulatory board and approves all actions that comply with the procedural requirements of the state administrative procedure act, without undertaking a substantive review of the actions of the regulatory board. *See Patrick*, 486 U.S. at 104-05.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Washington Health Professional Services (WHPS) Program Eligibility and Referral/Discharge Criteria	Number:	W 01.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 15 ¹⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: WHPS reserves the right to refer the nurse to Nursing Care Quality Assurance Commission (NCQAC) or discharge the nurse at any time in cases of, but not limited to: unauthorized substance use, material non-compliance, or inability to effectively monitor.

PROCEDURE:

1. Program Eligibility

Nurses must meet the following eligibility requirements:

- A. Agree to limit practice to one state.
- B. Hold, or be eligible to obtain, ~~an active~~ Washington State nurse license.
 1. After WHPS becomes aware of an expired license, the case manager instructs the nurse they may be afforded up to one month to renew their license.
 2. Nurses enrolled in another state program must meet the eligibility criteria and follow the business practices of that state's program. WHPS will require at least quarterly compliance reports from that state.
- C. ~~Is not~~Not be currently prohibited from WHPS participation (see conditions in 3. C).

D. ~~Agrees~~Agree in writing to the terms of their individual Program Participation Contract.

2. First Monitoring Episode

Monitoring episodes are commonly defined by the number of NCQAC referrals or WHPS program entries. Each episode, contract and dates will be tracked on a summary document in Affinity Operating Systems (AOS).

A. Significant material non-compliance (e.g. practicing without approval) or the first instance of unauthorized substance use will result in the nurse being referred to the NCQAC. See Appendix A

1. Nurses referred to the NCQAC will remain in monitoring “under referral” status pending disciplinary action.

2. At the discretion of WHPS, nurses referred to NCQAC (non-compliance) from their first monitoring episode may re-enter monitoring upon approval from the NCQAC. However, the nurse must go through the intake process prior to re-~~admittance~~admission and may not be given credit for previous monitoring time. All re-entries, contracts and dates will be chronologically tracked in a summary page on AOS.

B. NCQAC referrals must be approved by the WHPS Director.

C. All NCQAC referrals require a link to the electronic monitoring record be placed on the NCQAC page.

3. Second Monitoring Episode

A. Significant material non-compliance or the first instance of unauthorized substance use will result in the nurse being referred to the NCQAC. WHPS discharges the nurse if they are Away Without Leave (AWOL), uncooperative or unwilling to continue being monitored.

B. NCQAC referrals must be approved by the WHPS Director.

C. Upon discharge (non-compliance) from monitoring the nurse will be re-admitted upon referral from NCQAC and under the following conditions:

~~Provide~~The nurse will provide at least twelve (12) consecutive months of verified clean and sober (recovery) time. Evidence of being clean and sober includes, but is not limited to: random body fluid, hair or other biological testing (minimum of 12 per year with NCSBN recommended panel), completion of recommended

chemical dependency treatment, and participation in self-help and/or professional peer support groups.

Note: Affinity Online Solutions provides a random testing service that discharged nurses may purchase.

D. All NCQAC referrals require a link to the electronic monitoring record be placed on the NCQAC page.

E. Nurses must go through the intake process prior to re-admittance and may not be given credit for previous monitoring time.

F. All monitoring episodes, number and type of NCQAC referrals and contracts will be tracked chronologically in the nurse's AOS case file.

4. Program Non-compliance

The following shall occur within two (2) business days of case staffing (See Procedure W 07.01):

A. Notify the nurse by telephone and letter that s/he is being referred to NCQAC. WHPS highly recommends they continue with their recovery efforts and to document those activities.

B. Notify the Work Site Monitor (WSM) by telephone and letter, that the nurse has been referred to NCQAC. ~~WHPS refers the nurse back to NCQAC.~~

- WHPS no longer has the authority to remove the nurse from the workplace,
- WHPS can no longer monitor the nurse's safety to practice, and,
- if there are questions regarding liability issues to contact their legal department.

C. Notify the Peer Support Group Facilitator by telephone of the referral and that the nurse may continue to participate in the peer support group upon agreement of the facilitator and group.

D. Notify NCQAC by memo. Include in chronological detail, reason for entry, diagnosis, reason for discharge, compliance summary, prior non-compliance issues and actions by staff, and conditions for re-entry. Indicate if the nurse is AWOL, uncooperative, ~~priority of referral~~, or potential threat to public safety, and what the priority level of the referral is.

E. Document referral, reasons for discharge referral, and all relevant communications in the electronic case notes. Place copies of all letters in the nurse's physical monitoring record and scan into the electronic monitoring record, include all data and memo in a summary document and scan under Document Management.

F. When referred to NCQAC a link to the nurse's electronic monitoring record is required to be placed on the appropriate program page. WHPS Director will discuss with NCQAC the priority of referral and if WHPS is able to continue to monitor the nurse.

5. Program Discharge: Withdraw Due To Financial Reasons

A. Follow the notification procedures outlined above, with the exception that NCQAC referral memo will note that the nurse is withdrawing due to financial reasons and may return at the discretion of NCQAC and WHPS. If the nurse withdraws in writing, include the nurse's statement in the referral memo. It is strongly recommended that the nurse continue and document all recovery activities.

6. Incarceration

Any nurse incarcerated while in the program will be placed on an extended monitoring interruption. The NCQAC will be consulted regarding nurses incarcerated for greater than one year.

7. All referrals, necessary discharges and incarceration events will be included in the monthly performance summary or audit generated by the Director.

8. Upon discharge from the WHPS program, the nurse may choose to remain enrolled in the WHPS program. If NCQAC suspends the nurse's license, the nurse may choose to remain in the program. The rationale for remaining in the program: to provide evidence of clean and sober behavior in the event the nurse applies for reinstatement or modification of the NCQAC order. All contract requirements must be met and remain in effect.

WASHINGTON HEALTH PROFESSIONAL SERVICES (WHPS)

Appendix A Significant Material Non-Compliance

Compliance with all aspects of the WHPS Program is required. Non-compliance with any aspect of the program will have specific consequences consistently applied. Examples of significant material non-compliance include, but are not limited to:

- a. **Failure to maintain abstinence** - cease practice, Substance Use Disorder (SUD) referral, relapse will be reported to NCQAC.
- b. **Positive drug test not explained by a valid prescription** - cease practice, SUD referral, relapses will be reported to NCQAC.
- c. **Missed drug tests** - 2nd cease practice, SUD referrals, 3rd missed test report to NCQAC. ([SUD in Nursing manual, p.143](#))
- d. **Specimen substitution or adulteration** - cease practice, SUD referral, report to NCQAC.
- e. **A pattern of behavior inconsistent with good recovery** - cease practice, Work Site Monitor (WSM) notified, SUD referral, return to treatment, and increase in contract time.
- f. **Drug diversion** - cease practice, WSM notified, report to NCQAC.
- g. **Prescription forging, tampering or modifying** - cease practice, WSM notified, report to NCQAC.
- h. **Illegal possession of drugs (legend or illegal drugs)** - cease practice, WSM notified, report to NCQAC.
- i. **Arrests involving use or possession of alcohol or drugs** - cease practice, WSM notified, report to NCQAC.
- j. **Accepting employment or modified duties without prior approval** - cease practice, WSM notified, contract extension, report to NCQAC.
- k. **Violation of work practice restrictions** - cease practice, WSM notified, face to face Case Manager, report to NCQAC.
- l. **Absences from required meetings, therapy, evaluations, contract extension, increase in drug screening** - further evaluation, face to face meeting with Case Manager, report to NCQAC.

m. Refusal to sign requested information releases - cease practice, WSM notified, report to NCQAC.

Actions

For any instance of significant material non-compliance, WHPS may take actions including, but not limited to:

- a. NCQAC referral- mandatory for unauthorized use, third missed drug screen, and working without approval
- b. Program discharge for being AWOL, unable or refusal to comply
- c. Removal from practice (WHPS cannot take license action)
- d. Increase in drug screen frequency
- e. Additional testing including, but not limited to hair, nail and blood analysis
- f. Referral for substance use evaluation
- g. Additional contract time.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Admission Types	Number:	W 02.01
Reference:	RCW 18.130.160, RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 8, 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: Describes the types of admissions allowed for the WHPS program

PROCEDURE:

Eligible nurses may enter WHPS as follows:

1. Voluntary Self-referral

~~WHPS may deny admission if~~ the nurse diverted controlled substances for other than self-use, caused known harm, ~~abuse~~abused or ~~neglect to~~neglected patients, diverted drugs by replacing a drug with another substance, has a past probation, revocation or suspension of their license, pending criminal action or prior felony, terminated from an Alternative To Discipline (ATD) program for noncompliance, or is deemed to pose significant risk to consumers. WHPS requires the nurse to immediately report this to the NCQAC.

A. When contacted directly by the nurse, employer or other third party, WHPS provides the opportunity for the nurse to enter the intake process.

B. Nurses requesting admission to WHPS who do not have an open complaint at the NCQAC will be admitted as “voluntary²” and their participation will not be disclosed to the NCQAC. If admitted as “~~Voluntary~~voluntary” and a subsequent referral from the NCQAC is received, WHPS updates participation status in AOS as “non-disciplinary” or “disciplinary” as appropriate.

C. Voluntary self-referrals whom WHPS believes are a clear and present danger to patients, do not follow through with recommended program entry, or fail to comply with their program participation contract ~~may~~will be referred to the NCQAC.

D. Voluntary self-referrals are not required to report to the NCQAC if there has been no patient harm.

E. When referred by a third party and the nurse fails to contact WHPS or complete the intake process, WHPS ~~may~~will provide the referral source with information regarding filing a formal complaint with the NCQAC.

F. If non-compliant with monitoring contract, and as agreed in contract, will be reported to NCQAC.

2. Non-disciplinary referral

A. Nurses who have open complaints may be provided the opportunity to enter WHPS as an alternative to license discipline. This agreement is made between the nurse and the NCQAC.

B. If WHPS receives a non-disciplinary referral from the NCQAC (e.g., SARC referral)), and the nurse has not yet made contact with WHPS, WHPS mails an introduction letter to the nurse inviting them to contact WHPS and discuss program participation.

3. Discipline orders

A. Discipline types referred to WHPS:

1. Agreement to Practice Under Conditions (APUC)
2. Stipulation to Informal Disposition (STID)
3. ~~Statement of charges or~~ Order

B. WHPS will not reach out to the nurse referred by way of discipline. Doing so would interfere with the adjudicative process.

C. At the conclusion of the intake process (may be time limited by order)), WHPS will notify the NCQAC and/or legal services by letter regarding case status.

4. Referral deadlines

A. NCQAC may extend referral deadlines. WHPS requires any extensions be provided in writing and ~~will~~ placed in the nurse's monitoring record.

5. The chronology or reasons for changes in admission types and number of admissions and contracts will be entered into a separate document in AOS for easy access and tracking.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Confidentiality and Records Management	Number:	W 03.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: WHPS maintains confidentiality to the maximum extent provided by state and federal law. Releases of Information (includes contract authorization to communicate/release information) are used for all third party communication concerning a nurse. Appropriate releases should be signed as soon as the nurse enters the intake process and as part of the contract process.

PROCEDURE:

1. Confidentiality

A. On an annual basis, WHPS staff complete *Protecting Electronic Information Training* and sign confidentiality agreements. Signed confidentiality agreements are kept in the Director's desk files and Human Resources.

B. Ancillary staff with access to the secure records room must have department access authorization.

2. Monitoring Records

A. WHPS maintains monitoring records in both physical and electronic formats.

B. WHPS indefinitely maintains electronic records in a secure, password protected electronic records system.

C. Physical records are stored in a secure records room.

a. Staff return all physical records to the secure records room at the end of the business day.

b. Staff transfer physical records of discharged and graduated nurses to the State Records Center on an annual basis and ~~retained~~retain for 30 years.

D. Physical records shall include the following:

- Program Intake records
- Legal orders
- Evaluation and treatment reports
- Probation reports
- Out-of-State Monitoring reports
- Prescription Monitoring forms
- Laboratory Reports indicating unauthorized substance use.
- Program Participation Contracts
- Any other physical communications generated by WHPS, nurse, disciplinary authority, etc.

3. Communication with Treatment Providers, Employers, and Others

A. WHPS will not communicate with external third parties without appropriate authorization to release information. The signed Program Participation Contract provides WHPS with authorization to communicate regarding the nurse with current and prospective employers, mental health and chemical dependency treatment providers, probation departments, drug court agencies, health providers, disciplinary bodies, peer support group facilitator, drug test collection sites and third party administration services (e.g., drug screening contractor ~~) and~~, other disciplinary boards, and out of state alternative programs.

B. In order to conduct appropriate monitoring, nurses must engage in their program by communicating directly with WHPS. Therefore ~~nurse's, nurses'~~ legal representatives will generally be directed to the ~~Nursing Commission Unit, Legal Services Manager of the NCQAC Legal Unit~~. WHPS staff will communicate with the Director or the ~~Nursing Commission Unit, Legal Services~~ Manager, before engaging with a nurse's legal representative.

C. If a nurse declines to sign or revokes necessary authorization to release information, it may be determined that the nurse ~~is not able to~~cannot be effectively monitored and shall be referred to the NCQAC with possible discharge.

4. Public Disclosure

A. Treatment and monitoring records are protected from public disclosure in accordance with RCW 18.130.175. This includes nurses requesting copies of or to view their own monitoring and treatment records.

B. All record requests will be reviewed by the Director and forwarded to the Public Disclosure Records Unit. As necessary, WHPS reviews requests with the Public Disclosure Unit to determine which records are releasable.

C. Subpoenas received by WHPS will be reviewed by the Nursing Commission Unit, Legal Services Manager.

5. Media Requests

A. WHPS will not respond directly to media requests. All media requests shall be referred to the Executive Director, ~~Nursing Commission Unit~~ NCQAC.

6. Admission Types

A. Voluntary Self-referral: Nurses are not reported to the NCQAC if they meet program requirements and do not present a public safety risk.

B. NCQAC Referrals (In Lieu of Discipline, Agreement to Practice Under Conditions, STID, Order): WHPS will release documents and provide reports to the Nursing Commission Unit, Legal Services Manager, Attorney General's Office, and NCQAC as necessary to fulfill legal orders and administrative procedures.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Intake	Number:	W 04.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: The intake process is vital as it is usually the nurse's first contact with WHPS and establishes a cooperative relationship going forward. Due to the nature of the process, nurses are likely to be under significant stress and experiencing shame and guilt. Therefore, the intake process is designed to be supportive of the nurse.

The Intake Case Manager is responsible for gathering and distilling the available information and formulating program participation contract recommendations. While contract recommendations are based on the guidance contained in the WHPS procedures, contract clauses may be individualized dependent upon circumstances and needs.

PROCEDURE:

1. Intake

A. Interview

1. Facilitate discussion of nurse's history and current situation, verify willingness to participate in program.
2. Utilize active listening skills and motivational interviewing techniques.
3. Verify referral source (as appropriate), check ILRS for pending disciplinary action.
4. Provide a description of WHPS services, and refer nurse to Participant Handbook for details.

5. Review NCQAC processes i.e. may be contacted by health care investigator, NCQAC will be notified, different types of admission, verify other Alternative To Discipline (ATD) participation.
6. Complete the WHPS Program Intake Form, attach form to AOS documents.
7. Provide instructions to obtain criminal history report and driving abstract for the substance use evaluation.
8. Provide at least three referrals for a substance use evaluation (may refer for an integrated assessment based on history and presentation).
9. Set a task for one week from date of intake for the nurse to provide evaluation appointment details.

B. Creating the Monitoring Record

1. Verify participation eligibility.
2. Search electronic database for prior WHPS contact/participation.
3. Create a physical and electronic file, enter into the Master List.
4. Enter Intake summary into electronic Administration Notes-include prior entries, participation and outcome, i.e., graduation, discharged for non-compliance.
5. Set a task to receive place, date, and time of evaluation.
6. Have nurse sign a Release of Information authorization(s) allowing communication between WHPS and the evaluating agency and other parties as necessary.
7. Fax evaluation guidelines and intake summary to the evaluation service, include WAC 246-840-780 mandates that evaluator shall not also be provider of treatment.
8. Set a task for ten (10) working days for receipt of evaluation.
9. Scan and upload evaluation into the electronic medical record-attach to Documents.

C. Contract Development

When not offered a contract, notify the nurse and NCQAC by letter. All Intakes will be presented in Case Staffing for contract recommendations and review of evaluation results.

1. Review available information and develop contract recommendations—~~fill~~, **Fill** out new Case Staffing Intake Summary Form with comprehensive history and data-specify treatment required, therapist reports required, attach form to AOS Documents.
2. Assign to a Case Management Team.
3. Send contract and program information packet to nurse -specify treatment requirements in contract.
4. Set a task for ten (10) working days for receipt of the signed Program Participation Contract.

5. Scan the signed contract into the electronic medical record and place in the physical file. Notify the Case Management Team. Attach contract to Documents in AOS.

2. Timeline

A. Nurses referred to WHPS under a Substance Abuse Referral Contract (SARC) have 45 days from the date they signed the SARC to complete the intake process and submit the signed Program Participation Contract. Failure to do so will result in notification by letter that they have an additional seven (7) days to submit the signed contract.

B. All nurses referred under order will have the number of days stipulated in the order to complete the intake process and submit the signed Program Participation Contract. Failure to do so will result in notification by letter that they have seven (7) additional days to submit the signed contract.

C. In the absence of extenuating circumstances nurses who do not meet contract deadlines will be referred back to the NCQAC.

DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE

Title:	Substance Use Evaluation and Treatment Services	Number:	W 05.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 168 , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: Describe the process, personnel and actions associated with substance use evaluations used by the Washington Health Professional Services program.

PROCEDURE

1. Evaluation referrals

A. The Intake Case Manager assists nurses by providing at least three substance use evaluation referrals ensuring the nurse has a role in the choice of service. The nurse must complete Release of Information authorizations with both WHPS and the evaluation service.

B. WHPS accepts only Division of Behavioral Health and Recovery (DBHR) certified services. Appropriate exceptions will be made for out of state nurses.

Reference: DBHR certified services may be found in the Directory of Certified Chemical Dependency Services in Washington State Resource Manual.
<http://www.dshs.wa.gov/dbhr/daDirectory.shtml>

C. The Intake Case Manager determines that the evaluation service is agreeable to providing evaluations in accordance with WHPS Guidelines. Adherence to an

evaluation format provides thorough, consistent evaluations and recommendations for treatment. Fax evaluation guidelines and provider letter. Evaluation services must agree to the following:

1. To provide case status information to WHPS after appropriate authorization to release information is obtained.
2. Fee schedules and flexibility in payment plans that enable those experiencing financial problems or are underinsured to receive appropriate services.

D. If the nurse completed an acceptable evaluation prior to contacting WHPS, the nurse may request the service send a copy of the evaluation, treatment recommendations, and treatment records to WHPS. Acceptable evaluations must have occurred with the previous 90 days and meet all WHPS requirements.

E. The WHPS Director will be notified of any complaints involving the quality of services provided by evaluation and treatment services.

2. Evaluation Guidelines

A. All substance use evaluations must respect confidentiality. This includes conducting the interview in a confidential setting. All evaluations must be an in-depth assessment allowing for adequate time to be spent with the individual and must adhere to ~~WAC~~ 246-840-780 relevant DBHR requirements for evaluations.

B. Evaluations must be conducted through a DBHR certified service by a:

1. Chemical Dependency Professional (CDP). Evaluations by a CDPT will not be accepted, or
2. M.D. Addictionologist, or
3. Approved state licensed evaluator with expertise in substance abuse/addiction. This may include a Psychologist, a Marriage and Family Therapist, a Clinical Social Worker or an ARNP. Evaluators in these categories may be asked to provide a copy of their current curriculum vitae. A Master's degree in Psychology without a license will qualify if the evaluator can demonstrate training and experience in addiction counseling and diagnosis.

C. Evaluations must include:

1. A complete Bio-Psycho-Social history.
2. At least two chemical dependency screening tools, i.e.: SASSI, MAST, CAGE, DAST, etc. The SASSI is preferable but not required.

3. Written verification that the nurse's license history has been reviewed using the Department of Health's website Provider Credential Search at www.doh.wa.gov.
4. Review of driving abstract. (to be provided by the nurse at the time of the evaluation) <http://www.dol.wa.gov/driverslicense/requestyourrecord.html>.
5. Review of criminal history report. (to be provided by the nurse at the time of the evaluation) www.wsp.wa.gov W.A.T.C.H. link.
6. Baseline, observed urinary drug screen including EtG. (WHPS may require additional testing).

D. Narrative must include:

1. Bio-Psycho-Social summary including history of previous and/or current treatment.
2. Current Diagnostic and Statistical Manual of Mental Disorders (DSM), five axis diagnosis and justification, including Global Assessment of Functioning (GAF) score at time of evaluation.
3. Level of Care Treatment Recommendations per current American Society of Addiction Medicine (ASAM), Patient Placement Criteria, and Stage of Change in which nurse appears to present; other recommendations such as mental health evaluation, Alcohol Drug Information School etc.
4. Results of the urinary drug screen with EtG testing.
5. Professional opinion regarding the nurse's ability to practice with reasonable skill and safety. The evaluator is asked to consider:
 - Stability in area of concern
 - Problem solving ability
 - Cognitive functioning
 - Ability to cope with stressful situations
 - Mental status
6. List of collateral information used
7. Any additional pertinent information

E. The Intake Case manager

1. **Review/Reviews** all evaluations and recommendations.
2. Consults with the case management team and/or evaluation facility regarding DSM diagnosis and ASAM placement criteria. Specific treatment recommendations will be agreed upon in staffing and must be included in the contract.
3. **Fax/Faxes** treatment provider the cover letter and a copy of the therapist report, due monthly during IOP and quarterly thereafter, to include a full Discharge Summary and follow up recommendations.

4. Adds treatment requirements as a Document in AOS.

F. If the nurse disagrees with the evaluation, or if the evaluation does not reflect the seriousness of the event(s) leading to the evaluation, a second opinion evaluation may be requested. The following conditions apply:

1. The evaluation must be conducted in accordance with WHPS guidelines and timelines established by WHPS and the NCQAC.
2. The nurse must authorize release of information between each evaluation service (allowing services to communicate with each other regarding all aspects of their evaluations) and WHPS.
3. If there is disagreement between the evaluations WHPS will make final monitoring recommendations based on all available information.

3. Treatment Requirements

- A. Nurses are expected to comply with all specified treatment recommendations.
- B. Once the treatment provider has been identified, a cover letter and therapist report will be sent out immediately. CM consults with provider if necessary to ensure nurse entry and compliance with treatment.
- C. Therapist reports ~~are to~~will be submitted monthly during early treatment phase.
- D. Therapist reports must include a statement about current ability to practice with reasonable skill and safety.
- E. Therapist reports will address any recommendations for further evaluation or assessment for pain management, mental health issues or others, and nurse agrees to obtain these as ~~requested~~recommended.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Terms and Conditions of Contract Compliance	Number:	W 06.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE

The length and terms of Program Contracts are determined by the substance use evaluation, time in recovery, profession and professional duties, and the specifics of the nurse's use patterns and behavior. The nurse must agree in writing to all contract terms; and ~~may~~ not alter the contract, ~~in order~~ to be eligible for program participation.

Nurses whose substance use evaluation indicates an inability to practice with reasonable skill and safety must refrain from practice until satisfactory progress in treatment is made.

Note: Nationally accepted substance use disorder monitoring guidelines are contained in the National Council of State Boards of Nursing: Substance Use Disorder in Nursing Resource Manual <https://www.ncsbn.org/2106.htm>

PROCEDURE

1. Levels: (See 5. DSM V diagnosis guidance)

A. Level I

1. The nurse recognizes misuse of alcohol or other drugs, but has no or an equivocal substance use diagnosis.

- When program participation is not indicated and there is an open ~~compliant~~ **complaint**, the nurse's participation will be reevaluated if referred back as a result of the complaint investigation.

2. Level I Monitoring Contracts are from six months to two years in length.
3. Nurses referred under an Agreement to Practice Under Conditions (APUC) order will generally be offered a Level I Contract in order to verify recovery and safety to practice.

Agreement to Practice Under Conditions (APUC)

Diagnosis	Contract
No Diagnosis	6 months
Abuse	1 year
Dependency (in remission)	2 years

- Recent substance misuse and/or related criminal conviction (within previous year) may warrant a level II or III contract.
- Nurses referred under an APUC and who have been in sustained recovery for greater ~~than 3~~ **than three (3)** years may not be appropriate for monitoring. Demonstration of recovery may be supported by documentation including, but not limited to: Treatment completion, letters of endorsement, drug screening records, and self-help group attendance records.

B. Level II

1. The nurse has a substance abuse diagnosis and may ~~or may not~~ have disciplinary action taken on their license, or may have a complaint pending.
2. Level Two monitoring contracts are from three to four years in length.
3. Self-help and Peer Support Group attendance requirements are determined on a case by case basis.

C. Level III

1. The nurse has a substance dependency diagnosis and may ~~or may not~~ have disciplinary action taken on their license or may have a complaint pending.
2. Level III monitoring contracts are at least five years in duration. If the nurse has a dependency diagnosis in sustained full-remission, they may be given a shorter contract to account for the length of time they have been actively involved in their recovery and maintaining sobriety. Demonstration of recovery may be

supported by documentation including, but not limited to: Treatment completion, letters of endorsement, drug screening records, and self-help group attendance records.

D. If there is reasonable concern about the ability to practice safely, the nurse will be asked to cease or refrain from practice. A SUD evaluation must be submitted addressing safety to practice issues. Non-compliance with any contract terms, unauthorized substance use, missed, ~~adulterated~~substituted, or adulterated drug screens may also require the nurse to cease practice.

E. Non-compliance with any of the terms of the contract may result referral to NCQAC.

F. Violation of any aspect of nursing law may be considered non-compliance with contract and may result in referral to NCQAC.

2. Contracts Requirements: Agree to limit practice to this state only

A. Specific requirements to be addressed include, but are not limited to: Nurse admits the existence of problems related to substance use, or has SUD, and voluntarily agrees to participate.

- Specific Substance abuse treatment requirements, monthly or quarterly reports.
- Abstinence from all mood altering substances, alcohol and OTC meds, immediate self-report of any unauthorized use, submit to any re-evaluations required and abide by recommendations and cease practice requirements.
- Agreement to appear in person as requested by WHPS.
- Medication management-initial Rx verification, quarterly reports, SUD evaluation.
- Must notify all health care providers of substance use history prior to receiving any prescription, and submit report confirming providers awareness of history.
- Random and for cause drug screening.
- Self-help group attendance 3/week, participation, monthly reports, obtain sponsor.
- Weekly Peer support group attendance and participation-monthly reports.
- Employment conditions-work place restrictions, WSM criteria & requirements, monthly reports on work place performance.
- Self-reports on recovery status monthly.
- Authorization to release information.
- Obtain prior approval for pending relocation out of state.
- Pay all fees and costs associated with program.
- Obligation to report non-compliance with contract to NCQAC.
- Non-compliance with any terms may require cease practice, WSM notification.
- Immediate notification of any prescriptions for analgesics.
- Notification within two days of any hospitalization or surgical procedures.
- Workplace disciplinary meeting or employment counseling.

- Any change in work setting or WSM, change in contact information, termination or resignation, diversion or use of alcohol at work, prescription forgery, fraudulent calling in of prescriptions;
- Any crimes committed, arrests, deferred sentences or conviction following nolo contendere;
- Any new disciplinary complaint.

B. Work practice restrictions may include, but are not limited to:

- Not function in an unsupervised role.
- No staffing agency, home health or adult family home work.
- Will not work double shifts; must be off more than 8 hours between shifts.
- Will not work overtime or take on-call assignments.
- Will not work a three shift (day, evening, night) rotation within a seven (7) day period.
- Will not float from unit to unit.
- Will not work nights.
- Upon resuming practice, will not have access to, dispense, administer or count controlled substances, or any medication that a facility counts and controls such as benzodiazepines, until re-evaluated in 6-12 months.
- Will not have multiple employers.

*Note*Notes: 1. Access restrictions are generally for 6 to 12 months. If there is evidence of drug diversion, prescription fraud or patient harm access is restricted for 12 months. Access restrictions may not be necessary for nurses whose sole misuse is alcohol and/or marijuana and there had been no work involvement.*

2. Tramadol (Ultram) may induce dependence similar to the opioids therefore will be considered a restricted controlled substance.

Case Managers may work with nurses and employers to amend work restrictions as long as appropriate protections are in place. Amendments are generally not considered until after 12 months of practice and complete compliance with all contract conditions.

C. Night shift, staffing agency, home health and adult family home employment may be considered on an individual basis. Registry work requires a minimum 3-6 months assignment. For home health and adult family home work an agreement outlining all supervision requirements will be signed by the nurse, employer, and WHPS.

D. Research has shown that health professionals have a lower relapse rate upon return to practice if they are taking monitored Naltrexone and/or Vivitrol receiving Medication Assisted Treatment (MAT). Amendment of controlled substance access restrictions will be considered for those nurses on Naltrexone and/or Vivitrol therapy-MAT. Generally, therapy will be required for a period of one to two years.

3. Transition Contracts

A. Three to five year contracts will be reviewed and amended as appropriate prior to the final year in order to transition nurses towards graduation. The purpose is to thoughtfully reduce the requirements and restrictions previously imposed on the nurse in an effort to prepare the nurse for life without monitoring. The timing of this contract is based on the nurse's progress in recovery and compliance with their monitoring contract.

