

2013 Environmental Scan

Annual review of emerging issues and trends that impact nursing regulation



**NCSBN 2013-2014
ENVIRONMENTAL SCAN**

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The 2013-14 NCSBN Environmental Scan

INTRODUCTION

The NCSBN Environmental Scan is produced annually on the cusp of the new year to assist boards of nursing (BONs) with their future planning. It can be used for setting legislative agendas, strategic planning and anticipating emerging issues.

One of the most important emerging issues of 2014 will be the next phase of implementation for the Affordable Care Act (ACA). This law brings the most significant and controversial changes for U.S. health care since the enactment of Medicare and Medicaid in 1965. If predictions are correct, the requirement of health insurance for every American could mean that 32 million more consumers will flood the health care market seeking primary and preventive services, in addition to treatment for acute and chronic health care needs. This potential influx and many of the provisions of the ACA could have a far reaching impact on BONs. In keeping with NCSBN's strategic plan to "provide members with current information and analysis on the evolving health care environment regarding the ACA and how it impacts boards of nursing," the 2013-14 environmental scan will highlight important aspects of the ACA and its regulatory implications, while holistically addressing emerging issues in other aspects of nursing and health care.

A variety of sources were used to develop this report, including research and scholarly articles, news articles, websites, databases, peer reviewed journals, direct communication/presentations, annual BON reports and Web surveys. Certain consistent sources of data and graphs are used from year to year to help formulate comparisons and identify trends. New issues, new problems and new data characterizing 2013-14 are also included. An abundance of information was reviewed and analyzed in order to provide a report that can be used to assess the regulatory environment and guide strategic planning. Not all applicable information and data can be captured in this report; however, every attempt was made to produce a well-documented comprehensive report describing the state of BONs and the regulatory environment.

HEALTH CARE IN THE U.S.

The U.S. provides some of the best care in the world. It is known for excellence in health care technology, drug research and specialty medicine, such as cancer treatment and organ transplant (Wenger, 2013). U.S. nurses are considered the most trusted of all professions (Gallup, 2014). Studies have shown that advanced practice registered nurses (APRNs) provide care that is equal to a physician (Stanik-Hutt, et al., 2013). The country is marked by world class medical centers that are gateways to some of the most innovative and comprehensive care in the world. Yet, despite all its assets, patient outcomes in the U.S. are not always optimal. A comparison with 34 countries through the Organization for Economic Co-operation and Development (OECD) showed the U.S. had slipped from 18th to 27th for years of life lost due to premature death, from 20th to 27th for life expectancy at birth, and from 14th to 26th for healthy life expectancy in the time period of 1990 through 2010 (Silow-Carroll & Lamphere, 2013).

The etiology of this paradox is the lack of focus on population health in the U.S. (Wenger, 2013). A geographic lack of providers and high costs often make health care inaccessible to many, especially the uninsured and disadvantaged populations. Expense, coupled with a high rate of uninsured and significant health care disparities, contributes to the less than optimal outcomes associated with the American health care system.

Confirming the causality of these findings is the most recent publication of the National Health Care Quality Report (2013a). This annual report is mandated by Congress on the quality of health care delivery in the U.S. It includes the findings from the *National Health Disparities Survey*, an annual analysis focusing on health care delivery in relation to social and socioeconomic factors. Three themes emerged out of these reports characterizing health care delivery in the U.S.:

1. Health care quality and access are suboptimal, especially for minorities and low-income groups.
2. Overall quality is improving, access is getting worse and disparities are not changing.
3. Urgent attention is warranted to ensure continuous improvement in:
 - Quality of diabetes care, maternal child care and adverse events
 - Disparities in cancer careQuality of care among states in the south. (Department of Health and Human Services, 2013a, p.2)

The economic issues related to health care in the U.S., along with the social determinants, spurred fervent debate among the executive and legislative branches of the federal government and led to the enactment of the ACA in 2010.

The Affordable Care Act (ACA)

The ACA is a combination of two bills passed by Congress and signed by President Obama in 2010. Congress passed the Patient Protection and Affordable Care Act (H.R. 3590) and the Health Care and Education Reconciliation Act of 2010 (H.R. 4872). President Obama signed these both of these pieces of legislation into law, creating Public Law 111-148 (the Patient Protection and Affordable Care Act) and Public Law 111-152 (the Health Care and Education Reconciliation Act of 2010). Together, these laws make up the ACA, one of the most significant and contentious pieces of health care legislation in U.S. history. While it is impossible and beyond the scope of this report to summarize the entire law, the following section outlines important aspects of the law that will go into effect in 2014.

The purpose of the ACA is the provision of health care insurance to all residents of the U.S. This is accomplished by:

- 1) A government mandate that requires all U.S. residents to select a health insurance plan via a federal government or state-based website;
- 2) Prohibiting insurers to deny coverage based on a pre-existing condition; and
- 3) Expansion of the Medicaid program (limited state participation).