B. *Note: Transition contracts will generally not be considered until the nurse has worked successfully in healthcare for 12 months.* Nurses must demonstrate complete compliance during the previous two years to be eligible for a Transition Contract.

C. The case manager will set a task, prior to the final contract year, to evaluate the nurse's readiness for a Transition Contract.

D. Prior to beginning their transition contract nurses will be encouraged to submit a written summary of his/her recovery along with a relapse prevention plan.

E. During the last year of monitoring, the nurse's contract may be amended to reduce the number of drug tests, report submissions, self-help and peer groups, and work restrictions. Examples are:

- Drug testing 12/year.
- Monthly peer support groups.
- Quarterly self and Work Site Monitor reports.
- Twice per week self-help groups.
- The following minimal restrictions (or adjusted per individual circumstance):
 - no registry, home health agency or adult family home work.
 - will not have multiple employers.

Or, for nurses demonstrating strong recovery:

- Drug testing 8-12 times/year.
- Quarterly reports by Work Site Monitor & nurse.
- One time per week self-help and one time per month peer support group with quarterly reports to verify.
- No work restrictions.

E. Before a Transition Contract is approved, the case manager consults with the peer support group facilitator and work-site monitor to determine the nurse's readiness for a reduction in monitoring requirements and restrictions.

4. Out-of-State Contracts - Nurses must notify WHPS of anticipated move prior to relocating

A. WHPS nurses who move to another state to practice and meet the eligibility requirements for that state's alternative to discipline substance abuse monitoring program may be offered a WHPS Out-of-State Monitoring Contract. Case Managers must be in

contact with the other state program prior to offering an Out of State Contract. The primary monitoring role rests with the state that the nurse is residing in. WHPS will receive at least quarterly reports from the state monitoring program. Nurses are eligible to graduate from WHPS when written notification from the primary monitoring state of their completion with their monitoring program.

B. In some cases, nurses may reside outside of Washington State and continue to be directly monitored by WHPS. This will be determined on a case by case basis.

5. DSM V Diagnosis Guidance

Substance use disorder

- A. Mild: 3 year Level II contract
- B. Moderate/Severe: 5 year Level III contract

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Case Management	Number:	W 07.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 <u>8</u> , 2016		
Supersedes:			
Approved:	<p style="text-align: center;">Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission</p>		

PURPOSE: Case Management is the hub of the program wheel receiving information from multiple sources such as treatment providers, employers, investigators, legal services, and boards/commissions. The Case Management Team utilizes this information to develop individualized monitoring contracts, substantiate compliance and recovery status, and protect public safety.

The intent of case management is to consider individual circumstances while monitoring nurses per applicable statute and regulation, WHPS procedures and contract requirements.

PROCEDURE

1. Case Management Teams consist of a Case Manager and Case Manager Associate. The Case Manager acts as the team leader, and makes final decisions regarding management of the nurse in the WHPS program.
2. The Case Manager will meet (telephone is acceptable) with all nurses prior to them signing their contract in order to explain contract/program requirements and answer any questions ~~and~~. The Case Manager must witness the nurse's signature on the contract in person.

3. All communications from nurses (telephone, e-mail, mail, etc.) will be returned within 24 hours or the next business day.

4. Case Managers and Case Manager Associates check all alerts first thing every morning, and follow up as required.

5. Case management monitoring activities include, but are not limited to, routine reviews and appropriate action on the following:

- Overall contract compliance.
- Monthly submission of Self-reports.
- Monthly submission of Self-help group attendance records.
- Monthly submission of Work-Site Monitor Evaluation reports.
- Monthly submission of PSG facilitator reports.
- Monthly submission of initial CD treatment.
- Quarterly aftercare, relapse prevention reports and DC summary.
- Employment requests, changes in WSM requests and approval.
- Following practice restrictions, specifically listed in employment contracts.
- Initial and quarterly prescription information forms for all prescriptions.
- Daily alerts and follow up for laboratory drug screening results.

5. Non-compliance with contract components requires nurse notification and corrective actions. In most situations, nurses will be given the opportunity to become compliant and will be informed of specific corrective action expectations and any consequences, i.e., contract extension, increase in test frequency, face to face meeting with CM.

6. Case Management Teams serve as the point of contact for work-site monitors, peer support group facilitators, licensing and NCQAC, and other stakeholders.

7. Case management meetings will be held weekly and as necessary. Case managers are to bring, but not limited to, initial Intake requests, instances of significant material non-compliance, and requests for contract amendments and procedure issues to each meeting. All case management decisions will be documented listing issues, actions taken, and consequences applied.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Job/Practicum Approval	Number:	W 08.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 <u>8</u> , 2016		
Supersedes:			
Approved:			
	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: Safely returning nurses to practice is a goal of WHPS. Six to twelve months of practice is desired to adequately assess the nurse's ability to practice with safety. Expectations for ~~nurse's~~nurses not returning to practice will be considered on an individual basis.

PROCEDURE

1. The nurse is required to notify their Case Manager prior to any and all changes in work status, position, or place of employment in order to obtain prior approval before starting a new healthcare position or taking on new healthcare duties.

Note: Nurses are encouraged to document all communication with WHPS through the confidential electronic messaging system.

2. Consistent with WHPS' mandate to ensure public safety when involved in a clinical practicum, nurses must notify the school of their participation in WHPS, obtain WHPS approval, and identify a school contact. The needs for worksite/practicum monitor reports are to be submitted monthly.

3. Appropriate authorization for release of information will be obtained in order to speak with the employer/school. In some cases a visit to the work/practicum site will be scheduled.

4. The Case Manager contacts the designated employer representative and explains WHPS's scope of function and WHPS involvement with the nurse. Any workplace restrictions,

limitations, and concerns are reviewed as well as specifications for the nurse's return to work or new duties. Most commonly this discussion takes place by phone, but can also be done in person. The Case Manager may also ask for a copy of the position or job class description for review. The Employment Contract shall include the list of WSM Criteria.

5. If the position is approved, the nurse must return the signed Employment Contract, including specific work restrictions & dates, and WSM Criteria to WHPS prior to beginning any work involving patient care. New Employment Contracts will be added with dates to Documents in AOS.

6. The signed Employment Contract is placed in the electronic nurse records under Documents and employment status is updated in the electronic case record.

7. A WSM packet will be mailed and any necessary assistance provided in regards to filing electronic reports. The WSM Orientation Module will also be mailed. ~~A reminder will be sent in two weeks to verify completion of Education Module.~~ (See Procedure W14 for work site monitoring).

8. In most cases, a ~~Work-Site Monitor~~ WSM is identified prior to beginning work. In situations where this is not possible the employer may assign a temporary monitor.

Working as a nurse or performing duties not approved by WHPS places patients at risk of harm and is a serious violation of the Monitoring Contract. Nurses working in unapproved capacities will be immediately removed from practice, referred to their NCQAC and may face discharge from WHPS.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION**

PROCEDURE

Title:	Medication Management	Number:	W 09.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: WHPS nurses may have co-morbid medical conditions or ~~are~~ be undergoing ~~medication-assisted treatment~~ Medication Assisted Treatment (e.g. suboxone, ~~vivatrof~~ Vivatrof). WHPS does not determine if mood-altering or potentially addictive medication treatment is necessary. This is a decision between the nurse and prescribing professional, who is aware of the nurse's WHPS participation and diagnosis. However, WHPS has a duty to reasonably assure that nurses on long-term, mood-altering or potentially addictive medication treatment are safe to practice. WHPS does this by encouraging alternative methods of medical management, and referring to specialists in the fields of addiction and pain management. Nurses are to notify any and all health care providers of Substance Use Disorder history and participation in WHPS prior to receiving any prescriptions. Nurses should identify one primary prescriber, one pharmacy and one dentist for regular visits, if possible.

WHPS nurses on long-term (three months), mood-altering or potentially addictive medications will be required to be evaluated by an American Society of Addictions Medicine (ASAM) certified Addictionologist with pain management expertise, or other specialist as necessary i.e., mental health, and schedule an appointment within thirty (30) days. Reasons for evaluation may include, but are not limited to: all narcotic analgesics, prescriptions up to three months or longer, dosages taken at the top or above recommended limits, similar medications taken for the same condition, prescriptions received from more than one provider, inconclusive diagnosis, lack of evidence supporting beneficial progress, and fitness for duty determination. Nurses may be asked to cease practice until a negative drug screen is received if there are concerns about safety to practice.

PROCEDURE:

1. Prescription Reporting: Nurses will immediately report all new prescriptions to their Case Manager.

A. The nurse will provide the prescriber with the WHPS Personal Health Care Provider Disclosure Letter and submit the signed letter to WHPS.

B. The nurse will immediately require the prescriber to complete and submit the WHPS Prescription Information Report to include:

1. Diagnosis and medication regimen, justification of need for narcotic analgesics, multiple medications.
2. Appointment frequency.
3. Nurse compliance and response to prescription medication.
4. Work restrictions (if any).
5. Fitness for duty while taking medications as prescribed.

C. For long-term therapies (greater than ~~3 months~~ three months) the nurse will require the prescriber to submit Quarterly (every 90 days) Prescription Information Report, which must specifically address safety to practice under current prescription regimen.

D. The case manager will review all prescription submissions for approval or follow-up as necessary with the nurse and prescriber.

E. All prescription reports will be documented in the nurse's electronic file. A case note will accompany any unapproved prescriptions including the rational and action(s) taken.

F. All positive drug screens will be reviewed in comparison to the nurse's approved prescription list. If appropriate documentation is not in place, the use of a prescribed medication may be considered unauthorized substance use.

2. Medication Management Referral is required for all mood altering or potentially addictive medications. Nurses will agree to cease practice if prescribed narcotic analgesics (follow Procedure W 10.01)

A. WHPS will notify the nurse that a medication management evaluation is required, and nurse may be asked to cease practice until a negative drug screen or the results of evaluation are received and reviewed.

B. ~~An~~ WHPS will provide an ASAM certified Addictionologist referral ~~-will be provided.~~

C. The nurse will schedule the initial appointment within 30 days and notify WHPS of the appointment date.

D. ~~Any~~ The nurse must sign any necessary releases of information to allow communication between WHPS and the nurse's medical providers ~~-must be signed.~~

E. Results of the evaluation must address appropriateness, rationale, and ongoing need for prescriptions; and recommendations for alternatives (if available); assessment of cognition, problem solving, memory, and judgment. Fitness for duty while nurse is taking prescriptions as ordered must also be addressed. Nurses will be asked to cease practice if safety to practice is a current concern.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Short Term Analgesic Use	Number:	W 10.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: Acute pain may occur in those with substance use disorders as a result of trauma, surgery, etc. Therefore, WHPS supports appropriate pain management for nurses with short term needs for narcotic analgesics.

PROCEDURE

1. The nurse will immediately notify their Case Manager and Worksite Monitor if they have or will be prescribed narcotic analgesic medication and have the prescriber fax a signed Disclosure Letter and Prescription Information Report Form to WHPS.
2. WHPS will:
 - A. Verify report of the reason the medication was prescribed, frequency and dose, specific date and time of anticipated last dose, and prescriber's name and contact information. If the prescription is for a one day medical procedure, the following may not be required.
 - B. Notify the employer and request that the nurse is removed from direct patient care whether their condition requires it or not. Explain that the nurse may not provide direct

patient care until 24 hours after taking the last prescribed dose, the employer agrees and WHPS approves.

C. Direct the nurse to call WHPS to report that they have taken their last prescribed dose. Verbally verify with the nurse that they have taken all doses and do not have any medication remaining. If any medication remains, WHPS will direct the nurse to return it to ~~the prescriber or an~~ appropriate take back location.

D. Schedule a drug screen (panel H or other specific to drug(s) of concern) at least 72 hours after last dose. It takes at least 72 hours for most analgesics with addiction potential to clear from the body; testing windows may be adjusted depending on the medication.

E. Notify the employer as to when the nurse may resume direct patient care activities.

As post treatment testing has not been completed the employer will be provided the following information:

Name has notified WHPS that he/she has taken their last dose of a ~~of a~~ prescribed short term pain medication. If you agree he/she may resume direct patient care activities on Date . He/she will be drug screened to reasonably verify discontinued use. Drug screening results will be available in approximately one week. During this period WHPS recommends that you remain observant for any signs of impairment. Contact WHPS at 360-236-2880 with any questions or to report concerns.

F. Document all actions in the electronic case notes with subject titles.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Unauthorized Substance Use	Number:	W 11.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 <u>8</u> , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: For purposes of monitoring and “uniform regulatory standards, noncompliance is the failure to adhere to any of the terms of the program ~~contacts.~~ Relapse contract. “[R]elapse is defined as any unauthorized use or abuse of alcohol, medications or mind-altering substances. Patient safety is jeopardized if a relapse is not identified early. Consistent monitoring and immediate identification of relapse is critical as it puts the nurse’s health in immediate jeopardy and may be fatal.”
(Substance Use Disorder in Nursing, National Council of State Boards of Nursing, 2011, Pp. 216).

PROCEDURE

1. The nurse will:
 - A. Report all unauthorized substance use to WHPS, the Worksite Monitor, and Peer Support Group (PSG) within 24 hours of unauthorized use.
 - B. Report all unauthorized substance use to the WSM and PSG within 24 hours of unauthorized use if discovered by WHPS, and not previously reported.
 - C. Cease practice immediately

D. Complete a next day, observed drug test as scheduled and requested by WHPS.
D. Schedule a substance use evaluation by a Department of Behavioral Health and Recovery certified service within two (2) days.

E. Begin recommended level of treatment as soon as possible, and,

F. Not return to practice until the treatment provider and WHPS determine the nurse is safe to practice.

2. WHPS will:

A. Assess each case individually with relapse behavior (e.g., use after a period of abstinence, return to prior use pattern, little or no program contact, use within the context of active practice) taken into account regarding appropriate response. (See Procedure 13.01, Program Eligibility). Unauthorized use occurring during initial treatment and/or prior to submission of negative drug screens after entry; may not be considered relapse due to lack of a period of abstinence; or significant recovery time; ~~any~~. Any examples of these ~~examples~~ will be included in the included in monthly compliance report generated by WHPS Director.

B. Case staff meeting, including a review of the nurse's contract compliance history and substance use evaluation. Requirement to cease practice will be requested.

C. All instances of unauthorized substance use will be staffed at the next weekly scheduled case staffing meeting if not sooner. If not available the case manager will assign someone to present or provide a written summary and action recommendation.

D. All unauthorized use will be reported to NCQAC, and will be included in the monthly compliance summary generated by the Director.

3. Unauthorized substance use contract time guidelines:

A. Add at least six (6) months to a year to the contract allowing for at least two (2) consecutive years of sobriety immediately prior to the possibility of graduation.

In the interest of public safety, cases that involve, but are not limited to workplace diversion, patient harm, or illegal activity (e.g., prescription forgery)

1. May necessitate restarting contract time, and
2. Will require cease practice and WSM notification until WHPS approves return
3. Report to NCQAC.

B. When substance use disorder evaluations result in an elevated diagnosis contract length and components will be adjusted accordingly.

| C. The nurse has ten (10) working days to return the amended contract. If the nurse chooses not to accept the contract, the nurse will be referred to the NCQAC.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Cease Practice Requirements	Number:	W 12.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 168 , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: The primary mission of WHPS is to protect the health and safety of the public. When there is reasonable concern about the ability to practice safely, the nurse ceases practice.

*NOTE: WHPS does not have authority to take action on a nurse's license. Cessation from practice is applied as a public safety measure and is contractually understood by the nurse and employer. **Any practice during the cessation period will be considered significant material non-compliance and reported to the NCQAC.***

PROCEDURE

1. Nurses will be requested to cease practice and have their WSM notified; in circumstances including, but not limited to:

- A. Failure to test as requested.
- B. A positive drug screen.
- C. A substituted or altered drug screen specimen.
- D. A report of possible impaired practice or inappropriate behavior.
- E. Use of prescribed short term narcotic analgesics (See Procedure W 10.01, Short

| Term Analgesic Use~~)~~).

| F. Material contract non-compliance.

| G. Self-report of unauthorized substance use.

| H. Practicing in an unapproved capacity.

| I. A report of diversion of controlled substances from work.

| J. Incidences of provable harm, abuse or neglect to patients.

2. Nurses removed from practice will be referred for a substance use evaluation and may be required to re-enter treatment before returning to practice. Additional evaluations (e.g. mental health) may also be required.

3. Nurses may not return to practice until approved by their evaluator/treatment provider and WHPS. Any unauthorized practice ~~may~~will result in NCQAC referral.

4. All cease practice requests will be included in the monthly compliance summary.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Case Staffing	Number:	W 13.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 168 , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: In order to ensure program quality and consistency, case staffing meetings will occur at least weekly.

PROCEDURE

1. The WHPS Director assigns a case manager to all Cases in Development prior to offering a contract. All cases involving unauthorized use, new medication management, relapse reports or workplace concerns, a pattern of missed check-ins, missed tests, dilute, and abnormal specimens will also be assigned.
2. Case staffing and Case manager meetings will be held weekly and as necessary.
3. Case Managers bring cases for review at each week's case staffing meeting. Cases for review include, but are not limited to: instances of unauthorized substance use, material contract non-compliance (e.g., unapproved work), contract amendments, early discharge requests and business practice applications questions.
4. If unavailable, the case manager assigns a substitute to present or provide a written summary and recommendations.
5. Decisions will be documented in the electronic case notes. A written report on each case staffed will be titled as Case Staffing "topic" and attached to the Documents drop down in AOS.

6. A summary of case staffing issues discussed and reviewed, recommendations and actions by staff will be included in the Director's monthly audit report.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Work Site Monitoring	Number:	W 14.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 168 , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: All nurses in the WHPS program employed in healthcare positions are required to have a Work Site Monitor.

PROCEDURE

1. The Work Site Monitor (WSM) reviews and signs the Employment Contract, evaluates the nurse's job performance, ensures adherence to work restrictions, and acts as WHPS's primary point of contact with the employer. The WSM Criteria will be listed in the Employment Contract and the WSM signature verifies compliance with these criteria.
2. The ~~Worksite Monitor~~WSM must provide direct supervision to the nurse unless an alternate monitoring relationship is approved by the case manager. Work place restrictions will be specified in the Employment Contract, with lines for initial dates of restrictions, and later dates that restrictions are lifted.
3. Once WHPS receives the signed Employment Contract a ~~Work Site Monitor~~WSM Packet will be mailed. WHPS provides the WSM with an electronic case management system password.
4. The WSM is required to complete the electronic WHPS Orientation Module within one (1) week of starting duties. If verification is not received, the CM notifies the WSM after ten (10) days, and encourage completion of the module.

5. The Case Manager directly communicates with the WSM or employee representative. In the event that practice must be restricted or the nurse exhibits behavioral changes which may be indicative of relapse, WHPS requires the nurse to cease practice until approved to return to work.
6. The WSM provides monthly reports on the status of the nurse's job performance and behavior.
7. When a different WSM is assigned to a nurse or there are changes made to the nurse's work restrictions, the Employment Contract must be reviewed and signed by the WSM and returned to WHPS within one (1) week. If the WSM is a temporary replacement for vacation or education, the temporary WSM verifies and signs that they meet the WSM criteria and be given a temporary password to report to AOS. The temporary WSM must complete the electronic WHPS Orientation Module one (1) week prior to starting duties. If verification is not received, the CM notifies the WSM after one (1) week, and encourages completion of the module.
8. In the event there are a limited number of people who can perform as a WSM, these situations must be discussed as the contract terms are confirmed. Alternate WSM options that meet the criteria are identified and approved.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Professional Peer Support Groups	Number:	W 15.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 <u>8</u> , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: Professional Peer Support Groups are facilitated by approved facilitators who report weekly attendance to WHPS. Professional Peer Support Groups are an important part of the monitoring program. Professional Peer Support Groups are different than Twelve Step meetings or psychotherapy groups. The role of the Professional Peer Support Group in the monitoring program includes:

- Sharing experience, strength, hope and support in addressing issues related to the process of recovery from chemical dependency.
- Providing support regarding professional issues including re-entry into practice.
- Providing resources for additional support services.
- Reporting unauthorized use or impairment.
- Providing input and recommendations relative to the needs of WHPS nurses.

PROCEDURE

1. WHPS recruits Professional Peer Support Group Facilitators around the state and maintains relationships with support groups.

A. WHPS hosts semi-annual Professional Peer Support Group Facilitator educational meetings.

B. A WHPS representative attends each Professional Peer Support Group at least once each year.

2. Approved Professional Peer Support Groups must:

- A. Subscribe to the abstinence model of recovery.
- B. Maintain nurse confidentiality except in the case of unauthorized use or impairment, and when the nurse may be a threat to self or others.
- C. Hold weekly meetings which are conducted by an approved Facilitator.
- D. Have a fee structure (\$10–20/meeting recommended) which will not be a barrier to participation in the group, to include offering sliding scale.
- E. Provide a facilitator to nurse ratio not to exceed 12 to 1.

3. Nurses are allowed six (6) absences per calendar year.

- A. A week will be added to the contract terms for every meeting absence above six (6) per calendar year.
- B. A pattern of missed meetings above the allotted six (6) may be considered material non-compliance and result in a referral to the NCQAC.

4. Peer Support Group Facilitators must:

- A. Have an active health care license and be in good standing with their licensing authority.
- B. Demonstrate knowledge and experience in the field of substance use disorders which may include mental health/co-occurring disorders.
- C. Have worked in their field for at least one year within the last three years OR has ~~Atat~~ least thirty (30) hours of continuing education in the area of chemical dependency or mental health.
- D. Have a minimum of twelve (12) months experience facilitating groups.
- E. Not have been a WHPS nurse within the past year (may co-facilitate with WHPS approval).
- F. Not be a direct treatment provider for a nurse.
- G. Provide a WHPS approved alternate facilitator that is not a member of the Professional Peer Support Group.

H. Have a signed Professional Peer Support Group Facilitator Agreement on file with WHPS.

I. Have a minimum of three (3) years continuous recovery -, if in recovery.

J. Submit monthly reports on each nurse verifying attendance and recovery status.

5. The Director of WHPS verifies compliance with these procedures and retains copies of the PSG facilitator applications and agreements for verification.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Graduation	Number:	W 16.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PROCEDURE: In order to be eligible to graduate, nurses must demonstrate the following:

1. Graduation
In order to successfully graduate from the WHPS program, the nurse must:
 - A. Comply with all aspects of their monitoring contract for the previous two years.
 - B. Complete the Transition Contract with no non-compliance issues.
 - C. Submit a written request for discharge, discussing their recovery and including a relapse prevention plan for their own benefit and use after discharge.
 - D. Submit letters of support for discharge from their Work Site Monitor and Professional Peer Support Group facilitator, and if applicable, their sponsor and therapist.
 - E. Case staffing is completed to verify eligibility to graduate.
2. WHPS sends written notification of the nurse's successful completion to:
 - A. The nurse with a certificate of completion and program evaluation survey
 - B. The Work Site Monitor
 - C. The Professional Peer Support Group Facilitator
 - D. If applicable, NCQAC and legal authorities
3. All physical and electronic records will be updated to reflect graduation status.

4. The nurse will be sent the Program Participation Survey: [\(See Attachment A\)](#).
5. Outside of significantly compelling circumstances (e.g., relocation to another state with only a few months left on a contract) early graduation requests will not be granted.
6. WHPS reserves the right to extend a nurse's contract when Case Management review identifies concerns such as, but not limited to; recent contract non-compliance, relapse behaviors, the worksite monitor and/or peer support group facilitator report concerns about the nurse's competency.

~~Add survey as appendix~~

DRAFT

ATTACHMENT A



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Washington Health Professional Services

Post Office Box 47872 • Olympia, Washington 98504-7872 • whps@doh.wa.gov • Tel 360.236.2880 • Fax 360.664.8588

PROGRAM EVALUATION

Directions: Rate the following items you found helpful or non-helpful to recovery. Please complete questions on reverse side of this evaluation. Thank you.

	Least Helpful				Most Helpful
Program Components					
Counseling	1	2	3	4	5
Monthly Self Reports	1	2	3	4	5
Work-site Monitor	1	2	3	4	5
AA/12 Step Meetings	1	2	3	4	5
Attendance Cards	1	2	3	4	5
Urine Drug Screens	1	2	3	4	5
Continuing Education	1	2	3	4	5
Mandatory Treatment	1	2	3	4	5
Professional Support Group	1	2	3	4	5
Program Affiliation					
Connection to Program	1	2	3	4	5
Contact with Case Manager	1	2	3	4	5
Contact with Program	1	2	3	4	5
Program Structure/Contract	1	2	3	4	5
Availability of Case Manager	1	2	3	4	5
Other					
Peer Support	1	2	3	4	5
Network Support	1	2	3	4	5
Reentry/Practice Restrictions	1	2	3	4	5

Profession _____

Length of time in WHPS program _____

Was the WHPS program helpful to your recovery? _____

Did you experience relapse while in the WHPS program? _____

If so, how many times? _____

Additional comments about your experience in the WHPS program: _____

Suggestions for improvement: _____

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Drug and Alcohol Testing	Number:	W 17.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 8, 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: WHPS randomly tests body fluid, hair, nail or other biological samples. Nurses may schedule or request body fluid, hair, nail or other biological sample tests at any time.

“Studies reflect that health care and other professionals who are subject to a monitoring agreement with significant consequences for non-compliance have a lower relapse rate than the general population” (McLellan, Skipper, Cambell, & DuPont, 2008; DuPont, McLellan, White, Merlo, & Gold, 2009; Knight, Sanchez, Sherritt, Bresnahan, & Fromson, ~~2009~~2007). Substance Use Disorder in Nursing, National Council of State Boards of Nursing, 2011, p.140-141.

PROCEDURE

1. Random Testing

A. The basic annual urine testing scheme for high risk professionals is:

Nurse Status	Minimum #/Year
Not working	12-18
Working	18-24
Transition year	12-18

i. Test schemes may be increased decreased, or modified (e.g., adding hair, nail, or blood tests) at the discretion of the Case Manager. The Case Manager may request additional testing any time there is reasonable cause to believe that the nurse may be at risk for relapse.

ii. Due to the increased risk of relapse associated with some specialties and work circumstances (e.g., anesthesiology, oncology, emergency room), these nurses may be required to submit additional testing including routine hair or nail testing.

B. Additional testing may be requested any time there is reasonable cause to believe that the nurse may be at risk for relapse.

C. Once WHPS establishes a Nurse Contract, the nurse must activate their drug screening service account prior to their first scheduled check-in date. Nurses are required to check-in Monday through Friday between the hours of 5:00 a.m. and 4:59 p.m. for testing notification. Two methods of daily check-in are available:

- i. Using the username and password provided to activate the account, OR
- ii. By calling the Interactive Voice Response (IVR) system.

D. Nurses must test on the same calendar day as the request in order to maintain contract compliance.

E. Collections will be observed. However, not all collection sites offer observed collection services. If observed collection is not available, a dry room setting will be utilized.

F. Nurses are responsible for payment of the drug screen and fees for collection at the time of notification. WHPS recommends a minimum account balance of \$100.00.

WHPS believes the inability to test due to finances is not acceptable justification for not testing. However, WHPS maintains an exigency account that may be used to loan nurses funds to cover the immediate cost of testing on a one time basis. This account may only be used with approval from the Director or designee.

G. Lab test results will be electronically posted and reviewed daily.

2. Hair Testing

A. Situations may necessitate hair (or other matrix) testing in order to augment evaluation or monitoring. WHPS is aware of the cost burden of these tests and will be judicious in their use. Situations that may require hair (or other matrix) testing includes but are not limited to:

~~A.1.~~ Nurse is unable to submit urine toxicology screen due to work or other limitations on a regular basis.

2. A third party evaluator recommends hair testing.

B. Nurse returns to active monitor after a period of absence.

C. WHPS requires a hair test when a nurse submitted (Procedures ~~18.01, 19.01~~ W18, W19 and 20.01 ~~W20~~)

- Four dilute urines within three (3) months or four (4) abnormal test specimens within six (6) months,
- A 2nd out of temperature specimen, or
- A substituted or adulterated specimen, or

D. The nurse has particular work or personal circumstances that increase or point to the risk of relapse including, but not limited to:

- Use history and past issues of non-compliance~~;~~.
- Working in high, risk settings (i.e. home health)~~;~~.
- Working in high risk profession (e.g. CRNA)~~;~~.
- WSM reports of concern.

3. Medical Review Officer (MRO) Review

WHPS offers nurses the ability to obtain MRO services through Affinity Online Solutions. The nurse may also obtain personal MRO services.

Requesting MRO services through Affinity Online Solutions:

A. The nurse requests MRO services through WHPS and deposits the service fee in their account.

B. WHPS verifies that the service fee has been deposited.

C. WHPS contacts Affinity Online Solutions to request an MRO review and verify that nurse funds are available.

D. AOS posts the MRO report in the nurse's electronic record.

4. Monitoring Interruption

Nurses should notify WHPS at least two (2) weeks prior to being away from their home/work area. This allows nurses to request an interruption from their program for a vacation, medical leave, or education. When the nurse submits a Monitoring Interruption request is submitted, the

Case Manager reviews the information. Any actions such as a suspension from the daily check-in requirement or drug testing during the interruption period is solely at the discretion of the Case Manager.

5. A compliance audit report capturing all instances of non-compliance with drug screens will be generated monthly. This summary report lists all positive screens not covered by valid prescriptions, all missed check-ins, missed tests, dilute, abnormal and out of temperature, and substituted or adulterated specimens, and actions taken by staff. The Director will review this report with each team individually or as a group to assure immediate and accurate responses are consistently applied.

6. The Director reviews the compliance audit report with the Associate Director, Operations/Licensing on a monthly basis. The Director also monthly shares the report with the Substance Use Disorder **Panel Team** of the NCQAC. Actions as a result of the positive screens are shared to demonstrate shared accountability for the nurses in the program.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION**
PROCEDURE

Title:	Missed Check-ins and Tests	Number:	W 18.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: WHPS holds the nurse responsible to check-in with the drug screening service, Monday-Friday, to determine if scheduled to test on that particular day. ~~The~~If selected, the nurse must test on that calendar day. It is the nurse's responsibility to know the operating hours of the selected collection site(s).

WHPS checks the electronic "Alert" notifications on a daily basis to identify missed check-ins and tests.

PROCEDURE

1. **Missed Check-Ins** – The nurse must check in to determine if they are to test. If the nurse does not check in, this is considered a missed check in. **If the nurse did not check in, and is scheduled for a test, go immediately to 2. Missed Test.**
 - A. The first missed check-in results in the nurse being notified and reminded that missed check-ins are a non-compliance issue and that further missed check-ins will result in additional testing.
 - B. The second and any subsequent missed check-ins will result in a test being scheduled and the testing frequency increased after the second missed check-in.

C. The third missed check-in within a three (3) month period will result in a non-compliance notice being sent, the WSM being notified, possible request to cease practice, and confirming that additional missed check-ins will result in referral to NCQAC.

D. A continued pattern of missed check-ins constitutes material non-compliance and will result in a referral to the NCQAC.

2. **Missed Tests** – **According to the** (See Substance Use Disorder in Nursing, National Council of State Boards of Nursing, 2011, p. 142 – 144).

A. The Case Manager verifies with the nurse that they did not test on the selection date. **A missed test is considered an instance of significant material non-compliance unless otherwise resolved through verification of extenuating circumstances (i.e., employer substantiation of inability of the nurse to leave the worksite to test).**

B. Lack of funds is not a justification for missing a test.

C. The Case Manager schedules an observed drug screen (Panel H or as appropriate for drugs of concern), requests the nurse test within two hours, and increases test frequency.

D. The Case Manager informs the WSM of the missed test. In most cases the nurse will be permitted to continue practice with employer agreement. However, depending on the circumstances, (e.g. nurse is not immediately available to test) WHPS may request the nurse cease practice until further determination. The Case Manager sends a notice of non-compliance.

E. The second missed test results in scheduling an observed test within two (2) hours, notification of WSM, possible cease practice request, and ~~a notice of non-compliance verifying third missed test. If there is a third missed test, the Case Manager will report to NCQAC. will be reported to the NCQAC.~~

F. Nurses will be required to obtain a chemical dependency evaluation and enter into recommended treatment after the second missed test.

G. Additional testing (hair, nail, and blood) may be required and testing frequency may be increased for a period determined by WHPS.

3. ~~The third unexcused missed test results in~~ After referral to the NCQAC. **The, the** nurse remains in the WHPS program and continues to comply with their schedule for tests.

4. For drug screens, see Substance Use Disorder in Nursing, National Council of State Boards of Nursing, 2011, p.154-155.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Positive Drug Screen Results	Number:	W 19.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PROCEDURE

1. The Case ~~manager~~Manager (CM) reviews positive drug screen reports on a daily basis and not more than 24 hours after posting.
2. The Case Manager Associate:
 - A. Prints the test report.
 - B. Checks for a current prescription that might account for the positive result.
 - C. Records the positive (unauthorized substance use) in AOS case notes and subject title.
 - D. Enters an AOS chart note.
3. If there is no prescription form in the file, the Associate informs the ~~Case Manager~~CM who immediately contacts the participant. If the positive test is the result of a prescribed medication, the case manager instructs the nurse to contact their prescriber to FAX the prescription form to WHPS that day.

| 4. If the participant denies use, the ~~Case Manager~~CM offers the opportunity to have the split/second sample tested by an independent laboratory and/or a Medical Review Officer (MRO) review.

5. If unauthorized substance use, or if the positive is for illicit substances, Procedure W 11.01, Unauthorized Substance Use.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Dilute and Abnormal Urine Specimens	Number:	W 20.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: Urine specific gravity below 1.003 in conjunction with a creatinine level lower than 20 mg/dl constitutes a dilute test. WHPS requires a re-test on all dilute specimens. A dilute test may result in cessation of practice until WHPS receives a verified negative result.

PROCEDURE

1. Dilute Specimens: All dilute specimens will have an observed test for the next day.
 - A. WHPS contacts the nurse and provides recommendations on how to avoid dilute specimens.
 - B. The Case Manager ([CM](#)) adds an observed test selection for the next day.
 - C. A second dilute within a three (3) month period results in a non-compliance notice being sent, request a written explanation from nurse for reason for dilute, frequency of testing may be increased, and contract time may be increased.
 - D. A third dilute specimen in a three (3) month period requires the nurse to undergo a medical evaluation to determine cause.

E. A fourth or subsequent dilute specimen after medical evaluation provides no cause, the ~~Case Manager~~CM schedules a hair test, notifies the WSM, ~~possibly requires the nurse to possibly~~ cease practice, attends a face to face evaluation with CM, and reports to NCQAC.

F. WHPS considers a ~~positive~~ dilute drug test as a valid positive result.

2. Abnormal Specimens: WHPS requires an observed, next day test for all abnormal specimens.

A. When either the specific gravity or creatinine level is below threshold the test, WHPS classifies the test as abnormal.

B. WHPS contacts the nurse and provides recommendations on how to avoid abnormal specimens. WHPS adds an observed test selection for the next day.

C. Repeated abnormal specimens: three (3) abnormal submissions within a six (6) month period result in additional testing and require the nurse to undergo a medical evaluation to determine cause.

D. A fourth or subsequent abnormal specimen after medical evaluation provides no cause, results in a hair test being scheduled, WSM notification, possible cease practice, face to face evaluation with CM, and report to NCQAC.

E. When an abnormal drug test result is positive, WHPS considers the test to be a valid positive result.

3. Out of Temperature Range Specimens

A. Urine specimens must be within 96 – 99 degrees F. at the time of collection.

B. WHPS immediately notifies the nurse of the out of temperature range specimen.

C. The ~~Case manager~~CM adds an observed test selection and requests the nurse to provide an observed specimen within two (2) hours of notification. The Case Manager sends a notice of non-compliance, requests a written explanation from the nurse for reason for out of temperature, increases testing frequency and considers increasing the contract time.

D. WHPS considers a second out of temperature specimen as a positive test.

E. WHPS considers a positive out of temperature range drug ~~teststest~~ as a valid positive test.

4. WHPS considers substituted or adulterated specimens as positive tests.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Policy and Procedure Review	Number:	W 21.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 8, 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

POLICY: The WHPS Director annually reviews the WHPS procedures to assure concurrence with program revisions. The WHPS Director presents all revisions to the NCQAC Substance Use Disorder Team- (SUDT). The NCQAC Substance Use Disorder Team may present revisions to the NCQAC.

PROCEDURE:

A. Every January, the WHPS Director compares current best practices and policies with existing procedures.

B. The WHPS Director provides the updated procedures to the NCQAC ~~Substance Use Disorder Team~~ SUDT to review in order to assure program and regulatory congruence.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Reporting	Number:	W 22.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: WHPS ensures data integrity and statistical accuracy in order to accurately review past performance, to assist in identifying business needs, support data-driven decisions, and improve business operations.

PROCEDURE

1. The WHPS Director compares statistical reports from two databases, which includes the AOS database, for accuracy and consistency of data.
2. WHPS generates monthly and annual reports and tracks nurse status by:
 - Profession (LPN, RN, ARNP and CRNA)
 - Stage of participation (case-in-development, monitoring, closure)
 - Type of admission (in lieu of discipline, discipline and voluntary)
3. The ~~WHPs~~WHPS Director tracks all performance measures and reports results to the NCQAC Substance Use Disorder Team.

4. WHPS Case Managers complete and file monthly reports of all outreach and educational efforts.

5. WHPS performs a monthly performance audit to include summary and non-compliance information.

6. The monthly statistics and audit reports will be reviewed and discussed monthly with the NCQAC Substance Use Disorder Team.

7. The annual report to be used for the annual evaluation of the program should include:

- length of time to determine eligibility for participation.
- length of time between when the program receives the referral to the execution of the agreement.
- number and types of referrals.
- number of nurses participating (new and existing nurses).
- return to work rates and time lines for new and existing nurses.
- success rates (number of nurses who successfully completed program and number of nurses removed from practice in timely fashion) and reasons for removal.
- relapse rates and number of relapses.
- recidivism rates for completers.
- caseloads of case managers.
- internal quality assurance frequency and findings.
- responses of case managers to non-compliance & relapse issues.
- confirmation that required documents can be tracked and verified.
- external audit findings of performance.
- legal or financial components as directed by NCQAC.
- results of annual Policy and Procedure review with NCQAC.
- policy recommendations to the NCQAC.
- educational outreach plans and reports.
- program direction to assure that decisions are congruent with current research, knowledge, best practices and compliance with legislative and NCQAC directives.
- annual summary of performance measures.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Security	Number:	W 23.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PROCEDURE PURPOSE: Certain information collected and maintained by the WHPS program is required to be confidential and protected from disclosure. WHPS staff must maintain this confidentiality. Records must be secured to maintain this protection.

PROCEDURE

1. All WHPS staff computers are set for automatic lock at ten (10) minutes.
2. Staff locks their computer when away from their workstations.
3. Staff secures working files in cabinets/drawers while away from workstations during business hours.
4. The file room is to be locked at all times.
5. Staff maintains a clean desk by returning files to the File Room when they depart the office for the day.

6. Case staffing occurs in a secure area.
7. All electronic documents containing personal information will be stored in a secured WHPS file on the S: drive.
8. Received FAX documents are e-mailed to a secure WHPS e-mail account and not directly printed.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Relationships with NCQAC	Number:	W 24.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: WHPS will maintain ~~relationships~~ [relationship](#) with NCQAC by working collaboratively and exchanging appropriate information to better protect the public, to be fiscally responsible, and to foster communication to enhance work processes.

PROCEDURE:

WHPS staff:

1. Assign, monitor and evaluate cases as planned, requested and appropriate with Nursing Commission Unit staff and Substance Use Disorder Team and Assistant Attorneys General for NCQAC. WHPS maintains a written record of these cases, reasons for referral, discussion of all involved parties, and actions taken.
2. Report non-compliance and public safety issues in a memo to NCQAC as required in procedures. The memo includes comprehensive information on compliance history, actions taken by staff on any prior non-compliance events, specific non-compliance incident, actions taken by WHPS staff prior to referral, and whether the nurse may be a threat to public safety.

~~3. Provide participation status updates, i.e., intake, active participation, referrals, demographics, relapses, other program violations, referrals to NCQAC, nurses who sign new contracts and reasons, graduations, and recidivism rate on a monthly basis and as requested. Include monthly summary report and audits on performance and non-compliance issues. There will be performance measure reports at each NCQAC meeting.~~

4. Provide legal testimony as requested.
5. Coordinate procedure changes as appropriate.
6. Provide reports as required in law and rule.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Outreach and Education	Number:	W 25.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:			
	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: WHPS provides education and outreach to employers and employees in healthcare, professional organizations, drug courts, educational facilities and Department of Health. The desired outcome of these efforts is to protect the public by facilitating awareness and understanding of the disease of addiction, encouraging organizations and individuals to recognize WHPS as a resource, and to increase the utilization of the program by impaired providers.

PROCEDURE

NCQAC Substance Use Disorder Team and the WHPS Director will:

1. Identify organizations that would benefit from WHPS services.
2. Conduct needs analysis to identify target audiences.
3. Contact rural employers and offer consultation services.
4. Develop and facilitate educational presentations.
5. Develop and maintain a user friendly WHPS web-site.
6. Build and maintain a collaborative relationship with monitoring programs in Washington and other states.
7. Provide annual education plans and reports to include resources of time and staff.
8. Develop education and outreach goals.
9. Provide dates and locations of proposed education activities or offerings.
10. Determine the type and length of education to be provided such as orientation or formal workshop.
11. Determine educational methods: onsite, PowerPoint presentations, e-media offerings, written materials provided, e.g., flyers, brochures, research materials.
12. Request any formal contact hours in nursing to be awarded.
13. Determine methods of evaluation (posttest, written evaluations)
14. Suggest available resources for both materials and offerings.

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Office Hours and Standards	Number:	W26.01
Reference:	RCW 18.130.160; <u>RCW 18.130.175</u> WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 ⁸ , 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: WHPS provides accessible and timely services to protect the public and support the role as a trusted source of information.

PROCEDURE

1. WHPS is open for business Monday through Friday (excluding holidays) from 8am to 5pm.
2. WHPS staff provides continuous telephone coverage. When WHPS staff is not available calls are transferred to the NCQAC unit.
3. Staff keeps their calendars up-to-date.
4. Staff notifies the office when they will be away from their desk for an extended period of time.
5. When in the office, staff makes sure they are reasonably available to answer phones (limit use of headphones, personal calls, etc.). If involved in a project that will take away from responding to normal office duties, staff will coordinate with others to ensure coverage. Phone messages are to be returned within one (1) business day; email messages are to be answered within five (5) business days.
6. The WHPS Director considers staff requests to work from an alternative site. Requests must be submitted to the Director in advance.

7. If all assignments are completed before the end of shift staff are to check with their supervisor for additional assignments.

8. The WHPS Director ensures adequate administrative office coverage during business hours. Standard work hours are Monday – Friday, 8am – 5pm. Deviation from this schedule may be approved by the WHPS Director.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Program Evaluation	Number:	W 27.01
Reference:	RCW 18.130.160; RCW 18.130.175 WAC 246-840-750 through 246-840-780		
Contact:	Paula R. Meyer, MSN, RN, FRE Executive Director		
Effective Date:	January 16 8, 2016		
Supersedes:			
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE: The ~~WHP~~[WHPS](#) Director gathers information to evaluate the program/services and its perceived effectiveness. The WHPS Director ~~determines~~ reviews current practices and determines their relevancy to guide business decisions.

PROCEDURE

1. Program Evaluation Survey

WHPS participates in an annual Program Evaluation Survey in conjunction with Washington Recovery Assistance Program for Pharmacy (WRAPP) and the Washington Physicians Health Program (WPHP).

2. Graduation Survey

WHPS mails the Graduation Surveys with each certificate. The WHPS director discusses incentives to improve return rate [with Associate Director, Operations/Licensing](#), and assures nurses these are read and utilized for program improvement.

3. Internal Audit

The WHPS Director conducts monthly audits to determine accuracy and completeness of data in AOS by randomly selecting and evaluating thirty (30) case files. Additional reports on more

comprehensive data regarding established performance measures and QA compliance information may be included.

4. ~~Program Audits~~ WHPS participates in Disciplinary Program, division, and department audits as requested.
5. WHPS generates monthly program performance audits and program summary and non-compliance audits reports ~~will be generated.~~
6. The WHPS Director reviews all audits and reports with the NCQAC Substance Use Disorder Team to evaluate and improve program effectiveness.
7. The annual evaluation of the WHPS program can include all of the above in addition to the annual report.

DRAFT

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Substance Abuse Orders	Number:	A20. <u>909</u>
Reference:	RCW 18.130.160; RCW 18.130.175; RCW 18.130.170 ; RCW 18.130.180; WAC 246-840-780; WAC 246-840-770; WAC 246-840-740		
Contact:	Paula R. Meyer, Executive Director		
Effective Date:	January 8, 2016		
Supersedes:	September 12, 2014; April 14, 2000; July 15, 2000; March 11, 2005; July 1, 2005; September 9, 2011, September 13, 2013		
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

POLICY:

The Nursing Care Quality Assurance Commission (NCQAC) supports the following principles:

- Safeguarding the public’s health and safety is the paramount responsibility of NCQAC.
- NCQAC must first protect the public and then, if possible, remediate the nurse.
- Chemical dependency is a treatable condition.
- Where unprofessional conduct may be the result of substance use disorder, the nurse’s participation in a monitoring program immediately protects the public and allows the nurse to receive treatment and recover.
- Appropriate and effective treatment can save a professional's career, license, and even his/her life.
- Monitoring chemically impaired nurses requires specialized education and knowledge.
- Public protection is best addressed through consistent approaches to discipline.

While the NCQAC maintains full authority to tailor sanctions to individual cases, the approaches outlined below are strongly recommended.

PROCEDURE:

In cases where a nurse has committed unprofessional conduct, and the violation was likely the result of chemical dependency or substance use disorder, the nurse will be referred to the Washington Health Professional Services Program (WHPS).

1. A Reviewing Commission Member (RCM) evaluates all investigative files involving unprofessional conduct related to chemical dependency or substance use disorder. The RCM presents the case to a Case Disposition Review Panel ("Panel") for possible disciplinary action.
 - ~~The~~Prior to forwarding the investigative file to the RCM, the Panel may decide not to authorize discipline against a nurse's license so long as the nurse makes contact with the monitoring program within five (5) business days of signing a Substance Abuse Referral Contract (SARC) and complies with the terms of the monitoring contract. (See Procedure A49, Substance Abuse Referral Contracts). The nurse may be required to sign a SARC in accord with WAC 246-840-780 as a precondition of the Panel's decision to close the case without disciplinary action. Under these circumstances, the nurse enters the monitoring program "in lieu of discipline," and the case is closed as a "Unique Closure."
 - If a complaint investigation reveals evidence of chemical dependency or substance use disorder, but the nurse has not agreed to a SARC, then the NCQAC may offer a Statement of Allegations with a Stipulation to Informal Disposition (STID) to enter WHPS.
 - In the event the investigation reveals serious misconduct, the NCQAC takes disciplinary action to protect the public. Serious misconduct may include, but not be limited to:
 - Abuse of a patient.
 - Theft of money or property (other than drugs) from a patient or family member.
 - Arrest or conviction as defined in Policy A21.
 - Sexual contact or boundary violations as defined in WAC 246-840-740.
 - Gross incompetence seemingly not related to drug or alcohol abuse.
 - Diversion of drugs by replacing a drug with another substance (tampering).
 - This procedure does not prohibit expedited case closure at the case management level when appropriate per existing ~~policy~~Procedure A22.
2. If a nurse enters the monitoring program voluntarily and is referred to the NCQAC for noncompliance with the monitoring contract, the case may be assessed by a Substance Use ~~and Abuse Disorder~~ Team (SUDT) in order to expedite case resolution. If there is no evidence of misconduct related to nursing practice or there is insufficient evidence to proceed with any action, the case will be closed under the appropriate closure code and remain closed.

3. If a nurse who initially entered the monitoring program in lieu of discipline or under a STID is referred back to the NCQAC by the monitoring program for noncompliance with the terms of the monitoring contract, a ~~Substance Use and Abuse Team (SUAT)~~SUDT will assess the case and make a recommendation about setting the case's priority and the appropriate scope of the investigation. If there is evidence of unprofessional conduct, the NCQAC should serve a Statement of Charges (SOC), and propose an Agreed Order (AO). The SOC may cite the underlying drug related unprofessional conduct as well as any unprofessional conduct pertaining to the noncompliance. Additionally, if the nurse signed a Substance Abuse Referral Contract as a condition of the Panel's decision to uniquely close the original case, the NCQAC may also cite violation of the Substance Abuse Referral Contract, which is a violation of RCW 18.130.180 (7) and WAC 246-840-780. If the nurse is eligible to re-enter the monitoring program, the AO shall state the condition that they enter into a new monitoring contract, and comply with any and all required treatment and monitoring conditions. The terms of the AO will be satisfied when the nurse successfully completes the approved monitoring program.

4. If an AO is entered, but the nurse fails to comply with the requirements of the monitoring program, and is not eligible to re-enter the monitoring program, the NCQAC proceeds with a Motion For Hearing On Noncompliance (Fast Track) based upon substantial non-compliance with the AO. The action results in an unstayed suspension. To petition for reinstatement, the nurse must demonstrate:
 - ~~at~~At least 24 consecutive months of abstinence documented by random observed biological fluid testing, to include ~~ETG/ETSEtG/EtS~~ (at least 12 tests per year) and hair testing, if hair testing is deemed necessary by the Reviewing Commission Member, by an independent, licensed testing entity~~;~~.
 - ~~completion~~Completion of chemical dependency treatment~~;~~.
 - ~~participation~~Participation in professional peer support groups and NA/AA~~;~~and.
 - ~~a~~A recent (within 90 days of petitioning for reinstatement) chemical dependency evaluation by a NCQAC approved evaluator. The evaluation shall include:
 - ~~respondent's~~The nurse's condition or diagnosis~~;~~.
 - conclusions and prognosis~~;~~.
 - recommendations regarding the need for ongoing care and treatment~~;~~and.
 - professional opinion regarding ~~Respondent's~~the Nurse's ability to practice nursing with reasonable skill and safety.

5. If a nurse does not agree to an AO to enter into the monitoring program, but instead proceeds to a hearing where it is determined the nurse committed unprofessional conduct with a finding that the nurse misused drugs or alcohol or other finding substantiating a substance abuse problem, the NCQAC should not issue orders containing multiple substance abuse conditions, but rather:
 - In less serious cases, when approved by the Commission, the nurse may enter into an AO (settlement) to enter the monitoring program for monitoring and treatment.

- If the nurse does not agree to enter monitoring, or in more serious cases, the final order should result in an unstayed suspension, without the ability to petition for reinstatement for a minimum of 24 months. To petition for reinstatement, the nurse must demonstrate at least 24 consecutive months of abstinence documented by random observed biological fluid testing, to include ETG/ETS (at least 12 tests per year) and hair testing, if hair testing is deemed necessary by the Reviewing Commission Member, by an independent, licensed testing entity, completion of chemical dependency treatment, participation in professional peer support groups and NA/AA, and provide a recent (within 90 days of petitioning for reinstatement) chemical dependency evaluation by a commission - approved evaluator.
6. A Statement of Charges (SOC) should be issued in any case where the nurse obtained drugs in violation of RCW 18.130.180(6), including diversion or violation of any drug laws, where the evidence indicates the nurse is prescribing, selling, or distributing drugs to others and is not personally using or addicted.

DRAFT

DRAFT

~~SUBSTANCE ABUSE REFERRAL CONTRACT~~

~~A complaint(s) alleging unprofessional conduct has been filed with the Nursing Care Quality Assurance Commission (NCQAC) against _____, (Respondent). The Nursing Care Quality Assurance Commission has reason to believe that the alleged unprofessional conduct may be the result of substance use and/or abuse.~~

~~In return for Respondent entering the Washington Health Professional Services Program (WHPS), the NCQAC agrees to take no disciplinary action against Respondent's credential regarding case number/file number _____ as long as Respondent complies with all of the terms of this Substance Abuse Referral Contract and successfully completes the WHPS program.~~

~~By signing this Substance Abuse Referral Contract, Respondent admits to the truthfulness of the investigative report for case number/file number _____ and agrees to the admissibility of the evidence contained therein.~~

~~1. On or before five (5) business days of signing this Substance Abuse Referral Contract, Respondent must contact WHPS and begin the process of signing a WHPS Monitoring Contract and enrolling in the WHPS program.[†]~~

~~2. The length of the WHPS Monitoring Contract will be up to the sole discretion of the WHPS program. Contracts generally have a term of five (5) years. The WHPS program's recommendation to enter into a monitoring contract and the term of the monitoring contract is not based exclusively upon a substance abuse evaluation.~~

~~3. Respondent must execute a WHPS Monitoring Contract on or before forty five (45) calendar days of signing this Substance Abuse Referral Contract.~~

~~4. Respondent agrees to comply with all aspects of the WHPS program which may include, but are not limited to:~~

~~_____ (a) undergoing intensive substance abuse treatment in an approved treatment facility~~

~~_____ (b) remaining free of all mind altering substances including alcohol except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101~~

~~_____ (c) completing the prescribed aftercare, which may include individual and/or group psychotherapy~~

[†] Washington Health Professional Services
P.O. Box 47872
Olympia, WA 98504-7872
Phone: 360-236-2880 Fax: 360-664-8588
WHPS@doh.wa.gov

~~_____ (d) causing the treatment counselor(s) to provide reports that include treatment prognosis and goals to the WHPS program at specified intervals~~

~~_____ (e) submitting to random drug screening as specified by the WHPS program~~

~~_____ (f) attending recovery support groups as specified by the WHPS program~~

~~_____ (g) complying with specified employment conditions and restrictions as defined by the WHPS Monitoring Contract to include notifying WHPS and receiving approval prior to a change in work status, shift, employment position, or place of employment.~~

~~_____ (h) signing a waiver allowing the WHPS program to release information to the NCQAC if the nurse does not comply with the requirements of the WHPS Monitoring Contract or is unable to practice with reasonable skill or safety~~

~~5. Respondent is responsible for paying all costs associated with participation in WHPS~~

~~6. Respondent shall report to the NCQAC if he/she fails to comply with this Substance Abuse Referral Contract or with his/her WHPS Monitoring Contract.~~

~~7. Respondent will be subject to disciplinary action under RCW 18.130.160 if he/she does not comply with all aspects of the WHPS program, his/her specified employment restrictions, or this Substance Abuse Referral Contract.~~

~~_____
RESPONDENT _____ DATE _____ LICENSE NUMBER _____~~

~~_____
PANEL CHAIR _____ DATE _____~~

~~_____
WHPS REPRESENTATIVE _____ DATE _____~~

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Substance Abuse Referral Contracts	Number:	A49.02
Reference:	RCW 18.130.170; RCW 18.130.180		
Contact:	Mary Dale, Discipline Manager		
Effective Date:	September 13, 2013 <u>January 8, 2016</u>		
Supersedes:	January 11 <u>September 13, 2013</u>		
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE STATEMENT: The purpose of this procedure is to set up guidelines for the management of cases in which the respondent nurse admit to a substance abuse issue and agree to enter the Washington Health Professional Services Program (WHPS). After review by the Commission, the case may be closed as a unique closure in compliance with policy A20, Substance Abuse Orders.

PROCEDURE

1. During an investigation, the investigator determines whether unprofessional conduct may be the result of substance abuse. The investigator may send a Substance Abuse Referral Contract (SARC) to the respondent nurse immediately if the case meets all of the following criteria:

- The respondent nurse admits, in writing, to misuse of controlled substances, alcohol, or other drugs.
- The unprofessional conduct does not rise to the level of “serious misconduct” as identified in NCQAC policy A20.
- The respondent nurse has not been previously referred to WHPS in lieu of discipline or ordered into the program.

If the respondent nurse has previously participated in WHPS, the file will be referred to the Substance Use and Abuse Disorder Team (SUATSUDT) for an evaluation and a recommendation to the Commission.

2. The investigator sends a SARC to the respondent nurse for signature.
- If the respondent nurse signs the SARC, the investigator then ensures it is signed by a WHPS case manager.

- If the respondentnurse refuses to sign the SARC, the investigator completes the investigation as usual.

3. The case file is sent to Case Management after the investigation is completed.

- If the respondentnurse does not have a WHPS contract in place, SUATSUDT administrative personnel checks the WHPS contract status immediately and then every three weeks afterwards.
 - If the respondentnurse does not have a WHPS contract in place after 45 days, as required by the SARC, the case is taken back to SUATSUDT for recommendation to the Commission.
- If/when the respondentnurse signs a WHPS contract, the case is presented to the Case Management panel for Unique Closure.
 - If approved for Unique Closure, the original SARC is signed by a CMT panel member or its designee.
- The Commission considers the case for possible discipline:
 - If the respondentnurse refused to sign the SARC, or
 - If the respondentnurse has not signed a WHPS contract within 45 days of signing the SARC.

If a respondentnurse is in WHPS in lieu of discipline (with a SARC in place) and the respondentnurse is terminated from WHPS, within five business days of receipt of the WHPS closure letter:

- SUAT administrative personnel opens a new complaint in the Integrated Licensing & Regulatory System (ILRS).
- SUAT performs an assessment/triage. Items considered during the triage include:
 - WHPS closure letter
 - Prior investigative report(s)
 - SARC (if any)

SUAT administrative personnel writes a recommendation to the Commission based on the triage notes. The new complaint, including the SUAT recommendation, is given to the NCQAC Complaint Intake to continue with the regular complaint process.

[ATTACHMENT- SUBSTANCE ABUSE REFERRAL CONTRACT \(SARC\)](#)

SUBSTANCE ABUSE REFERRAL CONTRACT

A complaint(s) alleging unprofessional conduct has been filed with the Nursing Care Quality Assurance Commission (NCQAC) against _____, (the Nurse). The Nursing Care Quality Assurance Commission has reason to believe that the alleged unprofessional conduct may be the result of substance use and/or abuse.

In return for the Nurse entering the Washington Health Professional Services Program (WHPS), the NCQAC agrees to take no disciplinary action against the Nurse's credential regarding case number/file number _____ as long as the Nurse complies with all of the terms of this Substance Abuse Referral Contract and successfully completes the WHPS program.

By signing this Substance Abuse Referral Contract, the Nurse admits to the truthfulness of the investigative report for case number/file number _____ and agrees to the admissibility of the evidence contained therein.

1. On or before five (5) business days of signing this Substance Abuse Referral Contract, the Nurse must contact WHPS and begin the process of signing a WHPS Monitoring Contract and enrolling in the WHPS program.²

2. The length of the WHPS Monitoring Contract will be up to the sole discretion of the WHPS program. Contracts generally have a term of five (5) years. The WHPS program's recommendation to enter into a monitoring contract and the term of the monitoring contract is not based exclusively upon a substance abuse evaluation.

3. The Nurse must execute a WHPS Monitoring Contract on or before forty-five (45) calendar days of signing this Substance Abuse Referral Contract.