This approach to expanding access to health insurance coverage creates state-based American Health Benefit Exchanges through which individuals can purchase coverage. Separate exchanges allow small businesses to purchase coverage for their employees. As of January 2014, those individuals without coverage (i.e., an employer sponsored plan, Medicare, Medicaid, a public insurance program or private option) will be required to pay a tax penalty. On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of this individual mandate. The penalty however, has been set at a minimum and the Congressional Budget Office has estimated that the penalty provision of the individual mandate will affect less than two percent of Americans (Baker, 2013).

The state-based health insurance exchanges were launched on Oct. 1, 2013. State websites were introduced with various degrees of success as heavy consumer volume slowed some state's websites to a crawl (O'Donnell & Kennedy, 2013). The first week the exchanges were open, New York and California reported strong demand (Krauskopf & Beasley, 2013); however the majority of enrollees were Medicaid recipients. In order for the ACA to work, young, healthy adults must enroll in a health plan.

Many states struggled with the decision over whether or not to establish an insurance exchange. On the one hand, by setting up an exchange under the ACA, a state would further its role as an administrative arm of the federal government. The federal government would require the state to adhere to detailed federal rules, allowing the state limited flexibility. On the other hand, if the state declined to establish an exchange under the ACA, residents of the state will have access to

the federally-run exchange, thereby increasing federal control over the insurance market, which is traditionally overseen by states (see Appendix A) (Kincaid, 2013).

As of November 2013, 17 jurisdictions have established state-based marketplace and 27 states have defaulted to a federally facilitated marketplace (Henry J. Kaiser Family Foundation, 2013). Seven states have opted for a hybrid called a state partnership exchange, where states can assume responsibility for a combination of exchange functions, while the federal government assumes responsibility for other aspects of the exchange. For example, states may carry out many plan management functions or assume responsibility for in-person consumer assistance and outreach (Center for Consumer Information and Insurance Oversight, 2013).

The White House continues to encourage all states to establish a state-based exchange by offering various incentives for early adoption, including the suggestion that early adopters would serve as forerunners of the state-based model and developing the format of a state-based model. Also issued was a warning that the federal government may not be able to offer assistance dollars to later adopters. Other stakeholders are also strongly encouraging state governments to adopt the state-run exchange model, including in-state insurance companies, advocates for low-income people and other corporate interests (Kincaid, 2013).

The ACA also permits private health insurers to contract with the federal government to offer nationwide insurance policies. Some fear that these policies will erode state authority by enabling the federal government to regulate intrastate insurance products (Kincaid, 2013). Ultimately, this would lessen state-based consumer protections.

There have been more than 19 million unique visits to the federal government ACA website. Although millions of Americans attempted to purchase health insurance plans on the first day of its launch, there were many technical problems associated with the website, www.healthcare.gov, in its first three weeks. The frustration that has resulted from the numerous glitches in the website have caused individuals, businesses, and politicians to criticize the way in which it has been rolled-out in the marketplace.

There has also been confusion from those already having health care policies as there have been reports of health plan participants receiving cancellation letters from their insurance companies. These cancellations are for policies that do not meet the ACA standards. Health plans must cover 10 categories of “essential benefits,” which includes preventive services, maternity care, mental health and substance abuse. Many of the new options that meet these requirements are resulting in higher monthly premium costs.

Another government website, marketplace.cms.gov, opened on Oct. 1, 2013, and is intended for professionals helping consumers. It contains a number of educational resources that health care professionals can use to help educate the public about the ACA and its provisions.

An analysis of census data reveals that more than half of the low-wage workers who do not have insurance will not be reached by the new law. About 60 percent of the uninsured working poor live in one of the 26 states that declined to participate in the Medicaid expansion. Those roughly 8 million Americans do not making enough money to qualify for federal subsidies on the health exchanges, but make too much money to qualify for Medicaid (Tavernise & Gebeloff, 2013).

The ACA contains a provision that the federal government will pay 100 percent of the cost of newly enrolled Medicaid participants until 2016 for all states that expand their Medicaid program significantly. By 2020 the federal government will pay 90 percent (Kincaid, 2013). To qualify, the state must expand Medicaid eligibility up to 138 percent of the federal poverty level.

As of November 2013, 26 jurisdictions were moving forward with Medicaid expansion; 25 jurisdictions were not expanding their programs at all (See Appendix A) (Henry J. Kaiser Family Foundation, 2013). Many state officials voiced concerns that the additional federal funding would eventually diminish. Other concerns include whether the federal government will actually give states enough flexibility to manage the Medicaid program, whether hospitals will receive adequate compensation to care for more patients and whether the physician workforce could accommodate the increase demand for care (Kincaid, 2013).

In an effort to encourage more governors to participate in Medicare expansion, President Obama assured states that they could reverse their decision to expand Medicare at any time and that they could restrain Medicare costs by reducing payments to certain health care providers. Other stakeholders also continue to lobby governors to expand Medicare, including hospitals and other businesses that shoulder a large share of the cost of insuring low income individuals. These groups argue that Medicare expansion will reduce the number of unpaid services provided to low income patients that taxpayers must ultimately cover (Kincaid, 2013).