4. The Nurse agrees to comply with all aspects of the WHPS program which may include, but are not limited to:

(a) undergoing intensive substance abuse treatment in an approved treatment facility.

(b) remaining free of all mind-altering substances including alcohol except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101.

(c) completing the prescribed aftercare, which may include individual and/or group psychotherapy.

² Washington Health Professional Services
P.O. Box 47872
Olympia, WA 98504-7872
Phone: 360-236-2880 Fax: 360-664-8588
WHPS@doh.wa.gov

_____ (d) causing the treatment counselor(s) to provide reports that include treatment prognosis and goals to the WHPS program at specified intervals.

_____ (e) submitting to random drug screening as specified by the WHPS program.

_____ (f) attending recovery support groups as specified by the WHPS program.

_____ (g) complying with specified employment conditions and restrictions as defined by the WHPS Monitoring Contract to include notifying WHPS and receiving approval prior to a change in work status, shift, employment position, or place of employment.

_____ (h) signing a waiver allowing the WHPS program to release information to the NCQAC if the nurse does not comply with the requirements of the WHPS Monitoring Contract or is unable to practice with reasonable skill or safety.

5. _____ The Nurse is responsible for paying all costs associated with participation in WHPS.

6. _____ The Nurse shall report to the NCQAC if he/she fails to comply with this Substance Abuse Referral Contract or with his/her WHPS Monitoring Contract.

7. _____ The Nurse will be subject to disciplinary action under RCW 18.130.160 if he/she does not comply with all aspects of the WHPS program, his/her specified employment restrictions, or this Substance Abuse Referral Contract.

_____ NURSE _____ DATE _____ LICENSE NUMBER

_____ PANEL CHAIR _____ DATE

_____ WHPS REPRESENTATIVE _____ DATE



PROPOSED RULE MAKING

CR-102 (June 2012)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

Agency: Department of Health- Nursing Care Quality Assurance Commission

- Preproposal Statement of Inquiry was filed as WSR 14-21-007 ; or
- Expedited Rule Making--Proposed notice was filed as WSR _ ; or
- Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

- Original Notice
- Supplemental Notice to WSR
- Continuance of WSR

Title of rule and other identifying information: (Describe Subject)

WAC 246-840-125 and WAC 246-840-202 through -207, Retired Active Credential and Nurse Continuing Competency. Reorder and renumber sections. Review, update, clarify, and modify existing standards; create exemptions for those seeking advanced nursing degrees; and incorporate new suicide prevention training requirements.

Hearing location(s): CenterPoint Conference Center
20425 72nd Ave S
Kent, WA 98032

Date: 11/13/15

Time: 2:30

Submit written comments to:

Name: Teresa Corrado, Licensing Manager

Address: P.O. Box 47864

Olympia, WA 98504

e-mail: <http://www3.doh.wa.gov/policyreview/>

fax 360-236-4738

by (date) 11/02/2015

Assistance for persons with disabilities: Contact

Bobbi Allison by 11/02/2015

TTY (800) 833-6388 or () 711

Date of intended adoption: 11/13/2015

(Note: This is NOT the effective date)

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

The proposed rule creates an extension and changes the results of those who fail to meet continuing competency requirements, resulting in disciplinary action rather than completion of a refresher course. It also changes the time of audit to be prior to renewal rather than after. The sections are reordered and renumbered for improved readability. Definitions are updated. The updates establish audit exemptions for those nurses enrolled in an advanced nursing program beyond pre-licensure. The rules implement suicide prevention legislation and deleted language regarding self-assessment and reflection as it is not enforceable.

Reasons supporting proposal:

The proposed rules improve and clarify the audit process for better compliance and increase readability. They provide support to nurses furthering their nursing education and implement legislation for suicide prevention training. The proposal simplifies rules by removing non-enforceable requirements, improving consistency throughout the rules and giving due process for those failing to meet the continuing competency requirements.

Statutory authority for adoption:

RCW 18.79.110 and RCW 43.70.442

Statute being implemented:

RCW 18.79.110 and RCW 43.70.442

Is rule necessary because of a:

Federal Law?

Yes

No

Federal Court Decision?

Yes

No

State Court Decision?

Yes

No

If yes, CITATION:

CODE REVISER USE ONLY

**OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED**

DATE: September 30, 2015

TIME: 4:54 PM

WSR 15-20-055

DATE 09/30/2015

NAME (type or print)

Paula R. Meyer, MSN, RN, FRE

SIGNATURE

Paula R. Meyer MSN, RN, FRE

TITLE

Executive Director, NCQAC

(COMPLETE REVERSE SIDE)

NCQAC Business Meeting

November 13, 2015

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:

None

Name of proponent: (person or organization) Nursing Care Quality Assurance Commission

- Private
 Public
 Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Teresa Corrado	111 Israel RD SE Tumwater, WA 98501	360-236-4708
Implementation.... Teresa Corrado	111 Israel RD SE Tumwater, WA 98501	360-236-4708
Enforcement..... Teresa Corrado	111 Israel RD SE Tumwater, WA 98501	360-236-4708

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

Yes. Attach copy of small business economic impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone

fax

e-mail

No. Explain why no statement was prepared.

A small business economic impact statement was not prepared. The proposed rule would not impose more than minor costs on businesses in an industry.

Is a cost-benefit analysis required under RCW 34.05.328?

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name: Teresa Corrado

Address: 111 Israel RD SE Tumwater, WA 98501

phone 360-236-4708

fax 360-236-4738

e-mail teresa.corrado@doh.wa.gov

No: Please explain:

WAC 246-840-125 Retired active credential. (1) A registered or licensed practical nurse may place their credential in "retired active" status by meeting the requirements of this section.

(2) A registered or licensed practical nurse who holds a retired active credential may only practice in intermittent or emergent circumstances.

(a) Intermittent means the registered or licensed practical nurse will practice no more than ninety days a year.

(b) Emergent means the registered or licensed practical nurse will practice only in emergency circumstances such as earthquakes, floods, times of declared war, or other states of emergency.

(3) To obtain a retired active credential a registered or a licensed practical nurse must:

(a) Meet the requirements in WAC 246-12-120.

(b) Pay the appropriate fee in WAC 246-840-990.

(4) To renew a retired active credential the registered nurse or licensed practical nurse must:

(a) Meet the requirements in WAC 246-12-130. The retired active credential fee is in WAC 246-840-990.

(b) Have completed forty-five hours of continuing nursing education every three years in compliance with WAC ~~((246-840-203(1)(a)(iii)(A) through (F)))~~ 246-840-220 (2)(b). Education may include CPR and first aid.

(c) Demonstrate they have practiced at least ninety-six hours every three years. Practice may be paid or volunteer, but must require nursing knowledge or a nursing license.

(d) Renew their retired active credential every year on their birthday.

(5) To return to active status the registered or licensed practical nurse must:

(a) Meet the requirements in WAC 246-12-140. The active renewal fee is in WAC 246-840-990.

(b) Meet the continuing competency requirements in WAC ~~((246-840-205))~~ 246-840-230 (5)(d).

(6) A registered or licensed practical nurse who holds a retired active credential is subject to a continuing competency audit((-

~~(a) All late renewals and a percentage up to five percent of registered and licensed practical nurses renewing their license may be audited by the commission.~~

~~(b) A registered or practical nurse being audited will have thirty calendar days to complete and submit to the commission the audit form documenting at least ninety-six hours of active practice, and forty five hours of continuing nursing education every three years. Active practice hours are not to exceed ninety days each year.~~

~~(c) To document practice hours and continuing nursing education a registered or licensed practical nurse shall comply with WAC 246-840-206 (4) and (5))~~ as outlined in WAC 246-840-220, 246-840-230, and 246-840-240.

NEW SECTION

WAC 246-840-200 Continuing competency purpose statement. Patients, families, and communities expect safe, competent, and compassionate nursing care. WAC 246-840-200 through 246-840-260 establish a self-directed continuing competency program which includes participation in active practice and continuing nursing education for registered nurses and licensed practical nurses as a mechanism to help keep patients safe and improve nursing practice.

NEW SECTION

WAC 246-840-210 Continuing competency definitions. The definitions in this section apply throughout WAC 246-840-200 through 246-840-260 unless the context clearly requires otherwise.

(1) **"Active nursing practice"** means engagement in paid, unpaid, or volunteer activity performing acts requiring substantial nursing knowledge, judgment, and skills described under RCW 18.79.040, 18.79.050, and 18.79.060. Active nursing practice may include, but is not limited to, working as an administrator, quality manager, policy officer, public health nurse, parish nurse, home health nurse, educator, consultant, regulator, and investigator or case manager.

(2) **"Advanced nursing degree"** means education preparation beyond one's initial education for nurse licensure.

(3) **"Attestation"** means the affirmation by signature of the nurse indicating compliance with the standards and terms of the continuing competency requirements.

(4) **"Compliance audit"** means a review of documents to determine whether the nurse has fulfilled the requirements in WAC 246-840-220 through 246-840-260.

(5) **"Continuing competency"** is the ongoing ability of a nurse to maintain, update and demonstrate sufficient knowledge, skills, judgment, and qualifications necessary to practice safely and ethically in a designated role and setting in accordance with the scope of nursing practice. A nurse achieves continuing competency through active practice and continuing nursing education.

(6) **"Continuing nursing education"** refers to systematic professional learning experiences obtained after initial licensure and designed to augment the knowledge, skills, and judgment of nurses and enrich nurses' contributions to quality health care and the pursuit of professional career goals, related to a nurse's area of professional practice, growth and development.

(7) **"Nurse"** means a registered nurse and licensed practical nurse.

(8) **"Review period"** is three full licensing renewal cycles. For purposes of a compliance audit, the review period will be the three years preceding the audit due date.

(9) **"Technical assistance"** means guidance provided by commission staff to help the nurse comply with laws and rules.

NEW SECTION

WAC 246-840-220 Continuing competency requirements—Active status. (1) At the end of the three-year continuing competency cycle, a nurse must attest on a form provided by the department of health declaring completion of the required active nursing practice hours and continuing nursing education hours.

(2) The nurse must complete, within each three-year review period:

(a) A minimum of five hundred thirty-one hours of active nursing practice; and

(b) A minimum of forty-five hours of continuing nursing education.

(3) A nurse will have a full three years to meet the requirements in subsections (1) and (2) of this section. The hours may be accumulated at any time throughout the three-year review period. The review period begins on the licensee's first birthday after receiving the initial license.

(4) Nurses must complete a qualified suicide prevention training as follows:

(a) Beginning January 1, 2016, registered nurses, except for registered nurses holding an active certified registered nurse anesthetist license, and licensed practical nurses must complete a one-time training in suicide assessment, treatment, and management from a qualified suicide prevention training program. The training must be completed by the end of the first full continuing competency reporting period after or during the first full continuing competency reporting period after initial licensure, whichever is later.

(b) Beginning July 1, 2017, a qualified suicide training program must be on the model list, required under RCW 43.70.442, to be accepted.

(c) A qualified suicide prevention training program must be an empirically supported training including assessment treatment and management, and must be at least six hours in length which may be provided in one or more sessions.

(d) The hours spent completing a qualified training program in suicide assessment, treatment, and management under this section counts toward continuing competency requirements in subsection (2)(b) of this section.

(5) Nurses who are enrolled in, or have completed prerequisite classes for, an advanced nursing education program are exempt from the continuing competency requirements during their current review period. A final transcript or transcript of classes documenting current progress towards an advanced degree will be required by the commission for approval of the exemption.

NEW SECTION

WAC 246-840-230 Continuing competency audit process and compliance. (1) The commission shall conduct a compliance audit:

(a) On all late renewals if continuing competency requirements under WAC 246-840-220(2) are due;

- (b) Through random selection; and
 - (c) At the discretion of the commission, on nurses under the disciplinary process.
- (2) The commission will notify a nurse selected for compliance audit at the address on record with the department. For a nurse selected randomly, notification will be sent with the renewal notice.
- (3) The nurse must submit continuing education in clock hours.
- (4) When the nurse is unable to document compliance with WAC 246-840-220, technical assistance may be provided.
- (5) If the nurse is unable to provide the required documentation of compliance with WAC 246-840-220, the nurse may elect to:
- (a) Place his or her license on inactive status as outlined in WAC 246-840-120;
 - (b) Let his or her license expire;
 - (c) Request an extension under WAC 246-840-240;
 - (d) Enter into an agreement, on a form provided by the commission, to complete a minimum of one hundred seventy-seven hours of active nursing practice and fifteen hours of continuing nursing education within one year. A compliance audit will be conducted at the end of the year to ensure compliance with the agreement.
- (6) Failure to complete the required hours and provide the required documentation, or intentional deceit, fraud, or misconduct in reporting continuing competency may result in discipline for unprofessional conduct under RCW 18.130.180.

NEW SECTION

WAC 246-840-240 Extension. A nurse who does not meet continuing competency requirements in WAC 246-840-220 within the three-year audit review period may request an extension of up to one year to allow the nurse to complete the remaining hours. The commission will conduct an audit at the end of the extension period to ensure compliance. In order to qualify for an extension, a nurse must agree to complete the remaining practice and continuing education hours within one year or less. If the remaining active nursing practice hours and continuing nursing education hours are not completed within one year, the commission will refer the nurse for disciplinary action.

NEW SECTION

WAC 246-840-250 Continuing competency requirements—Reactivation from expired status. (1) All nurses applying for reactivation must meet the requirements of chapter 246-12 WAC, Part 2 and WAC 246-840-111.

(2) If a license is expired for more than one year, the nurse must provide evidence of five hundred thirty-one hours of active nursing practice in any United States jurisdiction, and forty-five hours of continuing nursing education in the last three years.

(3) If the nurse cannot provide the evidence required in subsection (2) of this section, the nurse shall agree, on the form provided

by the commission, to complete a minimum of one hundred seventy-seven hours of active nursing practice and fifteen hours of continuing nursing education within the first year following reactivation. The commission will conduct an audit at the end of the year to ensure compliance with the agreement.

(4) If the practice hours and continuing nursing education hours required in this section are not completed within one year of reactivation, the commission will refer the nurse for disciplinary action.

NEW SECTION

WAC 246-840-260 Continuing competency requirements—Reactivation from inactive status. (1) All nurses applying for reactivation must meet the requirements of chapter 246-12 WAC, Part 4 and WAC 246-840-120.

(2) If a license is inactive for more than one year, the nurse must provide evidence of five hundred thirty-one hours of active nursing practice in any United States jurisdiction, and forty-five hours of continuing nursing education in the last three years.

(3) If the licensee cannot provide the evidence required in subsection (2) of this section, the nurse shall agree, on a form provided by the commission, to complete a minimum of one hundred seventy-seven hours of active nursing practice and fifteen hours of continuing nursing education within the first year following reactivation. The commission will conduct an audit at the end of the year to ensure compliance with the agreement.

(4) If the active nursing practice hours and continuing nursing education hours required in this section are not completed within one year of reactivation, the commission will refer the nurse for disciplinary action.

REPEALER

The following sections of the Washington Administrative Code are repealed:

- | | |
|-----------------|---|
| WAC 246-840-201 | Continuing competency purpose statement. |
| WAC 246-840-202 | Continuing competency definitions. |
| WAC 246-840-203 | Continuing competency requirements—Active status. |
| WAC 246-840-204 | Continuing competency requirements—Reactivation from expired status. |
| WAC 246-840-205 | Continuing competency requirements—Reactivation from inactive status. |
| WAC 246-840-206 | Continuing competency audit process and compliance. |
| WAC 246-840-207 | Failure to meet continuing competency requirements. |

AMENDATORY SECTION (Amending WSR 95-21-072, filed 10/16/95, effective 11/16/95)

WAC 246-840-500 Philosophy governing approval of nursing education programs. The commission believes that quality nursing education provides the foundation for safe and effective nursing practice. Nursing education shall be accessible and promote student and faculty diversity. While the commission (~~herein~~) has established minimum standards for approved (~~schools of~~) nursing education programs, it believes that each (~~school of~~) nursing education program should have flexibility in developing and implementing its philosophy, purposes, and objectives. Such development and implementation should be based not only upon the minimum standards for approved (~~schools of~~) nursing education programs, but also upon sound educational and professional principles for the preparation of registered (~~and~~) nurses, practical nurses, advanced registered nurse practitioners, and other nurses who pursue graduate nursing degrees and postgraduate degrees and certifications to meet current and future nursing needs of the public. The commission believes that there must be congruence between the total program activities of the (~~school of~~) nursing education program and its stated philosophy, purpose and objectives.

The commission further believes that the (~~minimum~~) standards for approved (~~schools of~~) nursing (~~can be~~) education programs are useful (~~to schools of nursing by~~) for promoting self-evaluation and peer evaluation, which may lead to further program development and on-going continuous quality improvement.

Formatted: Font: Courier New, 12 pt, Underline, Font color: Black, Raised by 8 pt

[Statutory Authority: RCW 18.79.110. WSR 95-21-072, § 246-840-500, filed 10/16/95, effective 11/16/95.]

AMENDATORY SECTION (Amending WSR 05-12-058, filed 5/26/05, effective 6/26/05)

WAC 246-840-505 Purposes of commission approval of nursing education programs. The commission approves nursing education programs to:

(1) Assure preparation for the safe and effective practice of nursing by setting minimum standards for nursing education programs preparing persons for licensure as registered nurses (~~(or)~~), practical nurses, advanced registered nurse practitioners, or for preparing nurses for additional graduate education or higher levels of nursing practice.

(2) Provide criteria for the approval, development, evaluation, and improvement of new and established nursing education programs.

(3) Assure (~~(candidates)~~) graduates of nursing education programs are educationally prepared for licensure at the appropriate level of nursing practice.

(4) Facilitate interstate endorsement of graduates of commission approved nursing education programs (~~(of nursing)~~).

(5) Assure nursing education standards for out-of-state distance learning nursing education programs placing students in Washington state for clinical or other practice experiences are equivalent to in-state nursing education programs.

(6) Assure internationally educated nurses' educational preparation is equivalent to that of in-state nursing education programs.

[Statutory Authority: RCW 18.79.110 and 18.79.150. WSR 05-12-058, § 246-840-505, filed 5/26/05, effective 6/26/05. Statutory Authority: RCW 18.79.110. WSR 95-21-072, § 246-840-505, filed 10/16/95, effective 11/16/95.]

AMENDATORY SECTION (Amending WSR 05-12-058, filed 5/26/05, effective 6/26/05)

WAC 246-840-510 Approval of initial (new) in-state nursing education programs. (~~((1) Application for program development.))~~ (1) New nursing education programs must submit a commission approved applica-

tion for approval to operate a new undergraduate, post-licensure, or graduate nursing education program in Washington state.

(2) Graduate programs changing from a master's degree in nursing to a doctoral ~~degree in~~ of nursing practice degree must submit a substantive change request identified in WAC 246-840-554(32).

(3) The commission shall consider the need, size, type and geographic location when approving a program.

Phase I: Submission of application and feasibility study

(14) A postsecondary educational institution wishing to establish a nursing education program or additional program in nursing shall ((seek nursing commission approval to begin the process in the following manner)) submit an application and feasibility study as follows:

(a) Submit to the commission a statement of intent to establish a nursing education program or additional program on a form provided by the commission((7)) and a completed feasibility study that includes ((at least)) the following information:

(i) (~~Nursing~~) Studies documenting the current and future supply and demand needs for ~~entry level, postgraduate, or graduate~~ nurses in the area of the proposed nursing education program;

(ii) Purposes and classification of the proposed nursing education program;

(iii) Availability of qualified candidates for the nurse administrator and faculty positions;

(iv) Budgeted nurse administrator and faculty positions over the course of five years;

(v) (~~Availability~~) Source and description of adequate ~~and acceptable~~ clinical or practice facilities for the nursing education program;

(vi) (~~Availability~~) Description of adequate ~~and acceptable~~ academic facilities for the nursing education program;

(vii) Potential effect on other nursing programs (~~in the area~~) within a sixty mile radius of the proposed nursing education program location;

(viii) Evidence of financial resources adequate and acceptable for the planning, implementation, and continuation of the nursing education program ~~for the next five years~~;

(ix) Anticipated student population; (~~and~~)

(x) Tentative time schedule for planning and initiating the nursing education program; and

(xi) Accreditation status of the parent institution.

(b) Respond to the commission's request(s) for additional information.

~~((c) Receive or be denied nursing commission approval for program development.))~~

Phase II: Nursing education program development

~~(25) ((Program development. Upon approval))~~ Only after receiving commission approval for nursing education program development, the educational institution shall:

(a) Appoint a qualified nurse administrator ~~((and))~~;

(b) Provide appropriate resources, consultants, and faculty to develop ((a)) the proposed nursing education program((b)); and

(c) At least three months prior to ((admission of)) advertising and admitting students ((and with sufficient time for commission review)), submit the proposed program plan that includes ((all of)) the following:

(i) Program purpose and outcomes;

(ii) Organization and administration within the educational institution and within the nursing unit or department including the nurse administrator, faculty, and nursing support staff;

(iii) Resources, facilities, and services for students and faculty;

(iv) Policies and procedures as identified in WAC 246-840-519(3) (a)-(d) for student selection, admission, progression, remediation, withdrawal and graduation, ((and)) student and faculty record systems, student and faculty reporting of incidents (including medication errors and near misses), ADA accommodations for students, grievances and complaint processes, and practice or clinical expectations (including the administration of medication or prescribing in the clinical setting);

(v) A plan for hiring and retaining faculty, including qualifications, responsibilities, organizational structure, and faculty/student ratio in classroom, clinical, and practice experiences;

(vi) Curriculum, including course descriptions, course outcomes, and course topical outlines;

(vii) Initial year and five-year sustaining budget;

(viii) Projected plans for the orderly expansion and ongoing evaluation of the program.

~~((e))~~ (d) If required by the commission, arrange a survey visit to the campus to clarify and ~~((amplify))~~ augment materials included in the written proposed program plan. The visit ~~((will))~~ may be conducted by a representative of the commission before a decision regarding approval is ~~((rendered))~~ made.

~~((d) Receive or be denied initial approval of the proposed nursing program.))~~

Phase III: Initial approval

~~(36) ((Initial approval.~~

~~(a))~~ The nursing education program may only admit students if it has received initial approval by the commission~~((+~~
~~(b))~~).

(a) The ~~((school))~~ nursing education program shall submit progress reports as requested by the commission~~((+and~~
~~(e))~~).

(b) Survey visits shall be scheduled as deemed necessary by the commission during the period of initial approval. A site survey, conducted by the commission, will determine whether graduates may test for the licensure examination ~~((NCLEX)®)~~ as identified in WAC 246-840-050 or graduate certification exams as identified in WAC 246-840-

302 (3)(a), (b), ~~and~~ (c) and (d) for advanced registered nurse practice.

Phase IV: Full approval

~~(47)~~ ~~((Full approval-~~

~~(a))~~ A self-evaluation report of compliance with the standards for nursing education as identified in WAC ~~((246-840-550 through 246-840-575))~~ 246-840-511 through 246-840-556, shall be submitted to the nursing commission within six months following graduation of the first class.

~~((b))~~ (a) The commission may conduct a survey visit to determine full approval of the program.

~~((e))~~ (b) The commission will review the self-evaluation report, survey reports and program outcome data in order to grant or deny full approval of the nursing education program under WAC ~~((246-840-530(1))~~ 246-840-558(1).

[Statutory Authority: RCW 18.79.110 and 18.79.150. WSR 05-12-058, § 246-840-510, filed 5/26/05, effective 6/26/05. Statutory Authority: RCW 18.79.110. WSR 95-21-072, § 246-840-510, filed 10/16/95, effective 11/16/95.]

NEW SECTION

WAC 246-840-511 Accreditation requirements for all nursing education programs located in Washington state. (1) (a) A nursing education program must be located in a postsecondary educational institution with approval from either the Washington state student achievement council or state board of technical colleges to grant the appropriate degree or certificate; and-

(2b) A nursing education program must be located in an institution accredited by a United States Department of Education approved regional accrediting body or national institutional accrediting body.

(32) All nursing education programs having received full commission approval on or before December 31, 2015, must become accredited or achieve candidacy status granted by a national nursing education accrediting body recognized by the United States Department of Education on or before January 1, 2020.

(43) New nursing education programs receiving full commission approval after January 1, 2016, must obtain national nursing education accreditation within four years of receiving full commission approval.

(54) Any nursing education program not having national nursing education accreditation must disclose to students in all publications

describing the program as lacking national nursing education accreditation and this may limit future educational and career options for the students.

[]

NEW SECTION

WAC 246-840-512 Standards and evaluation of nursing education

programs ~~located in Washington state~~. (1) The nursing education program shall meet minimum standards established by the commission as detailed in WAC 246-840-511 through 246-840-556.

(2) The nursing education program shall implement a written, comprehensive, systematic plan for ongoing evaluation that is based on program outcomes data and input from faculty, students, health care partners and consumers, and ~~which~~ that incorporates continuing improvement goals and measures.

(a) The plan must include evaluative criteria, methods used to evaluate, frequency of evaluation, assignment of responsibility, and measurable indicators or benchmarks of effectiveness for the nursing education program and instruction.

(b) The nursing education program shall document analysis of the data collected and actions taken as a result of use of the systematic program evaluation plan.

(c) Major changes in the professional nursing education program must be evidence-based.

(d) The nursing education program shall review and analyze the evaluative methods and instruments used to measure program outcomes for appropriateness according to the timeline specified in the plan.

(e) The nursing education program shall evaluate didactic and clinical course effectiveness each time a course is taught.

(f) Implementation of the plan for systematic program evaluation and ongoing quality improvements must be documented in faculty or faculty-related minutes.

(g) The following items must be included in the systematic program evaluation: Faculty, student and graduate satisfaction surveys, facility, resource and services surveys by faculty and students, faculty workload surveys and evaluations, national licensing examination rates, post licensure certification examination rates, student attrition and completion rates, employment rates after graduation, employer satisfaction, and program and student learning outcomes.

(h) Faculty and students shall participate in program planning, implementation, evaluation, and continuous quality improvement.

(3) Program information communicated by the nursing education program must be accurate, complete, and consistent.

[]

NEW SECTION

WAC 246-840-513 Reporting and recordkeeping requirements for nursing education programs ~~located in Washington state~~. (1) Within two business days, nursing education programs shall report to the commission, on forms provided by the commission, events involving a student or faculty member that the program has reason to believe resulted in patient harm, significant risk for patient harm, or diversion of legend drugs or controlled substances.

(2) The nursing education program shall keep a log of all events reported by a patient, family member, ~~students,~~ faculty or a health care provider resulting in patient harm or serious risk of patient harm, allegations of diversion and medication errors. The log must include:

(a) The date and nature of the event;

(b) The names of the student or faculty member involved;

(c) The name of the clinical faculty member responsible for the student's clinical experience;

(d) Assessment of findings and suspected causes related to the incident or root cause analysis;

(e) Nursing education program corrective action; and

(f) Remediation plan, if applicable.

(3) The nursing education program shall use the principles of just culture, fairness, and accountability in the implementation and use of all incident reporting logs with the intent of:

(a) Determining the cause and contributing factors of the incident;

(b) Preventing future occurrences;

(b) Facilitating student learning; and

(c) Using the results of incident assessments for on-going program improvement.

[]

NEW SECTION

WAC 246-840-514 Purpose and outcomes for approved nursing education programs ~~located in Washington state~~. (1) The purpose and ex-

pected outcomes of the nursing education program shall be stated clearly and must be available to the public in written form.

(2) The purpose and expected outcomes shall be consistent with nursing practice as outlined in chapters 18.79 RCW and 246-840 WAC.

(3) The nursing education program shall have a purpose statement and expected outcomes consistent with the parent institution and with generally accepted standards of nursing practice appropriate for graduates of the type of nursing program offered.

(4) The input of stakeholders including, but not limited to, health care partners and community members shall be considered in developing and evaluating the purpose and expected outcomes of the program.

[]

NEW SECTION

WAC 246-840-516 Organization and administration for all nursing education programs ~~located in Washington state~~. (1) The nursing education program must be an integral part of the accredited parent institution.

(2) The relationship of the nursing education program to the parent institution and other units within the parent institution must be

clearly delineated and included in an organizational chart, which indicates lines of responsibility and authority.

(3) The parent institution shall provide financial support and resources needed to operate a professional nursing education program, which meets the requirements of this chapter and fosters achievement of program goals and expected outcomes.

The financial resources must support adequate educational facilities, equipment, technology, and qualified administrative and instructional personnel sufficient to achieve program goals and outcomes.

(4) The nursing education program shall involve nursing faculty in determining academic policies and procedures.

(5) The nursing education program shall provide opportunity for student participation in the development and evaluation of program policies and procedures, curriculum planning and evaluation.

(6) The nursing education program shall provide accurate information to students and the public.

(7) The governing entity shall employ a qualified nurse administrator with clear institutional authority and administrative responsibility for the nursing program.

[]

NEW SECTION

WAC 246-840-517 Nurse administrator qualification requirements in nursing education programs located in Washington state. (1) The nursing education program administrator must be a professionally and academically qualified registered nurse with an active, unencumbered Washington nursing license.

Practical or Associate Degree Nursing Education Programs

(2) In a nursing education program offering practical or associate degree nursing education, the nurse administrator must have a minimum of:

(a) A bachelor of science in nursing (BSN) from a nursing education program accredited by a national nursing education accrediting body recognized by the United States Department of Education and a graduate degree, or a graduate degree from a nursing education program accredited by a national nursing education accrediting body recognized by the United States Department of Education;

(b) ~~Educational preparation in teaching nursing, or two years of experience in teaching nursing~~ Preparation in education that includes teaching adults, adult learning theory, teaching methods, curriculum

development, and curriculum evaluation, or two years of teaching experience in nursing education;

(c) Curriculum development and administration experience;

(d) Five years of experience as a registered nurse including two years of experience in nursing education; and

(e) Current knowledge of nursing practice at the practical nurse or associate degree program level as appropriate.

Baccalaureate and Graduate Nursing Education Programs

(3) In a nursing education program offering the baccalaureate or graduate ~~degree in nursing, the nurse administrator~~degrees in nursing, the nurse administrator must have:

(a) A minimum of a graduate degree with a major in nursing, from a nursing education program accredited by a national nursing education accreditation body recognized by the United States Department of Education and a doctoral degree preferably either in nursing or a health or related educational field from a college or university accredited by a national accrediting body recognized by the United States Department of Education, or a doctoral degree in nursing from a college or university accredited by a national nursing accrediting body recognized by the United States Department of Education;

(b) Preparation in education ~~that includes including preparation~~ in teaching adults, adult learning theory, teaching methods, curriculum development, and curriculum evaluation, or two years of teaching experience in nursing education;

(c) Preparation or experience in nursing administration or educational administration; and

(d) At least five years of experience as a registered nurse including two years of experience in nursing education at or above the highest level of the nursing education program the nurse administrator will be administering.

~~For RN to BSN nursing education programs, t~~The commission may grant an exception to the experience in nursing education requirement if the program can demonstrate that two academic years of ongoing educational consultation is provided to the nurse administrator by a person who meets or exceeds nurse administrator qualifications identified in this subsection.

(4) The nurse administrator shall be responsible for creation and maintenance of an environment conducive to teaching and learning through:

(a) Facilitation of the development, implementation, and evaluation of the curriculum.

(b) Communication and decision making regarding program needs, budget preparation and monitoring, and ongoing involvement with central administration and other units of the parent institution.

(c) Facilitation of faculty development and performance review for full-time and part-time faculty consistent with the policies of the institution and standards of professional nursing practice, and encouragement of faculty to seek ways of improving clinical skills and methods of demonstrating continued educational and clinical competence.

Evaluation of clinical performance of nursing faculty in practice situations must be performed by a qualified licensed nurse as appropriate to the level of practice being taught.

(d) Facilitation of faculty recruitment and appointment. The nurse administrator of the nursing education program shall establish a goal for acquiring faculty with diversity in ethnicity, gender, clinical specialty and experience.

(e) Recommendation of faculty for appointment, promotion, tenure, and retention consistent with the policies of the institution and standards in this chapter.

(f) Facilitation of the development of long-range goals and objectives for the nursing program.

(g) Facilitation of recruitment, selection, and advisement of students.

(h) Assurance that the rules and regulations of the commission are effectively implemented.

(i) Notification to the commission of events as identified in WAC 246-840-513 and 246-840-554(~~23~~).

(5) The nurse administrator must have sufficient time provided to fulfill relevant administrative duties and responsibilities.

[]

NEW SECTION

WAC 246-840-518 Resources, facilities and services for approved nursing education programs ~~located in Washington state~~. (1) A nursing education program shall have the fiscal, human, physical, technological, clinical and learning resources adequate to support program processes and outcomes.

(2) Classrooms, laboratories, and conference rooms must be available and adequate in size, number, and type according to the number of students and the educational purposes for, which the rooms are to be used.

(3) Offices must be available and adequate in size, number, and type to provide faculty with opportunity for uninterrupted work and privacy for conferences with students. Adequate space must be provided for clerical staff, records, files, and other equipment.

(4) An office allowing for private consultation with students and faculty, and support for administrative responsibilities must be available to the nurse administrator.

(5) Library facilities and computer access must be provided for use by the faculty and students. Physical facilities, hours, and scope and currency of learning resources must be appropriate for the purpose of the program and for the number of faculty and students.

(6) The nursing education program shall conduct ~~periodic~~ annual evaluations of resources, facilities, and services based on input from faculty and students. The schedule and results of these evaluations must be available to the commission upon request.

(7) The nursing education program shall demonstrate adequate financial support for faculty, support personnel, equipment, technology, supplies, and services.

[]

NEW SECTION

WAC 246-840-519 Student requirements in all approved nursing education programs ~~located in Washington state~~. (1) The nursing education program shall hold students accountable for professional behavior as identified in chapters 18.79, 18.130 RCW, and 246-840 WAC, including, academic honesty and integrity.

(2) Written policies and procedures for students must be available and communicated in a fair, accurate, inclusive, and consistent manner.

(3) The approved nursing education program ~~must~~ shall:

(a) Develop and implement written policies and procedures specific to nursing students including, but not limited to, the following:

(i) Student selection, admission, progression, remediation, graduation, withdrawal, and dismissal of students;

(ii) Student recordkeeping and systems;

(iii) ADA accommodations for students;

(iv) Student rights and responsibilities;

(v) Grievances and complaint processes;

(vi) Incident reports and tracking of reports;

(vii) Medication administration or selection by students and faculty role in supervising students during medication administration or selection processes;

(viii) Reporting and logging of events involving a student or faculty member that the nursing education program has reason to believe resulted in patient harm, significant risk for patient harm, or diversion of legend drugs~~medication errors and near misses~~;

(ix) Student professional dress;

(x) Professional behavior;

(xi) Background check requirements;

(xii) Immunization requirements;

(xiii) Clinical practice expectations; ~~and~~

(xiv) Student performance evaluations; and

~~(xv)~~ Other expectations of nursing students.

(b) Maintain a system of student records in accordance with institutional requirements. Student records shall be available to the commission staff during on-site surveys or investigations.

(c) Provide a written statement to nursing students of student rights and responsibilities.

(d) Require and assure that students seeking admission by transfer from another approved nursing education program, or readmission

for completion of the program, shall meet the equivalent of the program's current standards.

(e) Encourage admission of students from diverse populations.

[]

NEW SECTION

WAC 246-840-521 Additional student requirements for prelicensure registered nurse nursing education programs located in the state of Washington. The nursing education program shall provide the student in a prelicensure registered nursing program with written information on the legal role of the nursing technician as defined in WAC 246-840-010 and 246-840-840. The information must be provided prior to the time of completion of the first clinical course and shall clearly advise the student of his or her responsibilities, if he or she chooses to be employed as a nursing technician.

[]

NEW SECTION

WAC 246-840-522 Additional student requirements for RN to BSN and graduate nursing education programs. (1) The nursing education program shall ensure nursing students in RN to BSN and graduate ~~advanced registered nurse practitioner~~ nursing education programs are licensed as

a registered nurse in each state or United States territory where practice or clinical experiences occur. ~~Washington state.~~

Formatted: Not Highlight

Formatted: Not Highlight

(2) The nursing education program shall provide the student in a graduate nursing program with written or electronic information on the requirements for national certification as appropriate to the level of educational degree and specialty.

[]

NEW SECTION

WAC 246-840-523 Faculty requirements for nursing education programs. (1) Each nursing education program shall have a sufficient number of professionally and academically qualified faculty with adequate diversity of expertise in nursing to meet the nursing education program purpose, outcomes, and identified quality improvement processes.

(2) The nursing education program shall provide new faculty with sufficient orientation to achieve program purpose and outcomes, and to assure safe clinical and practice experiences for students.

(3) The program shall make available ongoing faculty development opportunities to assure faculty members are prepared, experienced, and current in subject matter taught.

(4) Nursing faculty shall have an active, unencumbered Washington state registered nurse license.

(5) Interdisciplinary faculty teaching in the nursing education program shall have academic and professional education and experience in their field of specialization.

(6) Adjunct clinical faculty employed solely to supervise clinical nursing experiences or practice experiences shall meet all the faculty qualifications for the program level they are teaching.

(7) Nursing faculty shall be responsible for:

(a) Developing, implementing, and evaluating the purpose and outcomes of the nursing education program;

(b) Designing, implementing, and evaluating the curriculum;

(c) Developing and evaluating nursing education policies as identified in WAC 246-840-519 (3)(a)-(d)~~student admission, withdrawal, dismissal, progression, retention, remediation and graduation policies~~ within the framework of the policies of the governing parent institution;

(d) Participating in or providing for academic advising and guidance of students;

(e) Evaluating student achievement, in terms of curricular objectives as related to both nursing knowledge and practice, including preceptorship or mentored experiences;

(f) Selecting, guiding, and evaluating student learning activities;

(g) Participating in activities to improve their own nursing competency in area(s) of responsibility and to demonstrate current clinical competency; and

(h) Developing criteria for the selection and evaluation of clinical and practice experiences in clinical facilities or clinical practice settings, which address safety and the need for students to achieve the program outcomes and course objectives.

[]

NEW SECTION

WAC 246-840-524 Degree requirements for faculty teaching in practical nursing education programs. In a nursing education program preparing practical nurses only, nursing faculty teaching nursing must have a minimum of a baccalaureate degree with a major in nursing from

a nursing education program that is accredited by a nursing education accrediting body approved by the United States Department of Education.

[]

NEW SECTION

WAC 246-840-526 Degree requirements for nursing faculty teaching in prelicensure registered nurse for RN to BSN education programs. (1)

In a nursing education program preparing registered nurses for licensure or for RN to BSN degree, nursing faculty teaching nursing ~~must~~ shall:

(a) ~~Have~~ have a minimum of a graduate degree in nursing from an accredited college or university and from a nursing education program that is accredited by a nursing education accreditation body recognized by the United States department of education, or a commission recognized nursing accreditation body, or

(b) ~~a~~ a ~~bachelor's ealaureate~~ bachelor's degree in nursing from a an accredited college or university and from a nursing education program that is accredited by a nursing education accreditation body recognized by the United States department of education, commission recognized nurs-

~~ing accreditation body with~~ and a graduate degree in a health or education related field from an accredited college or university.

[]

NEW SECTION

WAC 246-840-527 Degree and licensing requirements for nursing faculty teaching in a nursing education program leading to licensure as an advanced registered nurse practitioner ~~nursing education program~~. In a nursing education program preparing students for licensure as an advanced registered nurse practitioners, nursing faculty teaching nursing must meet the following qualifications:

(1) An active, unencumbered Washington state ARNP license;

(2) A minimum of a graduate degree in nursing from an accredited college or university and from a nursing education program that is accredited by a nursing education accreditation body recognized by the United States department of education; ~~commission recognized nursing education accrediting agency;~~

(3) Two years of clinical experience as a nurse practitioner, nurse midwife, nurse anesthetist, or clinical nurse specialist; and

(4) Current knowledge, competence and certification in the role and population foci consistent with teaching responsibilities.

[]

NEW SECTION

WAC 246-840-528 Degree requirements for nursing faculty teaching in a graduate nursing education program, not leading to licensure as an advanced registered nurse practitioner, -nursing education program.

For graduate nursing programs preparing nurses in advanced degrees, nursing faculty teaching nursing must meet the following qualifications:

(1) A graduate degree in nursing from an accredited college or university and nursing education program that is accredited by a nursing education accrediting body recognized by the United States department of education and is at or above the program level being taught; or a bachelor's degree in nursing from a nursing education program that is accredited by a nursing education accrediting body and graduate degree in a health or education related field from an accredited college or university; and

~~commission recognized nursing education accreditation agency and at or above the program level being taught, or a bachelors in nursing and graduate degree in related health care or educational field from an accredited college or university; and~~

Formatted: Indent: First line: 0"

(2) Demonstrated specialization, expertise, or preparation and experience for the courses being taught.

[]

NEW SECTION

WAC 246-840-529 Exceptions to nursing faculty degree requirements in pre-licensure registered nurse nursing education programs. The commission may grant exceptions to faculty degree requirements in pre-licensure registered nursing education programs under the following conditions:

(1) For faculty teaching in the classroom or laboratory, the nursing program shall provide documentation to the commission prior to employment that:

(a) Despite aggressive recruitment efforts, it has been unable to attract properly qualified faculty; and

(b) The individual will either teach one year or less, or be currently enrolled in a nursing, health-related, or education-related graduate degree program.

(2) For clinical faculty who will directly supervise registered nursing students at a clinical facility, the nursing education program

shall provide documentation to the commission prior to employment that the individual has:

(a) A minimum of a baccalaureate degree with a major in nursing from an -accredited college or university and from a nursing education program that is accredited by a nursing education accrediting body recognized by the United States department of education~~commission rec-~~
~~ognized nursing education accreditation agency~~; and

(b) Current clinical experience of at least three years in the clinical subject area taught.

(3) For faculty teaching registered nursing students in the classroom, laboratory or clinical setting, the individual is nursing faculty tenured prior to November 3, 1995.

[]

NEW SECTION

WAC 246-840-531 Clinical and practice experiences for students in approved nursing education programs. (1) All nursing programs preparing students for licensure shall have provide faculty planned clinical or direct patient care experiences based on program outcomes and goals.

(2) The number of clinical or direct patient care experience hours must be equivalent to programs of similar type:

(a) At least ~~four~~ three hundred hours for licensed practical nursing education programs;

(b) At least ~~six~~ five hundred hours for associate degree nursing education programs;

(c) At least ~~seven~~ six hundred hours for bachelors of science in nursing education programs;

(d) At least five hundred hours for masters level nurse practitioner nursing education programs;

(e) At least one thousand hours for doctoral of nursing practice nurse practitioner programs.

(3) All postlicensure nursing education programs shall have faculty planned practice experiences for students based on program outcomes and goals. Practice experience examples include, but are not limited to: Indirect and direct patient care, patient or population teaching, population interventions, student nurse teaching or the teaching of nursing students, leadership and change projects, research, accessing client or population data for the purpose of doing quality assurance projects, informatics, thesis or dissertation development and defense.

Formatted: Tab stops: 2.81", Left

(4) The number of practice hours must be equivalent to programs of similar type:

(a) At least one hundred hours for registered nurse to bachelor's degree programs; and

(b) At least one hundred hours for graduate nursing education programs.

(5) Faculty shall organize clinical and practice experiences based on the educational preparation and skill level of the student.

(6) Faculty shall plan, oversee, supervise and evaluate student clinical and practice experiences.

[]

NEW SECTION

WAC 246-840-532 Faculty to student ratios for clinical and practice experience in nursing education programs. (1) Practical and pre-licensure registered nursing education programs shall have a maximum faculty to student ratio of one faculty member to ten students in clinical settings involving direct patient care, and one faculty member to fifteen students at one time in practice settings that are observational or involve student precepted experiences.

(2) Registered nurse to bachelor nursing education programs shall have a maximum faculty to student ratio of one faculty member to fifteen students at one time in clinical and practice settings.

(3) Advanced registered nurse practitioner nursing education programs shall have a maximum faculty to student ratio of one faculty member to six students in clinical and practice settings.

(4) Graduate nursing education programs (not leading to licensure as an advanced registered nurse practitioner) ~~advanced practice programs~~ shall have a maximum faculty to student ratio of one faculty member to fifteen students in clinical and practice settings.

(5) A lower ratio of faculty to students may be required for students in initial or highly complex learning situations, or when student or patient safety warrant.

[]

NEW SECTION

WAC 246-840-533 Preceptors, interdisciplinary mentors, and proctors in clinical or practice settings for nursing education programs located in Washington state. (1) Preceptors may be used to enhance clinical or practice-learning experiences after a student has received

instruction and orientation from program faculty who assure the student is adequately prepared for the clinical or practice experience.

(2) Nursing education faculty in prelicensure nursing education programs shall not assign more than two students to each nurse preceptor.

(3) Nursing education faculty in a program leading to licensure as an advanced registered nurse practitioner ~~programs~~ shall not assign more than one student to each preceptor.

(4) A preceptor may be used in practical and registered nursing education programs when the preceptor:

(a) Has an unencumbered nursing license at or above the level for which the student is preparing;

(b) Is experienced in the facility and specialty area for at least two years;

(c) Is oriented to the written course and student learning objectives;

(d) Is not related to, or a personal friend of the student; and

(e) Is oriented to the written role expectations of faculty, preceptor, and preceptee student.

(5) A preceptor may be used in nursing education programs leading to licensure as an advanced registered nurse practitioner ~~nursing education programs~~ when the preceptor:

(a) Has an active, unencumbered license as an ARNP, a physician as identified in chapter 18.71 RCW, an osteopathic physician as identified in chapter 18.57 RCW, or equivalent in other states or jurisdictions;

(b) Is experienced in the facility and specialty area for at least two years;

(c) Is oriented to the written course and student learning objectives;

(d) Is not related to, or a personal friend of the student; and

(e) Is oriented to the written role expectations of faculty, preceptor, and preceptee student.

(6) Preceptors may be used in graduate nursing programs as appropriate to the course of study when the preceptor:

(a) Is experienced in the ~~facility and~~ specialty area for at least two years;

(b) Is oriented to the written course and student learning objectives;

(c) Is not related to, or a personal friend of the student; and

(d) Is oriented to the written role expectations of faculty, preceptor, and preceptee student.

(7) Interdisciplinary mentors who have experience and educational preparation appropriate to the faculty planned student learning experience may be used in some clinical or practice experiences.

(8) Faculty are responsible for the overall supervision and evaluation of the student and must confer with each preceptor or interdisciplinary mentor and student at least once before the student learning experience, at the mid-point of the experience, and at the end of the learning experience.

(9) Proctors who are qualified with educational and experiential preparation in the area being proctored and who are licensed health care providers under chapter 18.130 RCW, may be used on rare, short-term occasions when a faculty member has determined that it is safe for a student to receive direct supervision from the proctor for a particular task or skill. A proctor for the purpose of this section means a person who is licensed under chapter 18.130 RCW and is qualified to monitor a student during the delivery of a task or skill that the proctor is legally qualified to perform.

[]

NEW SECTION

WAC 246-840-534 Use of simulation for clinical experiences in LPN, RN, or RN to BSN nursing education programs located in the state of Washington state. (1) An LPN, RN, or RN to BSN nursing education program may use simulation as a substitute for traditional clinical experiences, not to exceed fifty percent of its clinical hours for a particular course.

(a) Simulation as used in this section means a technique to replace or amplify real experiences with guided experiences evoking or replicating substantial aspects of the real world in a fully interactive manner.

(b) Debriefing as used in this section means an activity following a simulation experience that is led by a facilitator, and encourages reflective thinking, and provides feedback regarding the participant's performance.

(c) The nursing education program shall have an organizing framework providing adequate fiscal, human, technological and material resources to support the simulation activities.

(d) Simulation activities must be managed by an individual who is academically and experientially qualified and who demonstrates contin-

ued expertise and competence in the use of simulation while managing the simulation program.

(e) The nursing education program shall have a budget sustaining simulation activities and training of the faculty.

(f) The nursing education program shall have appropriate facilities, educational and technological resources and equipment to meet the intended objectives of the simulation.

(g) All faculty involved in simulations, both didactic and clinical, shall have training in the use of simulation and shall engage in ongoing professional development in the use of simulation.

(h) Faculty to student ratios in the simulation lab ~~shall~~ must be in the same ratio as identified in WAC 246-840-532 for clinical learning experiences.

(2) Faculty ~~must~~ shall organize clinical and practice experiences based on the educational preparation and skill level of the student.

(3) Qualified simulation faculty must supervise and evaluate student clinical and practice experiences.

(a) The nursing education program shall demonstrate that simulation activities are linked to programmatic outcomes.

(b) The nursing education programs shall have written policies and procedures on the following:

(i) Short-term and long-term plans for integrating simulation into the curriculum;

(ii) An identified method of debriefing each simulated activity;
and

(iii) A plan for orienting faculty to simulation.

(c) The nursing education program shall develop criteria to evaluate simulation activities.

(d) Students ~~must~~ shall evaluate the simulation experience on an ongoing basis.

(e) The program shall include information about use of simulation in its annual report to the commission.

[]

NEW SECTION

WAC 246-840-536 Dedicated education units (DEUs) for practical nurse or registered nurse nursing education programs. (1) Nursing education programs in collaboration with a health care facility may use dedicated education units as identified in WAC 246-840-010 to provide clinical education and practice experiences for nursing students.

(2) A nursing education program using a dedicated education unit shall have an affiliation agreement identifying the roles and respon-

sibilities of health care staff, nursing education program faculty, and nursing students.

(3) Nursing education programs using dedicated education units shall use licensed nurses as preceptors as identified in WAC 246-840-533(4)(a)(b)(c)(d)(e) for practical and registered nurse programs, or WAC 246-840-533(5)(a)(b)(c)(d)(e) for programs leading to advanced registered nurse practitioner licensure.

(4) Nursing education program faculty shall only assign students to a licensed nurse preceptor as identified in subsection (3) of this section, based upon the nurse's knowledge, experience, and willingness to work with students.

(5) Nursing education faculty shall not assign more than two students to each licensed nurse preceptor.

(6) Nursing education faculty with the assistance from the preceptor shall be responsible for the evaluation of student clinical performance.

(7) Nursing education faculty shall be responsible for student learning in the dedicated education unit.

[]

NEW SECTION

WAC 246-840-537 Curriculum for approved nursing education programs ~~located in Washington state~~. (1) The curriculum of the nursing education program ~~shall~~ must enable the student to develop the nursing knowledge, skills, and ~~abilities~~ attitude necessary for the level, scope, and standards of competent nursing practice expected at the level of educational preparation.

(2) The curriculum will be revised as necessary to maintain a program reflecting advances in health care and its delivery.

(3) The curriculum, as defined by nursing education, professional and practice standards, shall include evidence-based learning experiences and methods of instruction, including distance education methods, consistent with the written curriculum plan.

(4) Clinical and practice experiences must include opportunities to learn and provide care to clients from diverse ethnic and cultural backgrounds. The emphasis placed on these areas and the scope encompassed shall be in keeping with the purpose and outcomes of the program.

(5) The length, organization, content, methods of instruction, and placement of courses must be consistent with the purpose and outcomes of the program.

(6) All nursing programs delivering curriculum through distance learning methods must ensure that students receive curriculum comparable to in-person teaching and the clinical and practice learning experiences are evaluated by faculty through formative and summative evaluations.

(7) Nursing programs shall not use external nursing examinations as the sole basis for program progression or graduation. External nursing exams for the purpose of this section, means examinations created by people or organizations outside a student's own nursing education program.

Formatted: Font: Courier New, 12 pt, Font color: Black, Raised by 8 pt

(8) Competency based testing for progression in nursing programs must be based on valid and reliable tools measuring the knowledge and skills expected at an identified level of student or nursing practice.

[]]

NEW SECTION

WAC 246-840-538 Curriculum for approved practical and registered nurse nursing education programs. (1) The approved practical and reg-

istered nurse nursing education program shall provide students the opportunity to acquire and demonstrate the knowledge, skills, and ~~abilities~~ attitude for safe and effective nursing practice.

(2) Practical and registered nurse nursing education programs must provide preparation in suicide risk assessment and management as identified in RCW 43.70.442 to include, but not limited to:

- (a) Incidence and prevalence of suicide;
- (b) Attitudes and approaches;
- (c) Warning signs and risk factors;
- (d) Assessment;
- (e) Interventions;
- (f) Management;
- (g) Legal and regulatory issues; and
- (h) Resources.

(3) Practical nurse and registered nurse nursing education programs must provide AIDS education as required in chapter 246-12 WAC, Part 8.

[]

NEW SECTION

WAC 246-840-539 Curriculum for practical nursing education programs. The practical nursing education program of study ~~shall~~ must include both didactic and clinical learning experiences and ~~shall~~ must be:

(1) Designed to include prerequisite classes in the physical, biological, social and behavior sciences that are transferable to colleges and universities in the state of Washington (effective September 1, 2017);

(2) Planned, implemented, and evaluated by the faculty;

(3) Based on the philosophy, mission, objectives, and outcomes of the program and consistent with chapters 18.79 RCW and 246-840 WAC;

(4) Organized by subject and content to meet program outcomes;

(5) Designed to teach students to use a systematic approach to clinical decision making and safe patient care;

(6) Designed to teach students:

(a) Professional relationships and communication;

(b) Nursing ethics;

(c) Nursing history and trends;

(d) Commission approved scope of practice decision tree;

(e) Standards of practice;

(f) Licensure and legal aspects of nursing;

(g) Concepts and clinical practice experiences in geriatric nursing, and medical, surgical, and mental health nursing for clients throughout the life span;

(h) Concepts of antepartum, intrapartum, postpartum and newborn nursing with only an assisting role in the care of clients during labor and delivery and those with complications; and

(i) Concepts and practice in the prevention of illness and the promotion, restoration and maintenance of health in patients across the life span and from diverse cultural, ethnic, social and economic backgrounds.

(7) Designed to prepare graduates for licensure and to practice practical nursing as identified in WAC 246-840-700 and 246-840-705; and

(8) Designed to prepare graduates to practice according to competencies recognized by professional nursing organizations.

(a) All practical nursing courses shall include:

(i) Components of: Client needs; safe, effective care environment; health promotion and maintenance; interdisciplinary communica-

tion and collaboration; discharge planning; basics of multicultural health; psychosocial integrity; and physiological integrity.

(ii) Skills laboratory and clinical practice in the functions of the practical nurse including, but not limited to, administration of medications, implementing and monitoring client care, and promoting psychosocial and physiological health.

(iii) Concepts of coordinated care, delegation and supervision.

(b) Practical nurse programs teaching intravenous infusion therapy shall prepare graduates for national certification by a nursing professional practical nurse certifying body.

[]

NEW SECTION

WAC 246-840-541 Curriculum for prelicensure registered nursing education programs. (1) The program of study for a registered nursing education program ~~shall~~ must include both didactic and clinical learning experiences and ~~shall~~ must be:

(a) Designed so that all prerequisite nonnursing course credits and nursing credits are transferable to the bachelor's in nursing programs as identified in the statewide associate in nursing direct transfer ~~associate nursing degree~~ agreement between community colleg-

es, colleges, and universities (effective September 1, 2017) or the statewide associate of applied science transfer degree;

(b) Designed to include instruction in the physical, biological, social and behavioral sciences. Content is required from the areas of anatomy and physiology (equivalent to two quarter credit terms with laboratory), chemistry, microbiology, pharmacology, nutrition, communication and computations;

(c) Designed to include theory and clinical experiences in the areas of medical surgical nursing and mental health nursing across the life span teaching students to use a systematic approach to clinical decision making and prepare students to safely practice professional nursing through the promotion, prevention, rehabilitation, maintenance, restoration of health, and palliative and end of life care for individuals of all ages across the life span.

Baccalaureate and entry-level master's degree programs shall also include theory and clinical experiences in community and public health nursing.

(d) Designed to include nursing history, health care trends, legal and ethical issues, scope of practice and commission approved scope of practice decision tree, and licensure and professional re-

sponsibility pertaining to the registered nurse role. Content may be integrated, combined, or presented as separate courses.

Baccalaureate and entry-level master's degree programs shall also include the study of research principles and application of statistics to health care practice and intervention.

(e) Designed to include opportunities for the student to learn assessment and analysis of client and family needs, planning, implementation, evaluation, and delegation of nursing care for diverse individuals and groups.

Baccalaureate and entry-level master's degree programs shall also include the study and practice of leadership, interdisciplinary team coordination, quality assurance and improvement, care coordination and case management.

(f) Planned, implemented, and evaluated by faculty;

(g) Based on the philosophy, mission, objectives and outcomes of the program;

(h) Organized logically with scope and sequence of courses demonstrating student learning progression;

(i) Based on sound educational principles and standards of educational practice;

(j) Designed so articulation or dual enrollment agreements between associate and bachelor's degree nursing programs or associate and master's degree nursing programs exists facilitating higher levels of nursing education in a timely manner;

(k) Designed to prepare graduates for licensure and to practice as registered nurses as identified in WAC 246-840-700 and 246-840-705; and

(l) Designed to prepare graduates to practice as associate degree or bachelor degree nurses as identified by professional nursing organizations.

(2) ~~All~~ Registered nursing courses shall include:

(a) Comprehensive content on: Client needs; safe practice, effective care environment; discharge planning, health promotion, prevention and maintenance; psychosocial integrity and physiological integrity.

(b) Clinical experiences in the care of persons at each stage of the human life cycle, with opportunities for the student to learn and have direct involvement in, responsibility and accountability for the provision of basic nursing care and comfort for clients with acute and chronic illnesses, pharmacological and parenteral therapies, and pain management.

(c) Opportunities for management of care, delegation, supervision, working within a health care team, and interdisciplinary care coordination.

[]

NEW SECTION

WAC 246-840-542 Curriculum for registered nurse to bachelor's or master's in nursing education programs. Registered nurse to bachelor's or master's in nursing education programs must:

(1) Develop curriculum to ensure the courses or content completed at the diploma or associate degree levels of nursing are not duplicated;

(2) Design curriculum to ensure student sufficient exposure to content in science and liberal arts;

(3) Design curriculum to allow students the exposure to apply new concepts to practice at the level of the bachelor's or entry level master's in nursing including, but not limited to, practice experiences identified in WAC 246-840-541 (1)(c), (d), and (e);

(4) Design curriculum to include critical thinking, problem solving, and clinical reasoning skills at the level of preparation;

(5) Design curriculum including a specific course or content directly related to role differences and effective role transition strategies at the level of preparation;

(6) Design curriculum including competencies in the following areas:

(a) The study and practice of leadership, interdisciplinary team coordination and collaboration, quality assurance and improvement, and care coordination and case management;

(b) The study and practice of community and public health; and

(c) The theory and application of research and evidence-based practice concepts, and processes.

[]

NEW SECTION

WAC 246-840-543 Curriculum for nursing education programs preparing students for licensure as advanced registered nurse practitioners (ARNP). ~~nursing education programs~~. (1) Nursing education programs preparing students for licensure as advanced registered nurse practitioners ~~(ARNP) nursing education programs~~ shall include content culminating in a graduate degree with a concentration in advanced nursing

practice as defined in RCW 18.79.059, WAC 246-840-010(2), and 246-840-300.

(2) The ~~ARNP~~-nursing education program preparing students for licensure as advanced registered nurse practitioners shall have as its primary purpose the preparation of advanced practice nurses for roles as defined in WAC 246-840-300 and 246-840-302.

(3) Post-~~master's~~ ~~ARNP~~ nursing education programs preparing nurses for licensure as advanced registered nurse practitioners shall teach all competencies designated for the ARNP role including clinical practice. Post-~~master's~~ students must meet the same ARNP outcome competencies as master's advanced registered nurse practitioner~~level-ARNP~~ students.

(4) The curriculum of the ~~ARNP~~ nursing education program preparing nurses for licensure as advanced registered nurse practitioners shall prepare the graduates to practice in one of the four ARNP roles: Certified registered nurse anesthetist, certified nurse midwife, clinical nurse specialist or certified nurse practitioner. The curriculum must include:

(a) Clinical and didactic course work preparing the graduate to practice in the role of the ARNP consistent with the designation being sought for licensure;

(b) Advanced physiology/pathophysiology, including general principles applied across the life span;

(c) Advanced health assessment, including assessment of all human systems, advanced assessment techniques, concepts, and approaches;

(d) Diagnostic theory and management of health care problems including diseases representative of all systems;

(e) Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics, pharmacotherapeutics of all broad categories of agent, and pharmacological management of individual patients;

(f) Preparation providing a basic understanding of the principles for decision making in the identified ARNP role;

(g) Role preparation in one of the six population foci of practice, which includes family or individual across the life span, adult gerontology, neonatal, pediatrics, women's health gender-related, and psychiatric mental health;

(h) Advanced practice nursing core, including legal, ethical and professional responsibilities of the ARNP; and

(i) At least five hundred hours in direct patient care in the ARNP role with clinical preceptor supervision and faculty oversight.

(5) ~~ARNP~~ Advanced registered nurse practitioner nursing education programs preparing students for two population foci or combined

nurse practitioner-clinical nurse specialist shall include content and clinical experience in both functional roles and population foci.

(6) Each student enrolled in an ~~ARNP~~ advanced registered nurse practitioner nursing education program shall have an active, unencumbered RN license in each ~~the~~ state or United States territory where the clinical practice occurs.

[]

NEW SECTION

WAC 246-840-544 Curriculum for graduate nursing education programs. (1) Graduate nursing education programs shall meet the standards established by the national nursing or nursing-related education accrediting body.

(2) The curriculum of graduate nursing education program shall be congruent with national standards for graduate level nursing education.

(3) The curriculum and practice experiences shall be consistent with the competencies of the specific area of practice, stated program outcomes, and established national standards by a professional nursing education accrediting body.

[]

NEW SECTION

WAC 246-840-546 Distance-learning nursing education course or courses offered by approved nursing programs ~~located in Washington state~~. Nursing education programs offering distance-learning courses shall:

(1) Ensure distance-learning courses meet established quality and security standards for online and distance learning education;

(2) Develop written policies and procedures ensuring quality assurance controls, security, maintenance, and service support for students and faculty who use the system;

(3) Ensure students receive curriculum comparable to in-person teaching;

(4) Complete ongoing student and faculty evaluations of distance learning courses; and

(5) Provide access to distance-learning courses when requested by the commission.

[]

NEW SECTION

WAC 246-840-547 Extended or satellite nursing campus of nursing education programs approved in Washington state. (1) An approved nursing education program shall obtain commission approval prior to advertising or admitting students in an extended or satellite nursing education campus.

(2) An approved nursing education program wishing to initiate an extended or satellite nursing program off the main campus of the university but located in the state of Washington, must submit an initial plan three to six months prior to the expected date of operations. The initial plan must identify:

(a) The impact on existing nursing education programs in a sixty mile radius from the location of the proposed extended or satellite campus;

(b) Faculty staffing for the extended or satellite program;

(c) How the nursing education program shall meet curriculum and academic standards of the main campus nursing education program;

(d) Adequate clinical or practice facilities for the satellite or extended nursing program;

(e) Academic facilities and resources that meet the requirements identified in WAC 246-840-518; and

(f) Nursing and institutional administration of the extended or satellite program and how the extended or satellite campus meets administration requirements as identified in WAC 246-840-516.

(3) The extended or satellite campus program shall coordinate annual reports and site survey evaluations with administration at the main campus.

[]

NEW SECTION

WAC 246-840-549 Internationally educated nurse program approval criteria for nursing education programs approved in Washington state.

(1) A commission approved nursing education program may apply on the forms provided by the commission to offer a nursing education program for internationally educated nurses who do not meet educational requirements for licensure. ~~on the forms provided by the commission.~~

(2) All nursing education programs for internationally educated nurses ~~must~~ shall have identified theory and clinical student learning objectives and program outcomes.

(3) The nursing education program for internationally educated nurses ~~must shall~~ include evaluation methods to measure student achievement of the stated theory and clinical objectives.

(4) The nursing education program for internationally educated nurses shall be regularly evaluated by faculty and students.

(5) The nursing education program for internationally educated nurses shall have written policies and procedures for student admission, withdrawal, dismissal, progression, remediation, and completion of the course.

(6) The nursing education program for internationally educated nurses shall maintain student records for at least five years.

(7) The nursing education program for internationally educated nurses shall submit certification of successful completion of the program to the commission office on forms provided by the commission.

[]

NEW SECTION

WAC 246-840-551 Internationally educated practical nurse program in an approved nursing education program. For internationally educated practical nurses who do not meet educational requirements for licensure, the nursing education program shall offer the following:

(1) A minimum of sixty hours of core theory content and one hundred twenty hours of simulated competency-based practice experiences.

(2) The theory course content ~~shall~~ must include, but not be limited to, a minimum of sixty hours in current basic concepts of:

(a) Nursing process;

(b) Pharmacology;

(c) Practical nursing today including legal expectations, the commission approved scope of practice decision tree, the Washington Nurse Practice Act as identified in chapter 18.79 RCW, and the Uniform Disciplinary Act identified in chapter 18.130 RCW;

(d) Basic communications and observational practices needed for identification, reporting, and recording patient needs;

(e) Basic physical, biological, and social sciences necessary for practice; and

(f) Practical nursing knowledge, skills, and ~~abilities~~ attitude to include, but not be limited to: Concepts of fundamentals, medical, surgical, and mental health nursing across the life span. These concepts must address diverse cultural, ethnic, social, and economic backgrounds of patients and populations.

(3) The practice course content ~~shall~~ must include a minimum of one hundred twenty hours of competency-based simulation practice in

the area(s) listed in subsection (2)(f) of this section. Exceptions may be approved by the commission after adequate rationale is provided by the nursing education program.

[]

NEW SECTION

WAC 246-840-552 Internationally educated registered nurse program in an approved nursing education program. For internationally educated registered nurses who do not meet educational requirements for licensure, the nursing education program must offer the following:

(1) A minimum of eighty hours core theory content and one hundred sixty hours of simulated competency-based practice in medical surgical nursing, mental health, family, child, and obstetrical nursing.

(2) The core course content shall include, but not be limited to, a minimum of eighty hours of theory in current concepts of:

(a) Nursing process;

(b) Pharmacology;

(c) Professional nursing today including legal expectations, the commission approved scope of practice decision tree, the Washington State Nursing Practice Act as identified in chapter 18.79 RCW, and the Uniform Disciplinary Act identified in chapter 18.130 RCW;

(d) Communications and observational practices needed for identification, reporting, and recording patient needs;

(e) Basic physical, biological and social sciences necessary for practice; and

(f) Registered nursing knowledge, skills, and abilities to include, but not be limited to, concepts of fundamentals, medical, surgical, parent, child, geriatric, family, community, and mental health nursing.

(3) The competency-based simulated practice experiences ~~shall~~ must include a minimum of one hundred sixty hours of practice in the area(s) listed in subsection (2)(f) of this section. Exceptions ~~shall~~ must be justified to and approved by the commission.

[]

NEW SECTION

WAC 246-840-553 Innovation projects for approved nursing programs located in Washington state. (1) A nursing education program may apply to implement an innovative approach by complying with the provisions of this section.

(2) Nursing education programs approved to implement innovative approaches shall continue to provide quality nursing education prepar-

ing graduates to practice safely, competently, and ethically within the scope of practice as defined in chapter 18.79 RCW and chapter 246-840 WAC.

(3) The purpose of innovations in nursing education program approval is to:

(a) Foster innovative models of nursing education to address the changing needs in health care;

(b) Assure innovative approaches protect the public; and

(c) Assure innovative approaches maintain quality outcome standards.

(4) ~~The Only a~~ nursing education program ~~that holds full commission approval~~ may be eligible ~~to implement for implementing the an~~ innovative approach ~~project.if the nursing education program holds full commission approval.~~

(5) The following information shall be provided to the commission at least three months in advance of requested implementation data:

(a) Identifying information to include name of nursing program, address, responsible party and contact information;

(b) A brief description of the current program;

(c) Identification of the regulation(s) affected by the proposed innovative approach;

(d) Length of time for which the innovative approach is requested;

(e) Description of the innovative approach, including objective(s);

(f) Brief explanation of why the nursing education program wants to implement an innovative approach at this time;

(g) Explanation of how the proposed innovation differs from approaches in the current program;

(h) Rationale with available evidence supporting the innovative approach;

(i) Identification of resources supporting the proposed innovative approach;

(j) Expected impact innovative approach will have on the program, including administration, students, faculty, and other program resources;

(k) Plan for implementation, including timeline;

(l) Plan for evaluation of the proposed innovation, including measurable criteria/outcomes, method of evaluation, and frequency of evaluation; and

(m) Additional application information as requested by the commission.

(6) The following are the standards for approval:

- (a) Eligibility and application criteria in subsections (4) and (5) of this section are met;
- (b) The innovative approach will not compromise the quality of education or safe practice of students;
- (c) Resources are sufficient to support the innovative approach;
- (d) Rationale with available evidence supports the implementation of the innovative approach;
- (e) Implementation plan is reasonable to achieve the desired outcomes of the innovative approach;
- (f) Timeline provides for a sufficient period to implement and evaluate the innovative approach; and
- (g) Plan for periodic evaluation is comprehensive and supported by appropriate methods of evaluation.

(7) If the application meets the standards, the commission may:

- (a) Approve the application; or
- (b) Approve the application with modifications as agreed between the commission and the nursing education program.

(8) If the submitted application does not meet the criteria in subsections (4) and (5) of this section, the commission may deny approval or ask for more information.

(9) The commission may rescind the approval or require the nursing education program to make modifications if:

(a) The commission receives evidence, which substantiates adverse impact; or

(b) The nursing education program fails to implement the innovative approach as presented and approved.

(10) The nursing education program shall provide the commission with progress reports conforming to the evaluation plan as requested by the commission.

(a) If any report indicates patients or students were adversely impacted by the innovation, the nursing education program shall provide documentation of corrective measures and their effectiveness; and

(b) The final evaluation report shall conform to the evaluation plan, detailing and analyzing the outcomes data.

(11) If the innovative approach achieves the desired outcomes, has not compromised public protection, and is consistent with core nursing education criteria, the nursing education program may request the innovative approach be continued.

[]

NEW SECTION

WAC 246-840-554 Ongoing evaluation and approval of nursing education programs located in Washington state. (1) Nursing education programs meeting the requirements of WAC 246-840-512 to WAC 246-840-556 may be approved by the commission for a maximum of ten years. To ensure continuing compliance with standards of nursing education, the commission shall survey and reevaluate each nursing education program for continued approval every five to ten years.

(2) To ensure continuing compliance with nursing education standards, nursing education programs may be required to participate in self-studies, self-evaluations and commission site evaluation visits at various times in the approval cycle depending on program outcomes and complaints received by the commission. The commission may conduct evaluations that are more frequent or conduct site visits and as deemed necessary by the commission.

(3) Any proposed substantive nursing education program change must be presented to the commission for approval at least three months prior to implementation.

(a) Substantive changes include the following:

(i) Changes in legal status, control, ownership, or resources of the institution;

(ii) Faculty numbers below the required staff for clinical as found in WAC 246-840-532 or clinical simulation sections identified in WAC 246-840-534 (1)(h);

(iii) Changes in faculty composition when their expertise or experiences are not adequate to teach those areas of nursing described in WAC 246-840-523 (1) and (3), 246-840-539, 246-840-541, 246-840-543, and 246-840-544;

(iv) Changes in the number of students admitted requiring one or more additional clinical or practice groups, or changing the required faculty to student ratios of 1:10 for prelicensure programs and 1:6 for nursing education programs preparing students for ARNP programs advanced practice registered nurse licensure; or

(v) Major curriculum revision or changes in the length of the program.

(A) Major curriculum revisions include:

(I) Changes in curricular delivery method;

(II) Changes in nursing model or conceptual framework;

(III) Changes in curriculum meaning or direction of the curriculum such as philosophy, program goals, program terminal objectives, course objectives and descriptions;

(IV) Changes in total program credits; or

(V) Addition or deletion of a satellite or extended campus.

(B) The following changes do not require commission approval:

(I) Movement of content from one course to another; or

(II) Formatting changes in syllabi.

(b) The nurse administrator of the program shall submit the following when requesting approval for substantive changes:

(i) A letter explaining the substantive change request;

(ii) The rationale for the proposed change and anticipated effect on the program including faculty workload, students, resources, clinical or practice experiences, and facilities;

(iii) A summary or grid that explains the difference between the current practice and proposed change;

(iv) A timeline for implementation of the change; and

(v) The methods of evaluation to be used to determine the effect of the change.

(3) The program ~~must~~ shall submit annual reports on forms provided by the commission and on the date specified.

[]

NEW SECTION

WAC 246-840-556 Ongoing approval, accreditation and commission reviews. (1) The commission may accept accreditation by a commission-recognized national nursing education accreditation body approved by the United States Department of Education as evidence of compliance with the standards of nursing education programs.

(a) The nursing education program shall submit to the commission a copy of any self-study submitted to the national nursing education accrediting body at the time the report is sent to the national nursing education accrediting body.

(b) The nursing education program shall submit to the commission within thirty days of receiving any report or accreditation letter from the national nursing education accreditation body to include, but not limited to: Continuous improvement progress reports, substantive change notification and accreditation action letters, site visit reports and program response letters, final site visit report and letter.

(c) The nursing education program shall submit notice of any change in program or institution accreditation status with the commis-

sion within thirty days of receipt of notice from the national accrediting body.

(d) Failure to submit notice of accreditation survey results within thirty days may result in a site visit or other sanctions as described in WAC 246-840-558.

(e) Programs holding approval based upon national nursing education accreditation must comply with WAC 246-840-511 through 246-840-556.

(f) The commission may grant approval for a continuing period, not to exceed ten years to nursing education programs with maximum continuing national accreditation.

(g) If the nursing program is accredited for less than maximum accreditation, the program must provide the commission with a copy of the report and a plan of correction for the items of noncompliance within thirty days of receipt from the accreditation body. The commission may require an additional report regarding noncompliance, or may conduct a site visit.

Evaluation of a Nursing Program by the Commission

(2) Programs not nationally accredited by a commission-recognized national nursing accreditation body are subject to a survey visit made

by representative(s) of the commission on dates mutually agreeable to the commission and the nursing education program.

(a) Prior to the survey visit, a nursing education program shall submit a self-evaluation report at least thirty days before the visit providing evidence of compliance with the standards of nursing education as identified in WAC 246-840-511 through 246-840-556.

(b) Prior to commission consideration, a draft of the commission survey visit report will be made available to the school for review for corrections in statistical data.

(c) Following the commission's review and decision, the commission will send the program nurse administrator, the president and vice-president of instruction written notification regarding approval of the program.

[]

NEW SECTION

WAC 246-840-557 Commission action following commission survey, complaint investigation, or national accreditation visits of nursing education programs located in Washington state. (1) When a matter directly concerning a nursing education program is being considered by the commission, any commission member associated with the program

shall not participate in the deliberation or decision-making action of the commission.

(2) The commission shall evaluate each program in terms of its conformance to the nursing education standards in this chapter.

~~_(3) The commission shall consider the need, size, type and geographic location when approving a program.~~

(43) Within thirty days of the commission's decision, the commission shall give written notice to the educational institution regarding its decision on the nursing education program's approval status, including the nurse administrator, the president and provost or vice-president of instruction.

(5) The commission shall grant continuing full approval to a nursing education program meeting the requirements of the law and this chapter. Full approval may carry recommendations for improvement and for correcting deficiencies.

(6) If the commission determines an approved nursing education program is not maintaining the education standards required for approval, the commission shall give written notice specifying the deficiencies and shall designate the period of time in, which the deficiencies must be corrected.

(7) The commission may require the program to submit a plan of correction, or the commission may issue a directed plan of correction.

(8) The commission may limit student numbers or deny admission of new students if the program has insufficient resources, including faculty or program administration.

(9) The commission may withdraw program approval if the program fails to correct the deficiencies within the specified period of time.

(10) The commission may summarily suspend approval of a program if circumstances constituting an immediate threat to public safety are present.

[]

NEW SECTION

WAC 246-840-558 Denial, statement of deficiencies, conditional approval or withdrawal of approval of nursing education programs located in Washington state. (1) The commission may deny full approval to new or existing nursing education programs if it determines a nursing education program fails substantially to meet the standards for nursing education as contained in WAC 246-840-511 through 246-840-556.

(2) The commission may issue a statement of deficiencies and request a plan of correction or directed plan of correction requiring compliance within a designated time period.

(3) The commission may grant conditional approval to a nursing education program failing to meet the minimum standards contained in the law and this chapter.

(a) Conditions must be met within a designated time period and shall be specified in writing.

(b) A conditionally approved program shall be reviewed at the end of the designated time period. The review ~~shall~~ will result in one of the following actions:

- (i) Restoration of full approval to existing programs;
- (ii) Issuance of full approval to a new program;
- (iii) Continuation of conditional approval; or
- (iv) Issuance of intent to withdraw approval.

(4) The following situations may be cause for review, investigation, and a site visit by the commission to determine if the minimum standards for education nursing programs are being met:

(a) Complaints relating to violations of WAC 246-840-511 through 246-840-556;

(b) Denial, withdrawal, or change of program accreditation status by a commission-recognized national nursing accreditation agency or general academic accreditation agency;

(c) Failure to obtain commission approval of changes requiring commission approval under WAC 246-840-554 and 246-840-556;

(d) Providing false or misleading information to students or the public concerning the nursing program;

(e) Violation of the rules or policies of the commission;

(f) Inability to secure or retain a qualified nurse administrator;

(g) Inability to secure or retain faculty resulting in substandard supervision and teaching of students;

(h) Noncompliance with the program's stated purpose, objectives, policies, and curriculum resulting in unsatisfactory student achievement or negative program outcomes;

(i) Failure to provide clinical or practice experiences necessary to meet the objectives of the nursing program;

(j) Faculty student ratio in direct patient care is greater than 1:10 in prelicensure programs or 1:6 in nursing education programs preparing nurses for advanced registered nurse licensure~~ARNP programs~~; and

(k) Failure to maintain an average national council licensing examination annual passing rate or average ~~ARNP~~ advanced practice certification annual passing rate of eighty percent. If a program:

(i) Fails to maintain an average passing or certification rate of eighty percent of first time ~~writers~~ test takers for one year, the program must complete an assessment of the problem. The program may request technical assistance from the commission.

(ii) Fails to maintain an average passing or certification rate of eighty percent of first time writers for two consecutive years, the program must complete an assessment of possible contributing factors and submit a plan of correction to the commission. The commission may place the program on conditional approval status. The program may request technical assistance from the commission.

(iii) Fails to maintain an average passing or certification rate of eighty percent of first time writers for three consecutive years, the program must complete an assessment of possible contributing factors, submit a plan of correction, and the commission may conduct an evaluation visit. The program may request technical assistance from the commission. The commission shall place the program on conditional approval status.

(iv) Fails to maintain a passing or certification rate of eighty percent for four out of five consecutive years, the commission shall continue the program on conditional approval, require a full survey evaluation visit, and may withdraw program approval following the site visit.

(5) The commission may withdraw approval from existing nursing education programs if it determines that a nursing education program fails to meet substantially the standards for nursing education as contained in WAC 246-840-511 through 246-840-556.

(6) All these actions shall be taken in accordance with the Administrative Procedure Act, chapter 34.05 RCW, and any applicable rules of the commission.

[]

NEW SECTION

WAC 246-840-559 Closing of an approved nursing education program located in Washington state.

Voluntary Closure

(1) When a governing institution decides to close a nursing education program it shall immediately notify the commission in writing,

stating the reason, plan, and date of intended closing. The governing institution may choose one of the following closing procedures:

(a) The nursing education program may continue until the last class enrolled is graduated if:

(i) The nursing education program continues to meet the standards for approval, WAC 246-840-511 through 246-840-556 until all of the enrolled students have graduated;

(ii) The date of closure is the date on the degree, diploma, or certificate of the last graduate; and

(iii) The governing institution notifies the commission in writing of the closing date; or

(b) The program may close after assisting in the transfer of students to other approved programs if:

(i) The program continues to meet the standards required for approval, WAC 246-840-511 through 246-840-556 until all students are transferred;

(ii) The governing institution submits to the commission a list of the names of students who have been transferred to approved programs and the date on , which the last student was transferred; and

(iii) The date on which , the last student was transferred shall be the closing date of the program.

Closing as a Result of Withdrawal of Approval

(2) When the commission withdraws approval of a nursing education program, the governing institution shall comply with the following procedures:

(a) Students of the nursing education program shall be notified in writing of their status and options for transfer to an approved program.

(b) The nursing education program shall close after assisting in the transfer of students to other approved programs. The commission must establish a period for the transfer process.

(c) The governing institution shall submit to the commission a list of the names of students who have transferred to approved programs and the date on which the last student was transferred.

Requirements for All Nursing Education Programs That Close

(3) Nursing education programs regardless of type of closure shall submit to the commission a plan for the secure storage and access to academic records and transcripts at the time of the decision to close the program.

[]

NEW SECTION

WAC 246-840-561 Reinstatement of approval for nursing programs located in Washington state. The commission may consider reinstatement of withdrawn approval of a nursing education program after one year and upon submission of satisfactory evidence that the program will ~~meet meets~~ the standards of nursing education, WAC 246-840-511 through 246-840-556. The commission may conduct a site visit to verify the evidence provided by the nursing education program.

[]

NEW SECTION

WAC 246-840-562 Appeal of commission decisions. A nursing education program wishing to contest a decision by the commission that affects the program's approval status shall have the right to appeal the commission's decision in accordance with the provisions of chapter 18.79 RCW and the Administrative Procedure Act, chapter 34.05 RCW.

[]

NEW SECTION

WAC 246-840-563 Criteria for approval of LPN and RN refresher course program located in Washington state. (1) A program making ap-

plication to the commission for approval of a refresher course for LPNs and RNs in Washington state ~~must~~ shall submit a commission approved application at least three months before expected date of implementation.

(2) For in-state refresher course programs, the refresher program shall have a designated nurse administrator who is responsible for the overall operation and evaluation of the refresher program meeting the following qualifications:

(a) Active, unencumbered Washington state RN license; and

(b) Bachelor's degree in nursing with a graduate degree in nursing from a nursing accredited nursing education program, or bachelor's degree in nursing from a nursing education accredited program and a graduate degree from a health-related field from an accredited university.

(3) The philosophy, purpose and objectives of the refresher course ~~shall~~ must be clearly stated and available in written form. They ~~shall~~ must be consistent with the definition of nursing as outlined in chapter 18.79 RCW and WAC 246-840-700 and 246-840-705.

Objectives reflecting the philosophy ~~shall~~ must be stated in behavioral terms and describe the capabilities and competencies of the graduate.

(4) All nurse faculty shall:

(a) Hold an unencumbered, active license to practice as a registered nurse in the state of Washington;

(b) Be qualified academically and professionally for their respective areas of responsibility.

(i) LPN faculty shall hold a bachelor's degree in nursing from a nursing accredited nursing program;

(ii) RN faculty shall hold a bachelor's degree in nursing and a graduate degree in nursing from a nursing education accredited program or a bachelor's degree in nursing from a nursing accredited program and a graduate degree in a health-related field from an accredited university.

(c) Be qualified to develop and implement the program of study with at least two years of teaching experience;

(d) Plan, develop, supervise and evaluate clinical experiences.

(e) Be sufficient in number to achieve the stated program objectives.

The maximum faculty to student ratio in the clinical area and simulation lab ~~shall~~ must be 1 to 12. Exceptions shall be justified to and approved by the commission.

(5) The course content, length, methods of instruction and learning experiences shall be consistent with the philosophy and objectives of the course. Outlines and descriptions of all learning experiences shall be available in writing.

(6) The refresher program shall have written policies to include, but are not limited to:

- (a) Admission requirements;
- (b) Progression requirements and grading criteria;
- (c) Dismissal criteria;
- (d) Clinical and practice requirements;
- (e) Grievance process;
- (f) Student expectations and responsibilities; and
- (g) Program costs and length of program.

(7) The program shall submit substantive change requests to the commission including changes in:

- (a) Program name, mailing address, electronic address, web site address, or phone number;
- (b) Curriculum;
- (c) Clinical, simulation or didactic hours;
- (d) Program instruction methods; or
- (e) Ownership including adding or deleting an owner.

(8) Evidence-based methods shall be used to measure the student's achievement of the stated theory and clinical objectives.

(9) The refresher course shall be evaluated by faculty and students regularly.

(10) The refresher course shall ensure that prior to clinical practice experiences, the enrolled student holds either a limited education authorization from the commission, or an active nursing license in Washington state.

(11) The refresher course shall ensure all students have clinical practice experiences established at the time of enrollment.

(12) Refresher course faculty or qualified preceptors may be used to teach in the clinical setting.

(a) Preceptors shall be licensed at same level of licensure as the student's refresher course type;

(b) Preceptors shall not be related to, or friends of the student;

(c) Preceptors shall receive the goals and objectives of the clinical practice course from the refresher program prior to the student's clinical experience; and

(d) Preceptors may assist faculty in the evaluation of the student's clinical learning experience.

(13) The refresher course shall not place students in the clinical setting without first validating student skills and knowledge to perform in the clinical setting.

(14) The refresher course shall maintain student records demonstrating the students have successfully completed the course and met the stated objectives for at least five years from date of course completion.

(15) The refresher course shall provide a certificate of successful completion of the course to the student. The certificate shall contain the following:

(a) Name of participant;

(b) Name of program;

(c) Number of didactic and clinical hours successfully completed;
and

(d) Date of participant's completion of the program.

(16) The refresher course program shall submit an annual report to the commission on commission designated forms.

(17) The refresher course program shall apply for renewal of approval every three years by submitting a commission approved renewal application no later than three months before expiration of the approval.

[]

NEW SECTION

WAC 246-840-564 Curriculum for LPN nurse refresher course. For practical nurse refresher course programs, the course content ~~shall~~ must consist of a minimum of sixty hours of theory content and one hundred twenty hours of clinical practice.

(1) The theory course content ~~shall~~ must include, but not be limited to, a minimum of sixty hours in current basic concepts of:

(a) Nursing process and patient centered care;

(b) Cultural competence across the life span;

(c) Pharmacology, medication calculation, administration, safety, and the mitigation and reporting of medication errors;

(d) Review of the concepts in the areas of:

(i) Current practical nursing practice, including legal expectations as identified in chapters 18.79 and 18.130 RCW, and nursing scope of practice, including the commission approved scope of practice decision tree;

(ii) Therapeutic and basic communications and observational practices needed for identification, reporting, and recording patient needs; and

(iii) Basic physical, biological, and social sciences necessary for practice.

(e) Review and updating of practical nursing knowledge and skills to include, but not be limited to, concepts of delegation, leadership, fundamentals, medical, surgical, geriatric, and mental health nursing.

(2) The clinical course content shall include a minimum of one hundred twenty hours of clinical practice in the area(s) listed in subsection (1)(e) of this section.

(a) Sixty hours of clinical practice may be obtained through lab simulation if the program has adequate lab space and equipment to accommodate student learning and is approved by the commission.

(b) Exceptions shall be justified to and approved by the commission.

[]

NEW SECTION

WAC 246-840-566 Curriculum for registered nurse refresher course.

For registered nurse refresher course programs, the course content ~~shall~~ must consist of a minimum of forty hours core course content, forty hours of specialty course content, and one hundred sixty hours of clinical practice in the specialty area.

(1) The core course content ~~shall~~ must include, but not be limited to, a minimum of forty hours of theory in current basic concepts of:

(a) Nursing process and patient centered care;

(b) Cultural competence across the life span;

(c) Pharmacology, major drug classifications, medication calculations and administration, side effects, adverse reactions, associated lab tests and mitigation and reporting of medication errors;

(d) Critical thinking, clinical reasoning, and evidence-based practice;

(e) Review of the concepts in the areas of:

(i) Current professional nursing practice, including legal expectations as found in chapters 18.79 and 18.130 RCW, and nursing scope of practice, including the commission approved scope of practice decision tree;

(ii) Therapeutic and clinical communication skills and observational practices needed for identification, reporting, and recording patient needs; and

(iii) Basic physical, biological and social sciences necessary for practice; and

(f) Review and updating of registered nursing knowledge and skills, including delegation, leadership, interdisciplinary team coordination and care management.

(2) The specialty course content shall include, but not be limited to, a minimum of forty hours of theory in current specialty nursing practice concepts of basic nursing related to the special area of interest such as surgical, pediatrics, obstetrics, psychiatric, acute, intensive, extended care, or community health nursing.

(3) The clinical course content shall include a minimum of one hundred sixty hours of clinical practice in the specialty area(s) of interest as listed in subsection (2) of this section.

(a) Eighty hours of clinical practice may be obtained through lab simulation if the program has adequate lab space and equipment to accommodate student learning and is approved by the commission.

(b) Exceptions shall be justified to and approved by the commission.

[]

NEW SECTION

WAC 246-840-567 Refresher course program for advanced registered nurse practice nurses. (1) A college or university approved by the

commission and located in the state of Washington to offer a graduate level nursing education program preparing students for advanced regis-
tered nurse licensure practice registered nursing (ARNP) program may apply to offer an ARNP refresher course program on a commission approved form.

(2) The nurse administrator or qualified designee of an approved ARNP program shall be responsible for the ARNP refresher course program. The designee shall meet the same qualification requirements as identified in WAC 246-840-517(3).

(3) The faculty teaching in the ARNP refresher program shall meet the requirements of WAC 246-840-523.

(4) The ARNP refresher course will provide didactic and clinical instruction in the full scope of practice of ARNP role and population foci as allowed in chapter 18.79 RCW and this chapter.

(5) At a minimum, the ARNP refresher program will include instruction and two hundred fifty hours of associated clinical practice and may offer more hours if required for licensure in:

- (a) Advanced physiology/pathophysiology;
- (b) Advanced health assessment;
- (c) Pharmacotherapeutics;

(d) Diagnosis and management of diseases or conditions consistent with current standards of care;

(e) Ordering and interpreting diagnostic and laboratory tests;

(f) Safe and competent performance of procedures;

(g) ARNP scope of practice as defined in chapters 18.79 RCW and 246-840 WAC;

(h) Accepted standards of practice for ARNP.

[]

NEW SECTION

WAC 246-840-568 Criteria for approval of refresher course program located outside Washington state. (1) Refresher courses from outside the state of Washington shall be reviewed individually for approval by the commission and must meet curriculum and clinical practice standards identified in WAC 246-840-563, 246-840-564, 246-840-566 or 246-840-569.

(2) The nurse administrator and faculty ~~must~~ shall hold an active, unencumbered RN license in the state of the program's domicile location and meet the requirements of WAC 246-840-563 (2)(b).

(3) The commission may:

(a) Approve a refresher program for no longer than five years;

- (b) Deny approval of a refresher program;
- (c) Withdraw approval of a refresher program;
- (d) Place a program on warning or conditional approval status;
- (e) Make on-site visits to determine compliance with commission requirements for initial or ongoing approval, or to investigate a complaint;
- (f) Require a program to submit a plan of correction; or
- (g) Issue a directed plan of correction.

(4) A refresher program wishing to contest a decision of the commission affecting its approval status shall have the right to appeal the commission's decision in accordance with the provisions of chapter 18.79 RCW and the Administrative Procedure Act, chapter 34.05 RCW.

[]

NEW SECTION

WAC 246-840-569 Commission action regarding refresher course programs. (1) The commission may:

- (a) Approve a refresher program for no longer than five years;
- (b) Deny approval of a refresher program;
- (c) Withdraw approval of a refresher program;
- (d) Place a program on warning or conditional approval status;

(e) Make on-site visits to determine compliance with commission requirements for initial or ongoing approval, or to investigate a complaint;

(f) Require a program to submit a plan of correction; or

(g) Issue a directed plan of correction.

(2) A refresher course program wishing to contest a decision of the commission affecting its approval status shall have the right to appeal the commission's decision in accordance with the provisions of chapter 18.79 RCW and the Administrative Procedure Act, chapter 34.05 RCW.

[]

NEW SECTION

WAC 246-840-571 Out-of-state distance learning nursing program approval for practice experiences in Washington state. (1) The commission may approve out-of-state distance learning nursing education programs for the purpose of clinical or practice experiences in the state of Washington. The out-of-state distance learning nursing education program shall:

(a) Complete and submit a commission approved application and demonstrate equivalency to requirements for in-state Washington nursing programs;

(b) Provide clinical and practice supervision and evaluation of students in Washington state;

(c) Ensure the faculty, preceptors and others who teach, super-
vise, or evaluate clinical or practice experiences in the state of Washington hold an active, unencumbered nursing license appropriate to the level of student teaching. Faculty must be licensed in the state of Washington as at an-~~the~~ ARNP level if teaching advanced registered nurse~~s~~ practitioner practice;

(d) Preceptors for students in a nursing education program pre-
paring nurses for advanced registered nurse practitioner licensure ~~students~~ shall not be related to the student or personal friends, and shall have an active, unencumbered license as an ARNP, a physician, as identified in chapter 18.71 RCW, an osteopathic physician in chapter 18.57 RCW, or equivalent in other states or jurisdictions;

(e) Ensure the faculty who teach didactic distance learning nursing courses hold a current and active, unencumbered nursing license in the state where the nursing program has legal domicile;

(f) Be accredited by a nursing education accrediting body approved by the United States Department of Education;

(g) Maintain accreditation status by the nursing education accrediting body;

(h) Report to the commission within thirty days of notice from the nursing education accrediting body if the accreditation status has changed; and

(i) Submit an annual report to the commission as identified in commission approved survey.

(2) The commission may conduct site visits or complaint investigations to clinical or practice locations to ensure compliance with commission requirements.

(3) The commission may withdraw clinical placement approval if it determines a nursing education distance learning program fails to meet the standards for nursing education as contained in WAC 246-840-511 through 246-840-556.

(4) The commission may refer complaints regarding the distance learning nursing education program to the home state board of nursing and appropriate nursing education accreditation body.

(5) A distance learning nursing education program wishing to contest a decision of the commission affecting its approval status for

clinical or practice experiences shall have the right to a brief adjudicative proceeding under the Administrative Procedure Act, chapter 34.05 RCW.

[]

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-840-130	Criteria for approved refresher course.
WAC 246-840-455	Requirements for advanced registered nurse practice educational programs in Washington state.
WAC 246-840-515	Branch campus and distance learning nursing education programs.
WAC 246-840-520	Ongoing evaluation and approval of nursing education programs.
WAC 246-840-525	Commission action following survey visits.
WAC 246-840-530	Denial, conditional approval or withdrawal of approval.
WAC 246-840-535	Reinstatement of approval.
WAC 246-840-540	Appeal of commission decisions.
WAC 246-840-545	Closing of an approved nursing education program.
WAC 246-840-548	Standards and evaluation of nursing education.
WAC 246-840-550	Standard I. Purpose and outcomes for approved nursing education programs.
WAC 246-840-555	Standard II. Organization and administration for approved nursing education programs.
WAC 246-840-560	Standard III. Resources, facilities, and services for approved nursing education programs.
WAC 246-840-565	Standard IV. Students in approved nursing education programs.
WAC 246-840-570	Standard V. Faculty in approved nursing education programs.
WAC 246-840-575	Curriculum for approved nursing education programs.

AMENDATORY SECTION (Amending WSR 08-11-019, filed 5/12/08, effective 6/12/08)

WAC 246-840-045 Initial licensure for registered nurses and practical nurses who graduate from an international school of nursing. (1)

Registered (~~(nursing)~~) nurse and practical (~~(nursing)~~) nurse applicants educated in a jurisdiction which is not a member of the National Council of State Boards of Nursing and applying for initial licensure must:

~~((1))~~ (a) Successfully complete a basic nursing education program approved in that country.

~~((a))~~ (i) The nursing education program must be equivalent to the minimum standards prevailing for nursing education programs approved by the commission.

~~((b))~~ (ii) Any deficiencies in the nursing program (theory and clinical practice in medical, psychiatric, obstetric, surgical and pediatric nursing) (~~(must)~~) may be satisfactorily completed in a commission approved nursing program or program created for internationally educated nurses identified in WAC 246-840-538, 246-840-53801 or 246-840-53803.

(b) Possess an active, unencumbered nursing license in that country.

(c) Obtain an evaluation or certificate from a commission approved credential evaluation service verifying that the educational program completed by the applicant is equivalent to nursing education in the state of Washington.

~~((2))~~ (d) Demonstrate English language proficiency by passing a commission approved English proficiency examination at a commission designated standard prior to commission approval to take the national licensing examination.

Individuals from ~~((countries where English is the primary language and where nursing education (theory and clinical) is conducted in English will have this requirement waived))~~ Canada (except for Quebec), United Kingdom, Ireland, Australia, New Zealand, Samoa, Guam, Mariana Island, and Virgin Islands will have this requirement waived.

~~((3))~~ (e) Complete seven clock hours of AIDS education as required in chapter 246-12 WAC, Part 8.

~~((4))~~ (f) Successfully pass the commission approved licensure examination as provided in WAC 246-840-050.

~~((5))~~ (2) Registered nurse and practical nurse applicants must submit the following documents:

(a) A completed licensure application with the required fee as defined in WAC 246-840-990.

(b) (~~LPNs must submit an:~~

~~(i))~~) Official transcript directly from the nursing education program or licensure agency in the country where the applicant was educated (~~(or)~~) and previously licensed.

(i) Transcript must be in English or accompanied by an official English translation. If the applicant's original documents (education and licensing) are on file in another state or with an approved credential evaluation ~~ing~~ agency, the applicant may request that the state board or approved credential evaluating agency send copies directly to the commission in lieu of the originals.

(ii) The transcript must:

(A) Include the applicant's date of enrollment, date of graduation and credential conferred.

(B) Describe the course names and credit hours completed.

(C) Document equivalency to the minimum standards in Washington state. Course descriptions or syllabi may be requested to determine equivalency to Washington state standards.

~~((ii))~~) (c) Documentation from a commission approved nursing program showing that any deficiency (~~in theory and clinical practice~~

~~in medical, psychiatric, obstetric, surgical and pediatric nursing))~~
has been satisfactorily completed.

~~((iii))~~ (d) Documents must show the applicant has passed a commission approved English proficiency examination ~~((at a commission designated standard. This documentation will not be required from individuals from countries where English is the primary language and where nursing education (theory and clinical) is conducted in English.~~

~~(c) RNs must submit:~~

~~(i) A certificate or credential from a commission approved credential evaluating service verifying that the educational program completed by the applicant is equivalent to registered nursing education in Washington state. This documentation will not be required for individuals who have passed the national licensing examination and are licensed as a registered nurse by another United States nursing board.~~

~~(ii) Documents showing the applicant has passed a commission approved English proficiency examination at a commission designated standard. This documentation will not be required for individuals from countries where English is the primary language or where nursing education, theory and clinical, is conducted in English))~~ or the requirement is waived as identified in subsection (1) of this section.

(e) Documentation of professional nurse license or nurse credential from the agency responsible for nurse licensure in the foreign country. Required information includes:

(i) The license number and status of the license or credential;

and

(ii) The original country of licensure or credentialing.

[Statutory Authority: RCW 18.79.110. WSR 08-11-019, § 246-840-045, filed 5/12/08, effective 6/12/08.]

AMENDATORY SECTION (Amending WSR 08-11-019, filed 5/12/08, effective 6/12/08)

WAC 246-840-090 Licensure for nurses by interstate endorsement.

Registered nursing and practical nursing applicants for interstate endorsement as a nurse may be issued a license without examination provided the applicant meets the following requirements:

(1) The applicant has graduated and holds a credential degree

from:

(a) A commission or state board approved program preparing candidates for licensure as a nurse; or

(b) ~~((Its))~~ A nursing program that is equivalent to commission approved nursing education in Washington state at the time of graduation as determined by the commission~~((, which program must fulfill the minimum requirements for commission or state board approved registered nursing programs in Washington at the time of graduation))~~.

(2) Students graduating from nursing programs outside the U.S. must demonstrate English proficiency by passing a commission approved English proficiency test if the nursing education is not in one of the following countries: Canada (except for Quebec), United Kingdom, Ireland, Australia, New Zealand, Samoa, Guam, Mariana Island, and Virgin

Islands, or complete one thousand hours of employment as a licensed nurse in another state.

(a) The English proficiency test must be taken before commission approval to take the national licensing exam.

(b) The one thousand hours of employment must be in the same licensed role as the nurse is applying for licensure in Washington state. Proof of employment must be submitted to the commission.

(3) The applicant was originally licensed to practice as a nurse in another state or territory after passing a state approved examination.

~~((3))~~ (4) The applicant possesses a current active nursing license without discipline in another state or territory, or, possess an inactive or expired license in another state or territory and successfully complete a commission approved refresher course.

(a) An applicant whose license was inactive or expired must be issued a limited education authorization by the commission to enroll in the clinical portion of the refresher course.

(b) The limited education authorization is valid only while working under the direct supervision of a preceptor and is not valid for employment as a registered nurse.

~~((4))~~ (5) For RNs: If the applicant is a graduate of a nontraditional program in nursing as defined in WAC 246-840-010 and:

(a) Was licensed as a practical/vocational nurse prior to licensure as a registered nurse, the applicant must document two hundred hours of preceptorship in the role of a registered nurse as defined in WAC 246-840-035 or at least one thousand hours of practice as a registered nurse without discipline of the registered nurse license by any other state or territory.

(b) Was not licensed as a practical/vocational nurse prior to licensure as a registered nurse, the applicant must document at least one thousand hours of practice as a registered nurse without discipline of the registered nurse license by any other state or territory.

~~((5))~~ (6) Complete seven clock hours of AIDS education as required in chapter 246-12 WAC, Part 8.

~~((6))~~ (7) Applicants must submit the following documents:

(a) A completed licensure application with the required fee as defined in WAC 246-840-990.

(b) An official transcript sent directly from the applicant's nursing education program to the commission.

(i) The transcript must contain adequate documentation to demonstrate that the applicant has graduated from an approved nursing pro-

gram or has successfully completed the prelicensure portion of an approved graduate-entry registered nursing program.

(ii) The transcripts shall include course names and credits accepted from other programs.

(c) Verification of an original registered nurse license sent directly to the commission from the state or territory of original licensure. This document must include verification that the original licensure included passing a state examination or computerized verification from NurSYS®.

(d) Verification of a current active or expired nurse license in another state or territory sent directly to the commission from that state's or territory's licensure agency. Verification that the applicant has successfully completed a commission approved refresher course may be accepted if the applicant's out-of-state licensure is on inactive or expired status.

(e) For RNs: If the applicant is a graduate of a nontraditional program in nursing as defined in WAC 246-840-010 and:

(i) Was licensed as a practical/vocational nurse prior to licensure as a registered nurse, the applicant must submit documentation of two hundred hours of preceptorship in the role of a registered nurse as defined in WAC 246-840-035 or at least one thousand hours of prac-

tice as a registered nurse without discipline of the registered nurse license by any other state or territory.

(ii) Was not licensed as a practical/vocational nurse prior to licensure as a registered nurse, the applicant must submit documentation of at least one thousand hours of practice as a registered nurse without discipline of the registered nurse license by any other state or territory.

[Statutory Authority: RCW 18.79.110. WSR 08-11-019, § 246-840-090, filed 5/12/08, effective 6/12/08; WSR 99-13-086, § 246-840-090, filed 6/14/99, effective 7/15/99. Statutory Authority: RCW 43.70.280. WSR 98-05-060, § 246-840-090, filed 2/13/98, effective 3/16/98. Statutory Authority: Chapter 18.79 RCW. WSR 97-13-100, § 246-840-090, filed 6/18/97, effective 7/19/97.]

**DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION
PROCEDURE**

Title:	Lists and Labels Recognition Criteria	Number:	J04.07 8
Reference:	RCW 42.56.070 (9); RCW 18.79.100		
Contact:	Paula R. Meyer, MSN, RN, FRE -(360) 236-4713		
Effective Date:	September 11 November 13 , 2015		
Supersedes:	September 11, 2015 ; September 13, 2002; November 16, 2007; July 11, 2008; March 13, 2009; October 19, 2009; September 12, 2014		
Approved:	Margaret E. Kelly, LPN, Chair Washington State Nursing Care Quality Assurance Commission		

PURPOSE:

Pursuant to RCW [42.56.070\(9\)](#), staff may give lists of individual nurses, including addresses, to professional associations and educational organizations recognized by the Nursing Care Quality Assurance Commission (NCQAC). An organization or association may be denied recognition by the NCQAC only for good cause after a hearing pursuant the Administrative Procedure Act, RCW 34.05.

[The NCQAC delegates to a panel of three commission members \(Panel\) the task of screening requests that do not clearly meet the criteria for staff approval and require commission discretion for approval or denial.](#)

PROCEDURE:

This procedure defines criteria for staff to evaluate ~~applications-requests~~ for lists and labels by professional associations and educational organizations. Such associations or organizations meeting these criteria may be given lists of individual nurses, including addresses, upon payment of an appropriate fee as allowed by RCW [42.56.070\(9\)](#). If the applicant does not [clearly](#) meet these criteria, [the Panel reviews the requests and makes the determination to approve or deny the request. If the Panel denial is appealed by the requestor, a a](#)-hearing before the [full](#) NCQAC ~~may~~[will](#) be scheduled, ~~at the request of the organization or association's request.~~

CRITERIA:

Educational Organization

An accredited or approved institution or entity preparing professionals for initial licensure in a health care field or providing continuing education for health care professionals.

Professional Association

A group of individuals or entities organized to:

- represent the interest of a profession or professions;
- develop criteria or standards for competent practice; or,
- advance causes seen as important to its members, which will improve quality of care rendered to the public.

Revised: [1109/143/2015](#)

Formatted: Font: Bold

Formatted: Underline

Formatted: Font: Courier New, 10 pt

Formatted: Normal

DRAFT

Commission Approved List and Labels Renewals 9/11/2015			
Professional Organization	Approved Profession (use 2-letter abbreviation)	Approval Date	Expiration Date
Adult Family Home Options	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
All approved schools of nursing as listed in the NCLEX candidate bulletin for U.S. or U.S. territories or jurisdictions	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
American Academy of Nurse Practitioners	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
American College of Nurse Midwives	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
American Nurses Association (ANA)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
American Red Cross	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
American Red Cross, Mount Rainier Chapter	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Anesthetists (WANA)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
ARNP United	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Association of Advanced Practice Psychiatric Nurses	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Association of Advanced Practice Psychology Nurses (AAPPA)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Association of Operating Room Nurses (AORN)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Benton Franklin County Medical Society	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Borooks College of health (ARNP)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Brian Frei, Clinical Educator	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Catalist, LLC	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Cecil G Sheps Center for Health Services Research	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Clark County Public Health	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Council of Nurse Educators of Washington State (CNEWS)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Fedelta Home Care Washington Case manager Association, Home Care and Hospice and National Private Duty Organization	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Fred Hutchinson Cancer Research Center	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Gannet Health Care Group	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Grays Harbor County Coroner	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Gritman Medical Center	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Harvard School of Public Health	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Health Education Network LLC	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Home Care Association of Washington (HCAW)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Horizon CME, Ince.	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
IMS Health	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Institute for Integral Development	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Institute for Natural Resources	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Institute from Brain Proposal	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
King County Nurses Association	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Kitsap Sun Newspaper	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Merrion Matters (PA State Nurses Assoc.)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020

Commission Approved List and Labels Renewals 9/11/2015			
Professional Organization	Approved Profession (use 2-letter abbreviation)	Approval Date	Expiration Date
Midwives Association of Washington State (Maws)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Mt. Baker Nurses Association	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
National Association of Nurse Practitioner Faculties	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
National Association of Nurse Practitioner in Women's Health	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
National Association of Pediatric Nurse Practitioners (NAPNAP)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
National Council of State Boards of Nursing (NCSBN)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
National Organization of Nurse Practitioners Faculties	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Nurse Practitioner Alternatives	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Nurse Practitioner Associates for Continuing Education (NPACE)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Nurse Practitioner Group of Spokane	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Northwest Organization of Nurse Executives (NWONE)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Old Dominion University	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Oregon Nurses Association	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Oregon Pediatric Nurse Practitioner Association (OPNPA) Oregon chapter	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
PESI Healthcare	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Pima Medical Institute	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Premera Blue Cross	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Publishing Concepts Inc (PCI)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Research Associate and Fellow	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Research Foundation of the State University of New York	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Right at Home Staffing	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
RL University (California)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Rural Hospital Associations	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
School Nurses Association of Washington (SNOW)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Seattle STD/HIV Prevention Training Center University of Washington	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
SEIU (Union)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
SEIU Healthcare 1199 NW	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
SEIU Healthcare 775 NW	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
SK & A Information SVS	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Swedish Medical Center	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Texas Nurses Association	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Therapeutic Consultants, Inc	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
University of North Carolina at Chapel Hill	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
University of Phoenix	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
University of Washington Educational Outreach	ARNP, RN, NT, LPN	9/11/2015	9/10/2020

Commission Approved List and Labels Renewals 9/11/2015			
Professional Organization	Approved Profession (use 2-letter abbreviation)	Approval Date	Expiration Date
Verisys Incorporation	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Walla Walla General Hospital	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Walter Anderson	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington Association of Nurse Anesthetists (WANA)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington Association of Perioperative Nurses (WAPN)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington Center for Nursing - Seattle Non Profit Organization	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington Hospice and Palliative Care Association	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington State Hospital Association (WSHA)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington State Nurses Association (WSNA)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington State Student Nurses	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
West Sound Advanced Practice Association	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Western University of Health Sciences College of Graduate Nursing	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
William Waldo	ARNP, RN, NT, LPN	9/11/2015	9/10/2020

Commission Approved List and Labels Renewals 9/11/2015			
Educational Organization	Approved Profession (use 2-letter abbreviation)	Approval Date	Expiration Date
Acadamus Training, LLC	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Acute Care Education, LLC	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Adult Family Home Options	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
All approved schools of nursing as listed in the NCLEX Candidate Bulletin for U.S. or U.S. territories and jurisdictions	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
American Sentinel University	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Bastyr University	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Boise State University	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Brooks College of Health, ARNP University of Florida	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
CE-Classes.com	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
CE International	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
CME Resources/CE Resources	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Continuing Education	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Cross Country Education	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Distance Learning Systems	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Eastern Washington University	ARNP, RN, LPN, NT	9/11/2015	9/10/2020
Federation of State Medical Boards	ARNP, RN, LPN, NT	9/11/2015	9/10/2020
Foundation for Health & Healing	ARNP, RN, LPN, NT	9/11/2015	9/10/2020
Gannett Healthcare Group	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Gentiva Health Services	ARNP, RN, NT, LPN	9/11/2015	9/10/2020

Commission Approved List and Labels Renewals 9/11/2015			
Educational Organization	Approved Profession (use 2-letter abbreviation)	Approval Date	Expiration Date
Gerry Grossman Seminars	ARNP, RN, LPN, NT	9/11/2015	9/10/2020
Harrison Medical Center	ARNP, RN, LPN, NT	9/11/2015	9/10/2020
Haase & Associates, Inc., dba Haase Seminars	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Health Education Network, LLC, DBA Health Ed	ARNP, RN, LPN, NT	9/11/2015	9/10/2020
Implant Seminars	ARNP, RN, LPN, NT	9/11/2015	9/10/2020
Independence Rehab LLC	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
International Association of Infant Massage / Family Massage Education Center	ARNP, RN, LPN, NT	9/11/2015	9/10/2020
Kalispell	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Legacy Good Samaritan Hospital, Cancer Services	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Lewis and Clark Graduate School Of Education and Counseling	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Med-Ed	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Medenet	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Medical-Legal Consulting Institute Inc. DBA Vickie Milazzo Institute	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Medical Simulation Corporation	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Myotonic Facilitation/Texas Chiropractic College	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
National Center for the Analysis of Healthcare Data Edward Via College of Osteopathic Medicine	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Oregon Dental Executive Association	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Oregon Health & Sciences University -	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Oregon Hearing Society	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Oregon Pediatric Nurse Practitioner Association (OPNPA) Oregon chapter	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Oregon State Council of Perioperative Nurses	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Overlake Hospital Medical Center	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Pacific Lutheran University School of Nursing	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Pima Medical Institute	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Portland Community College/Climb	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Premera Blue Cross	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Ready Bodies, Learning Minds	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Rehab Seminars	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Right at Home Staffing	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Russo CME	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
SC Publishing DBA Western Schools	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Seattle University, College of Nursing	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
St Martin's University	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
The Institute of Continuing Education	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
The Rx Consultant	ARNP, RN, NT, LPN	9/11/2015	9/10/2020

Commission Approved List and Labels Renewals 9/11/2015			
Educational Organization	Approved Profession (use 2-letter abbreviation)	Approval Date	Expiration Date
The Wellness Institute	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Therapy Network	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Tobacco Prevention Resource Center	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Transformative Groups, dba Association for Humanistic Psychology	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
University Learning Systems	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
University of Michigan	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
University of Nevada, Las Vegas	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
University of Washington	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
University of Washington School of Nursing (UWCNE)	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
University of Washington Tacoma Nursing Program	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Walla Walla General Hospital	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Walter Anderson	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington State Council On Problem Gambling	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington State Student Nurses	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington State University	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Washington State University, College of Nursing	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Western Pain Society	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Whatcom County Health Department, Whatcom County ABCD Program and Oral Health Coalition	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
William Waldo	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
Wu Hsing Tao School	ARNP, RN, NT, LPN	9/11/2015	9/10/2020
ZL Workshops	ARNP, RN, NT, LPN	9/11/2015	9/10/2020

Lists and Labels Denied Requests	
Organization Name	Date of Denial
Right At Home	4/10/2008
SEIU Healthcare 775NW	4/17/2008
Healthcare Resources	5/27/2008
Fastaff Travel Nursing	5/27/2008
Jack Blackburn	6/30/2008
Integrated Pharma Technologies	6/30/2008
Liberty County Place	7/28/2008
Law Offices of Julianne Kocer	8/27/2008
Department of L & I	10/17/2008
Virginia College of Osteopathic Medicine	10/17/2008
AAA Medical Staffing	10/17/2008
Research & Data Services – Library Services Department of L & I	10/17/2008
Dare to Care Enterprises	10/17/2008

Lists and Labels Denied Requests

Organization Name	Date of Denial
March of Dimes Greater Oregon Chapter	2/12/2009
Healthcare United	2/24/2009
Full Life Consulting	3/30/2009
Labor and Industries	4/4/2009
Sound Family Medicine	4/30/2009
LHC Group	4/30/2009
SEIU Healthcare District 1199 NW	8/11/2009
Cegedim Dendrite	8/11/2009
Kootenai Health	8/11/2009
Protouch Staffing	8/11/2009
Erin Murray	8/11/2009
Verisys/GMS	10/19/2009
StaffLink	11/2/2009
Fastaff Travel Nursing	12/4/2009
Gentiva Health Services	12/4/2009
Medcor, Inc	12/4/2009
Medcor, Inc.	12/4/2009
Fastaff Travel Nursing	12/4/2009
Trinity Health Care Staffing Group	12/4/2009
SK & A Information SVS	6/14/2010
Mail Marketing and United Enterprises	6/14/2010
Trinity Healthcare Staffing Group	6/17/2010
Distance Learning Systems	12/22/2010
Elite Speciality Staffing, Inc.	5/6/2011
Shaker Recruitment Advertising	6/7/2011
Seattle Met	7/13/2011
Tacoma Pierce County Health Department	7/13/2011
Adult Family Home Options	8/23/2011
Camp Korey	7/20/2012
IMS Health	12/5/2012
Shriners	3/20/2013
Extencicare	8/8/2013
Seattle Cancer Alliance/Fred Hutchins Cancer Research	8/14/2013
Advantage RN, LLC	8/15/2013
Continuing EDU.org (PDRC determined this entity was a database seller and revoked previous approval)	10/8/2013
Faith and Spirit Inc. DBA "Right at Home"	10/22/2013
Clinical Staff Nursing	11/13/2013
Verisys Corporation	11/13/2013
Diligent Medical Billing	12/23/2013
James Babb	4/8/2014
Washington State Coalition of Mental Health Prof's and Consumers	7/15/14

Lists and Labels Denied Requests

Organization Name	Date of Denial
Veeva Systems	7/15/14
RediClinic	9/19/14
Professional Research Services	9/19/14
J. Knipper and Company, Inc.	9/19/14
Merion Matters, Inc.	11/21/14
Health Market Science	03/27/15
Kootenai Health	03/27/15
Cascadia Continuing Education, LLC	05/19/15
Monster World Wide	05/19/15
All's Well Health Care	05/19/15
Misty Cauthen	05/19/15
Victory Medical Solutions	07/24/15

Expired Organizations on PDRC List

Organization	Profession	Approval Date	Expiration Date
Osher Research Center at Harvard Medical School	NT	5/18/2008	5/17/2013
Puget Sound Adlerian Society (PSAS)	NT	10/11/2007	10/09/2012
Recovery Systems Clinic	NT	8/6/2007	8/4/2012
SEROYAL	NT	8/6/2007	8/4/2012

Approvals Since 9/11/15

Organization	Profession	Approval Date	Expiration Date
McKissock LLC for Elite CME	ARNP, RN, NT, LPN	9/17/15	9/16/2020

Application for Approval to Receive Lists/Labels

This is an application for approval to receive lists and labels, not a request for lists and labels. You may request lists and labels after you are approved. Approval can take up to three months.

RCW 42.56.070(9) limits access to lists and labels. Lists of credential holders may be released only to professional associations and educational organizations approved by the disciplining authority.

- A “professional association” is a group of individuals or entities organized to:
 - Represent the interests of a profession or professions;
 - Develop criteria or standards for competent practice; or
 - Advance causes seen as important to its members that will improve quality of care rendered to the public.
- An “educational organization” is an accredited or approved institution or entity which either
 - Prepares professionals for initial licensure in a health care field or
 - Provides continuing education for health care professionals.

We are a “professional association”

We are an “educational organization.”

Meagan Sayers 4695247524
 Primary Contact Name ↓ Phone ↓ Fax ↓

Claire Tafelski
 Additional Contact Names (Lists are only sent to approved individuals) ↓

AMN Healthcare 75-2404573
 Professional Assoc. or Educational Organization ↓ Federal Tax ID or Uniform Business ID number ↓

8840 Cypress Waters Blvd Dallas, TX 75019
 Street Address ↓ City, State, Zip Code ↓

In an effort to streamline our internal credentialing process, AMN Healthcare is appending our existing provider database with license number, license status, provider specialty and home address. This update will remove the need for our credentialing department to manually populate this information.

1. How will the lists and labels be used? ↓

CRNA and APRN

2. What profession(s) are you seeking approval for? ↓

Please attach information that demonstrates that you are a “professional association” or an “educational organization” and a sample of your proposed mailing materials.

Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865
 Fax to: PDRC - 360-586-2171
 Email to: PDRC@DOH.Wa.Gov

Signature ↓  Date ↓ 08/25/2015

If you have questions, please call (360) 236-4836

<u>For Official Use Only</u>	Authorizing Signature: _____
Approved: _____	Printed NOAC Business Meeting _____
5-year one-time	November 13, 2015



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Nursing Care Quality Assurance Commission
PO Box 47864
Olympia, Washington 98504-7864

September 2, 2015

Meagan Sayers
AMN Healthcare
8840 Cypress Waters Blvd Suite 300
Dallas, TX 75019

Re: Request for Additional Information

Dear Ms. Sayers:

On August 25, 2015 we received your request for recognition by the Nursing Commission to receive lists and labels.

In order to qualify as an approved "professional association" you must meet the following definition:

- A group of individuals or entities organized to: represent the interests of the profession or professions; develop criteria or standards for competent practice; or advance causes seen as important to its members that will improve quality of care rendered to the public.

Based on the information you provided, we cannot determine whether you meet the definition of a professional association. The Nursing Commission will review your request at the next commission meeting on November 13, 2015. In order to assist us with our decision please provide documentation confirming your status as a professional association. We must receive this information in our office by October 16, 2015.

If you have any questions, please feel free to contact me at (360) 236-4741.

Sincerely,

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

Enclosure

DECLARATION OF MAILING

I declare that today, at Olympia, Washington, I sent a copy of this document to Meagan Sayers by mailing a copy properly addressed with postage prepaid.

Dated this 2nd day of September 2015.

Paula R. Meyer MSN, RN, FRE, Executive Director
Nursing Care Quality Assurance Commission
(360) 236-4741



Signature



Application for Approval to Receive Lists/Labels

This is an application for approval to receive lists and labels, not a request for lists and labels. You may request lists and labels after you are approved. Approval can take up to three months.

RCW 42.56.070(9) limits access to lists and labels. Lists of credential holders may be released only to professional associations and educational organizations approved by the disciplining authority.

- A "professional association" is a group of individuals or entities organized to:
 - Represent the interests of a profession or professions;
 - Develop criteria or standards for competent practice; or
 - Advance causes seen as important to its members that will improve quality of care rendered to the public.
- An "educational organization" is an accredited or approved institution or entity which either
 - Prepares professionals for initial licensure in a health care field or
 - Provides continuing education for health care professionals.

We are a "professional association"

We are an "educational organization."

Makayla Powers 425-828-4500 425-828-4505
 Primary Contact Name J Phone J Fax J

Shelley Gentry Kam 425-242-7083 Same ↑
 Additional Contact Names (Lists are only sent to approved individuals) J

Namaste Training 602 377 771
 Professional Assoc. or Educational Organization J Federal Tax ID or Uniform Business ID number J

12020 113th Ave NE Bldg C Ste 180 Kirkland WA 98034
 Street Address J City, State, Zip Code J

for educational training classes and hiring of caregivers
 1. How will the lists and labels be used? J

Retired RN's, LPN's, CNA's
 2. What profession(s) are you seeking approval for? J

Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.

Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865

Fax to: PDRC - 360-586-2171

Email to: PDRC@DOH.Wa.Gov

Makayla Powers 9/30/2015
 Signature J Date J

If you have questions, please call (360) 236-4836

For Official Use Only	Authorizing Signature: _____
Approved: _____	Printed Name: _____
Denied: _____	Title: _____
5-year	one-time
	Date: _____



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Nursing Care Quality Assurance Commission
PO Box 47864
Olympia, Washington 98504-7864

October 8, 2015

Makaylaa Powers
Namaste Training
12020 113th Ave NE Bldg C Ste 180
Kirkland, WA 98034

Re: Request for Additional Information

Dear Ms. Powers:

On October 1, 2015 we received your request for recognition by the Nursing Commission to receive lists and labels.

To qualify as an approved "educational organization" you must meet the following definition:

- An educational organization is defined as an accredited or approved institution or entity which either prepares professionals for initial licensure in a health care field or provides continuing education for health care professionals.

Based on the information you provided, we cannot determine whether you meet the definition of an educational organization. The Nursing Commission will review your request at the next commission meeting on November 13, 2015. In order to assist us with our decision please provide documentation confirming your status as an educational organization. We must receive this information in our office by October 20, 2015.

If you have any questions, please feel free to contact me at (360) 236-4713.

Sincerely,

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

Enclosure

DECLARATION OF MAILING

I declare that today, at Olympia, Washington, I sent a copy of this document to Makaylaa Powers by mailing a copy properly addressed with postage prepaid.

Dated this 8th day of October 2015.

Paula R. Meyer MSN, RN, FRE, Executive Director
Nursing Care Quality Assurance Commission
(360) 236-4713


Signature

12020 113th Ave NE, Bldg C, Ste 180
Kirkland, WA 98034
425.242.7083
425.828.4505
namastetraining.com



Fax

To: Chris Archuleta	From: Shelley Gentry Karn, RN
Fax: 360.236.4738	Pages: 3
Phone: 360.236.4713	Date: October 20, 2015
Re: Education Training School	cc:

Urgent
 For Review
 Please Comment
 Please Reply
 Please Recycle

Comments:

Hello Chris,

Thank you for returning my phone call. I placed the hard copies of the letter and license in the mail, but I was worried you would not receive by the stated deadline in Ms. Meyer's letter. Please contact me if your office requires anything additional supporting documentation. We are happy to be considered.

Sincerely,

Shelley Gentry Karn, RN



12020 113th Ave N E, C-180
Kirkland, WA 98034
425.242.7083

October 19, 2015

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

Dear Ms. Meyer,

Attached you will find our license from Workforce Training and Education Coordinating Board of Washington State. The license has renewed and is in process for November of 2015. Our school has been teaching Home Care Aide (H.C.A.) certification classes for the last two and half years, using DSHS approved curriculum, and then our students are sent to Prometrics for the final skills and written tests to gain licensure. Our instructors, who are also nurses and EMT's, are also certified through the state to teach H.C.A. classes.

Please feel free to give me a call if you have any questions, or need further documentation. We appreciate your time.

Sincerely,

A handwritten signature in black ink that reads "Shelley A. Gentry Karn RN".

Shelley A. Gentry Karn, RN
Namaste Training Director
12020 113th Ave NE Bldg C, Ste 180
Kirkland, WA 98034
425.242.7083
shelley@eastsideangels.com

Enclosure

WASHINGTON STATE

Workforce Training and Education Coordinating Board

This certifies that the post secondary educational institution named hereon is licensed by the authority of Chapter 28C.10 Revised code of Washington "Private Vocational Schools Act."

NAMASTE TRAINING, LLC
12020 113TH AVENUE NORTHEAST
BUILDING C, SUITE 180
KIRKLAND, WASHINGTON

VALID NOVEMBER 1, 2014 THROUGH OCTOBER 31, 2015

CANNOT BE TRANSFERRED TO ANOTHER OWNER/LOCATION

COPY

P.O. Box 43105
Olympia, Washington 98504-3105
Telephone: 360-753-5673



Executive Director

Oatney, Sibylle (DOH)

From: Oatney, Sibylle (DOH)
Sent: Thursday, September 17, 2015 8:59 AM
To: 'Svabik-Seror, Matt'
Subject: Application for list approval Re: Multiple healthcare professionals

Importance: High

Dear Matt Svabik-Seror:

This is in response to your request received on September 11, 2015 to receive a list of the following professional licensee(s): Multiple healthcare professionals.

Your Application for Approval to Receive Lists/Labels was received September 11, 2015 and forwarded to the appropriate licensing body.

You will be contacted by the program manager of appropriate licensing body in regard to your approval or denial. This process can take as long as three months.

If you have any questions about the status of your application, please refer to the following contact and their associated program:

Multiple Professions	Denice Wilmovsky	(360) 236-2903
----------------------	------------------	----------------

Sincerely,

Sibylle Oatney, Forms & Records Analyst 2
Health Systems Quality Assurance (HSQA)
HSQA/Public Disclosure Unit
111 Israel Road SE, PO Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4928 Fax: (360) 586-2171
Email: Sibylle.Oatney@doh.wa.gov

Public Health -- Always working for a safer and healthier Washington

From: Svabik-Seror, Matt [mailto:Matt.SvabikSeror@regence.com]
Sent: Friday, September 11, 2015 12:07 PM
To: DOH HSQA PDRC External Requests
Cc: Gibson, Maxine
Subject: FW: List Request Re: Healthcare professionals
Importance: High

Hello,

Attached is the completed list application document that was provided to us. Please submit this application to the appropriate licensing body. Thank you for your time! Have a great weekend!

Regards,

Matt Svabik-Seror

Cambia Health Solutions

Provider Services – Data Performance

Desk: (503) 220-6213 | Email: Matthew.Svabik-Seror@cambiahealth.com

From: Oatney, Sibylle (DOH) [<mailto:Sibylle.Oatney@DOH.WA.GOV>]

Sent: Friday, September 11, 2015 10:32 AM

To: Svabik-Seror, Matt <Matt.SvabikSeror@regence.com>

Subject: List Request Re: Healthcare professionals

Importance: High

Dear Matt Svabik-Seror:

Thank you for your request for a list of professionals credentialed in Washington State.

RCW 42.56.070(9) prohibits disclosure lists of individuals requested for commercial purposes. However, lists of applicants for professional licenses and of professional licensees may be made available to professional associations or educational organizations approved by the applicable licensing board.

You are currently **not an approved** professional association or educational organization. Therefore the requested list cannot be provided to you at this time. You may request to be approved by submitting the attached form.

To answer your question: The application has to be approved by the appropriate licensing body. The process can take as long as three months, based on when the healthcare providers commissions or boards meet.

Sincerely,

Sibylle Oatney, Forms & Records Analyst 2

Health Systems Quality Assurance (HSQA)

HSQA/Public Disclosure Unit

111 Israel Road SE, PO Box 47865

Olympia, WA 98504-7865

Phone: (360) 236-4928 Fax: (360) 586-2171

Email: Sibylle.Oatney@doh.wa.gov

Public Health -- Always working for a safer and healthier Washington

From: Svabik-Seror, Matt [<mailto:Matt.SvabikSeror@regence.com>]

Sent: Wednesday, September 09, 2015 11:14 AM

To: DOH HSQA PDRC External Requests

Cc: Gibson, Maxine
Subject: RE: Batch request for provider data?

Hi Aaron,

Thank you for your e-mail response and voicemail. The reason for requesting the list is because Cambia Health Solutions (Regence BlueShield and Asuris National Health), needs to credential healthcare providers. The provided information would assist our credentialing department. The provided list would be used for a commercial purpose. I understand the form is not needed. Is there any way we could trim down the 3 month commercial approval process, since this information is not being used for any marketing purpose?

Thank you!!

Regards,

Matt Svabik-Seror

Cambia Health Solutions

Provider Services – Data Performance

Desk: (503) 220-6213 | Email: Matthew.Svabik-Seror@cambiahealth.com

From: DOH HSQA PDRC External Requests [<mailto:PDRC@DOH.WA.GOV>]

Sent: Tuesday, September 08, 2015 10:51 AM

To: Svabik-Seror, Matt <Matt.SvabikSeror@regence.com>

Subject: RE: Batch request for provider data?

Matt Svabik-Seror:

We received your public records request on September 2, 2015, for the following records: A list of licensees.

We find that your request is not clear and ask that you clarify the following so that we may respond appropriately:

What is the purpose of the list? If it is for non-commercial purpose please fill out the attached form and sign section 1. If it is for commercial purpose you do not need to fill out the attached form at this time.

Once we determine that the request has been fully clarified, we will:

- Begin the process of locating and gathering the requested documents, and
- Within five business days, provide a reasonable estimate of the time for the agency's next response to your request.

If we have not heard back from you by September 22, 2015, we will consider this request abandoned and cancel it.

To answer your questions below:

Can we submit a batch request for provider's state licensing data? A: You may request multiple licensee types.

Is there a web service available for batch submissions? A: No

Do we submit via form, email, phone call? A: Email works best because of several forms that will need to be filled out.

What data is available? A: Several fields are available including name, license number, and date of birth. If you are approved for commercial lists, a list of fields will be sent to you.

How much does this type of request cost? A: There is no charge for an electronic list.

What is your turn around time? A: If you are going through the commercial list process this can take up to 3 months for approval.

If you have any questions or need additional information, please contact our office via email at pdrc@doh.wa.gov or phone at (360) 236-4836.

Sincerely,

Aaron Wayne Kelley, Forms and Records Analyst 3
Washington State Department of Health
Health Systems Quality Assurance (HSQA)
HSQA/Public Disclosure Unit
111 Israel Road SE, PO Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4812 Fax: (360) 586-2171
Email: aaron.kelley@doh.wa.gov

Public Health -- Always Working for a Safer and Healthier Washington

From: Svabik-Seror, Matt [<mailto:Matt.SvabikSeror@regence.com>]
Sent: Wednesday, September 02, 2015 1:22 PM
To: DOH HSQA PDRC External Requests
Cc: Gibson, Maxine
Subject: Batch request for provider data?

Hello,

I was advised by your customer service department to email this request to you. Please answer the below listed questions and let us know if a batch request is possible.

Can we submit a batch request for provider's state licensing data?
Is there a web service available for batch submissions?
Do we submit via form, email, phone call?
What data is available?
How much does this type of request cost?
What is your turn around time?

Thank you for your time!

Regards,

Matt Svabik-Seror
Cambia Health Solutions
Provider Services – Data Performance
Desk: (503) 220-6213 | Email: Matthew.Svabik-Seror@cambiahealth.com

IMPORTANT NOTICE: This communication, including any attachment, contains information that may be confidential or privileged, and is intended solely for the entity or individual to whom it is addressed. If you are not the intended recipient, you should delete this message and are hereby notified that any disclosure, copying, or distribution of this message is strictly prohibited. Nothing in this email, including any attachment, is intended to be a legally binding signature.

Ensure a sustainable future - only print when necessary.

Application for Approval to Receive Lists/Labels

This is an application for approval to receive lists and labels, not a request for lists and labels. You may request lists and labels after you are approved. Approval can take up to three months.

RCW 42.56.070(9) limits access to lists and labels. Lists of credential holders may be released only to professional associations and educational organizations approved by the disciplining authority.

- A "professional association" is a group of individuals or entities organized to:
 - Represent the interests of a profession or professions;
 - Develop criteria or standards for competent practice; or
 - Advance causes seen as important to its members that will improve quality of care rendered to the public.
- An "educational organization" is an accredited or approved institution or entity which either
 - Prepares professionals for initial licensure in a health care field or
 - Provides continuing education for health care professionals.

We are a "professional association"

We are an "educational organization."

Liz Hubert

503-225-5169

503-225-4860

Primary Contact Name ↓

Phone ↓

Fax ↓

Maxine Gibson / Matt Svabik-Seror

Additional Contact Names (Lists are only sent to approved individuals) ↓

Cambia Health Solutions (Regence BlueShield & Asuris Northwest Health)

91-0282080 (Regence) / 91-0495743 (Asuris)

Professional Assoc. or Educational Organization ↓

Federal Tax ID or Uniform Business ID number ↓

PO Box 1271 | MS PDX-E7H,

Portland, OR, 97207-1271

Street Address ↓

City, State, Zip Code ↓

To assist our credentialing department with updating our internal system with provider license data

1. How will the lists and labels be used? ↓

Healthcare providers and healthcare facilities

2. What profession(s) are you seeking approval for? ↓

Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.

Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865

Fax to: PDRC - 360-586-2171

Email to: PDRC@DOH.Wa.Gov

Matt Svabik-Seror
 Signature ↓

1/11/15
 Date ↓

If you have questions, please call (360) 236-4836

For Official Use Only		Authorizing Signature: _____	
Approved: _____	_____	Printed Name: _____	
Denied: _____	_____	Title: _____	Date: _____



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Nursing Care Quality Assurance Commission
PO Box 47864
Olympia, Washington 98504-7864

October 8, 2015

Liz Hubert
Cambia Health Solutions
PO Box 1271 MS PDX-E7H
Portland, OR 97207-1271

Re: Request for Additional Information

Dear Ms. Hubert:

On September 18, 2015 we received your request for recognition by the Nursing Commission to receive lists and labels.

In order to qualify as an approved "professional association" you must meet the following definition:

- A group of individuals or entities organized to: represent the interests of the profession or professions; develop criteria or standards for competent practice; or advance causes seen as important to its members that will improve quality of care rendered to the public.

Based on the information you provided, we cannot determine whether you meet the definition of a professional association. The Nursing Commission will review your request at the next commission meeting on November 13, 2015. In order to assist us with our decision please provide documentation confirming your status as a professional association. We must receive this information in our office by October 20, 2015.

If you have any questions, please feel free to contact me at (360) 236-4713.

Sincerely,

 MSN, RN, FRE

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

DECLARATION OF MAILING

I declare that today, at Olympia, Washington, I sent a copy of this document to Liz Hubert by mailing a copy properly addressed with postage prepaid.

Dated this 8th day of October 2015.

Paula R. Meyer MSN, RN, FRE, Executive Director
Nursing Care Quality Assurance Commission
(360) 236-4713


Signature

From: [Oatney, Sibylle \(DOH\)](#)
To: [Wilмовsky, Denise D \(DOH\)](#); [Pittman, Daidria \(DOH\)](#); [Anderson, Jennifer \(DOH\)](#)
Subject: Application for List Approval Re: Multiple Healthcare Professions - Matt Svabik-Seror
Date: Friday, October 16, 2015 1:24:04 PM
Attachments: [List_Application2.pdf](#)
[RBS WA DOH LETTER.pdf](#)
[ANH WA DOH LETTER.pdf](#)
[20151016 PDU ack letter.pdf](#)

Good afternoon ladies, attached are the documents from Matt Svabik-Seror. He would like to be approved to receive lists for the following healthcare professions: Acupuncturists (east Asian medicine practitioners), advanced registered nurses, audiologists, chiropractors, dental, dental hygienists, denturists, dietitian/nutritionists, family therapists, generic counselors, hearing and speech pathologists, marriage and family therapists, physician and surgeons, mental health counselors, midwives, naturopathic physicians, nutritionists, occupational therapists, occupational therapy assistants, pharmacists, physical therapists, physician assistants, osteopathic physician and surgeons, osteopathic physician assistants, podiatrists, psychologists, and speech language pathologists.

Sibylle Oatney, Forms & Records Analyst 2
Health Systems Quality Assurance (HSQA)
HSQA/Public Disclosure Unit
111 Israel Road SE, PO Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4928 Fax: (360) 586-2171
Email: Sibylle.Oatney@doh.wa.gov

Public Health -- Always working for a safer and healthier Washington

Sent: Friday, October 16, 2015 11:40 AM
To: DOH HSQA PDRC External Requests
Subject: Electronic List Request - Multiple Professions

Hello,

Attached is a completed list application with specific professions we are seeking approval for. Additionally, supporting documentation that demonstrates Regence BlueShield and Asuris Northwest Health are professional organizations is provided. Lastly, we are not including a sample of proposed mailing materials because we will not be using this information for any mailings.

We look forward to your response for each profession indicated on the application. Thank you for your consideration.

Regards,

Matt Svabik-Seror

Cambia Health Solutions

Provider Services – Data Performance

Desk: (503) 220-6213 | Email: Matthew.Svabik-Seror@cambiahealth.com

IMPORTANT NOTICE: This communication, including any attachment, contains information that may be confidential or privileged, and is intended solely for the entity or individual to whom it is addressed. If you are not the intended recipient, you should delete this message and are hereby notified that any disclosure, copying, or distribution of this message is strictly prohibited. Nothing in this email, including any attachment, is intended to be a legally binding signature.

Oatney, Sibylle (DOH)

From: Oatney, Sibylle (DOH)
Sent: Friday, October 16, 2015 1:22 PM
To: Svabik-Seror, Matt (Matt.SvabikSeror@regence.com)
Subject: Application for List Approval Re: Multiple Healthcare Professions
Attachments: Chiropractic Application.pdf

Importance: High

Dear Matt Svabik-Seror:

This is in response to your request received on October 16, 2015 to receive a list of the following professional licensee(s): Acupuncturists (East Asian Medicine Practitioners), advanced registered nurses, audiologists, chiropractors, dental, dental hygienists, denturists, dietitian/nutritionists, family therapists, generic counselors, hearing and speech pathologists, marriage and family therapists, physician and surgeons, mental health counselors, midwives, naturopathic physicians, nutritionists, occupational therapists, occupational therapy assistants, pharmacists, physical therapists, physician assistants, osteopathic physician and surgeons, osteopathic physician assistants, podiatrists, psychologists, and speech language pathologists.

Your Application for Approval to Receive Lists/Labels was received October 16, 2015 and forwarded to the appropriate licensing body. Please be advised that chiropractors require a different application. I have attached this application for your convenience.

You will be contacted by the program manager of appropriate licensing body in regard to your approval or denial. This process can take as long as three months.

If you have any questions about the status of your application, please refer to the following contact and their associated program:

Multiple Professions	Denice Wilmovsky	(360) 236-2903
Physicians and Surgeons (MDs) Physician Assistants	Daidria Pittman	(360) 236-2782
Advanced Nurse Practitioners	Jen Anderson	(360) 236-4702

Sincerely,

Sibylle Oatney, Forms & Records Analyst 2
Health Systems Quality Assurance (HSQA)
HSQA/Public Disclosure Unit
111 Israel Road SE, PO Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4928 Fax: (360) 586-2171
Email: Sibylle.Oatney@doh.wa.gov

From: Svabik-Seror, Matt [<mailto:Matt.SvabikSeror@regence.com>]

Sent: Friday, October 16, 2015 11:40 AM

To: DOH HSQA PDRC External Requests

Subject: Electronic List Request - Multiple Professions

Hello,

Attached is a completed list application with specific professions we are seeking approval for. Additionally, supporting documentation that demonstrates Regence BlueShield and Asuris Northwest Health are professional organizations is provided. Lastly, we are not including a sample of proposed mailing materials because we will not be using this information for any mailings.

We look forward to your response for each profession indicated on the application. Thank you for your consideration.

Regards,

Matt Svabik-Seror

Cambia Health Solutions

Provider Services – Data Performance

Desk: (503) 220-6213 | Email: Matthew.Svabik-Seror@cambiahealth.com

IMPORTANT NOTICE: This communication, including any attachment, contains information that may be confidential or privileged, and is intended solely for the entity or individual to whom it is addressed. If you are not the intended recipient, you should delete this message and are hereby notified that any disclosure, copying, or distribution of this message is strictly prohibited. Nothing in this email, including any attachment, is intended to be a legally binding signature.

Application for Approval to Receive Lists/Labels

This is an application for approval to receive lists and labels, not a request for lists and labels. You may request lists and labels after you are approved. Approval can take up to three months.

RCW 42.56.070(9) limits access to lists and labels. Lists of credential holders may be released only to professional associations and educational organizations approved by the disciplining authority.

- A “professional association” is a group of individuals or entities organized to:
 - Represent the interests of a profession or professions;
 - Develop criteria or standards for competent practice; or
 - Advance causes seen as important to its members that will improve quality of care rendered to the public.
- An “educational organization” is an accredited or approved institution or entity which either
 - Prepares professionals for initial licensure in a health care field or
 - Provides continuing education for health care professionals.

We are a “professional association”

We are an “educational organization.”

Elizabeth Hubert 503-225-5169 503-225-4860
 Primary Contact Name ↓ Phone ↓ Fax ↓

Matt Svabik-Seror \ Maxine Gibson
 Additional Contact Names (Lists are only sent to approved individuals) ↓

Cambia Health Solutions (Regence BlueShield & Asuris Northwest Health) 91-0282080 (Regence) / 91-0495743 (Asuris)
 Professional Assoc. or Educational Organization ↓ Federal Tax ID or Uniform Business ID number ↓

PO Box 1271 MS PDX - WW4-40P Portland, OR, 97207
 Street Address ↓ City, State, Zip Code ↓

To assist our credentialing department with updating our internal system with provider license data

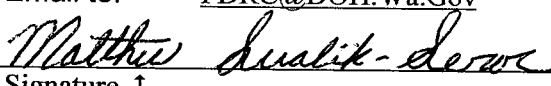
1. How will the lists and labels be used? ↓

We are seeking approval for 34 professions. Please see the second page of this document for complete list.

2. What profession(s) are you seeking approval for? ↓

Please attach information that demonstrates that you are a “professional association” or an “educational organization” and a sample of your proposed mailing materials.

Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865
 Fax to: PDRC - 360-586-2171
 Email to: PDRC@DOH.Wa.Gov

 10/16/15
 Signature ↓ Date ↓

If you have questions, please call (360) 236-4836

For Official Use Only	Authorizing Signature: _____
Approved: _____	Printed Name: _____
5-year one-time	
Denied: _____	Title: NCQAC Business Meeting Date: _____

Professions Cambia Health Solutions is Requesting for Electronic Lists

1. Acupuncturist (East Asian Medicine Practitioner)
2. Advanced Registered Nurse Practitioner (ARNP)
3. Audiologist
4. Chiropractor
5. Dental
6. Dental Hygienist
7. Dentist
8. Denturist
9. Dietitian/Nutritionist
10. East Asian Medicine Practitioner
11. Family Therapist
12. Genetic Counselor
13. Hearing and Speech
14. Hygienists – Dental
15. Marriage and Family Therapist
16. Massage Therapist
17. Medical Doctor
18. Mental Health Counselor
19. Midwife
20. Naturopathic Physician
21. Nutritionist
22. Occupational therapist
23. Optometrist
24. Osteopathic Physician
25. Osteopathic Physician Assistant
26. Pharmacist
27. Physical Therapist
28. Physician
29. Physician Assistants – Medical
30. Physician – Osteopathic
31. Physician Assistants – Osteopathic
32. Podiatric Physician and Surgeon
33. Psychologist
34. Speech-Language Pathologist



Regence BlueShield is an Independent Licensee
of the Blue Cross and Blue Shield Association

P.O. Box 21267 Seattle,
WA 98111-3267

October 8, 2015

State of Washington Department of Health
PO Box 47852
Olympia, WA, 98504

Dear State of Washington Department of Health,

Currently we use web address <https://fortress.wa.gov/doh/providercredentialsearch/> to look up license data to validate the credentials of providers we contract with. We do this to be compliant with the rules laid out by our governing organizations.

Our request is for an electronic file of licensure data, which would allow us to access this data in a more efficient manner and lessen the burden on the providers of the state of Washington. By receiving electronic access through a file download, API, or any other method, we could validate provider licenses in a frequent and efficient manner. We continuously update our systems with information obtained from organizations including Washington Department of Health.

Regence BlueShield is a health insurance entity that is organized to represent the interests of healthcare providers and insured members in the state of Washington. One of the most important services we provide to healthcare providers and our members is to validate the credentials of providers serving our members.

Your definition of a "professional association" is a group of individuals or entities organized to represent the interests of the profession or professions, develop criteria or standards for competent practice, or advance causes seen as important to its members that will improve quality of care rendered to the public. We believe we meet this criteria.

Please accept this letter as explanation that Regence BlueShield meets the State of Washington Department of Health's definition of a professional association.

Regards,

Elizabeth Hubert
Assistant Director
Provider Data Quality
Phone: 503-225-5169



P.O. Box 21267 Seattle,
WA 98111-3267

October 8, 2015

State of Washington Department of Health
PO Box 47852
Olympia, WA, 98504

Dear State of Washington Department of Health,

Currently we use web address <https://fortress.wa.gov/doh/providercredentialsearch/> to look up license data to validate the credentials of providers we contract with. We do this to be compliant with the rules laid out by our governing organizations.

Our request is for an electronic file of licensure data, which would allow us to access this data in a more efficient manner and lessen the burden on the providers of the state of Washington. By receiving electronic access through a file download, API, or any other method, we could validate provider licenses in a frequent and efficient manner. We continuously update our systems with information obtained from organizations including Washington Department of Health.

Asuris Northwest Health is a health insurance entity that is organized to represent the interests of healthcare providers and insured members in the state of Washington. One of the most important services we provide to healthcare providers and our members is to validate the credentials of providers serving our members.

Your definition of a "professional association" is a group of individuals or entities organized to represent the interests of the profession or professions, develop criteria or standards for competent practice, or advance causes seen as important to its members that will improve quality of care rendered to the public. We believe we meet this criteria.

Please accept this letter as explanation that Asuris Northwest Health meets the State of Washington Department of Health's definition of a professional association.

Regards,

A handwritten signature in black ink that reads "Elizabeth Hubert". The signature is written in a cursive, flowing style.

Elizabeth Hubert
Assistant Director
Provider Data Quality
Phone: 503-225-5169