There are significant factors in the ACA that will influence care and provider payment. The ACA moves away from “fee for service” toward a bundled payment system for hospitals and providers. In this program, a set amount is paid for all services and treatment related to a specific illness. One of the most significant changes for the health care delivery system is the provision to provide “value-based reimbursement (pay for performance).” Providers will be paid based on outcomes. Poorer outcomes result in significant penalties. Beginning in 2015, Medicare payments will be based on quality of care. There will also be penalties if patients have to be rehospitalized for an avoidable problem. There will be financial incentives for incorporating the electronic medical record into the patient care system. (Nather, 2013)

The establishment of accountable care organizations (ACOs), networks of hospitals and/or physicians, is another aspect of the ACA affecting providers. Providers in these groups are responsible for the cost of care for a group of patients. A variety of providers are within the ACO and they are required to collaborate to ensure quality care is provided in an efficient manner.

Providers will be accepting responsibility for outcomes beyond their individual scope of care. ACOs must meet specific benchmarks, focusing on prevention and carefully managing patients with chronic conditions. The ACA provides that qualified ACOs can apply to receive advanced payments to help pay for infrastructure investments necessary to coordinate care. However, if an ACO is unable to meet performance and cost saving benchmarks, it may have to pay a penalty. ACOs must also meet various quality measures to ensure that they are not saving money by omitting necessary provisions of care (Gold, 2013).

About 4 million Medicare beneficiaries are now in an ACO. The Department of Health and Human Services (HHS) estimates that ACOs could save Medicare up to \$940 million in the first four years. However, some economists warn that the rise of ACOs could lead to greater consolidation in the health care industry, allowing some providers to charge more because they have limited competition (Gold, 2013).

The intention of the ACA is to drive quality and save money. The reality of this remains to be seen. Can the law succeed and improve health care outcomes under these conditions or will it fail from undue burden being placed on providers and a delivery system not ready for multidimensional changes?

Policymakers predict the ACA will allow an additional 32 million more Americans to seek health care (The White House, 2010). This prediction relies on a number of assumptions, including all 32 million enroll in a plan, that all those insured will seek care, and that they are all new consumers to the health care system. Nevertheless, the focus on a potential shortage has precipitated a firestorm of debate suggesting that the current system is outdated and will not accommodate the expansion of health care needs, not only from new consumers to health care, but also a rising population of individuals age 70 and older. Modifications to the current system may have broad implications for regulators/BONs, including how to regulate newly developed roles for assistive personnel.

Will there be enough providers to accommodate the potential increased volume of consumers seeking health care? This looms as a major question as many propose a new and different delivery system for the future of U.S. health care.

THE NURSING WORKFORCE

National Employment Statistics and Information

- A 4.4 percent growth in workforce employment is predicted between 2013-2017. This is an improvement over the recession rate of 3.5 percent (2009-2013), but not as good as the pre-recession rate of 5.8 percent. Highest rates of growth are projected for health care and information technology (Career Builder and Economic Modeling Specialists International (EMSI), 2013). The ACA may impact these numbers if a significant number of health care providers ranging from professional to assistive personnel are needed, but it appears the emphasis will be on assistive personnel.

In a national report analyzing the job rate growth among 785 occupations from 2013-2017, the 50 fastest growing occupations are headed by personal care aides and home health aides, with an anticipated 21 percent increase in the number of positions available from 2013-2017. There is a 10 percent increase in jobs expected for medical assistants with a 9 percent increase for registered nurses (RN). An 8 percent increase is noted for both licensed practical/vocational nurses (LPN/VN) and nursing assistants (Career Builder & EMSI, 2013).

Comparable statistics have been published by the U.S. Bureau of Labor Statistics (2013b). It predicts that 711,900 additional RNs will be needed by 2020 to meet job growth and replace those RNs leaving the field. The RN occupational category is the occupation with the highest projected numeric change in employment; however, it is not one of the 20 occupations with the highest percent change of employment predicted between 2010 and 2020. That would be personal care aides (70 percent growth) and home health aides (69 percent growth). The U.S. Bureau of Labor Statistics predicts a 26 percent growth in nursing positions from 2010-2020 (2013b).

The U.S. Bureau of Labor Statistics (2013b) also predicts that 168,500 additional LPN/VNs will be needed by 2020 to meet job growth and replace those LPN/VNs leaving the field. The growth rate is projected to be 22 percent, exceeding the average for all occupations, which is 14 percent.

In terms of APRNs, analysts anticipate a 13 percent increase in positions for certified nurse midwives (CNMs) and certified registered nurse anesthetists (CRNAs), and 12 percent increase for certified nurse practitioners (CNPs) (Career Builder & EMSI, 2013).

The Current Nursing Workforce

With significant changes being proposed for the health care system and an expected increase in the number of health care consumers, there will be an intense focus on the number of nurses available to fill positions in a variety of settings.

As of November 2013, there were approximately 4,346,756* nurses (RN and LPN/VN) holding an active license (both RN and LPN/VN) in the U.S. (NCSBN National Nursing Database, 2013). There is a total of 3,993,534 RN licensees and 930,502 LPN/VN licensees.* According to the U.S. Bureau of Labor Statistics' most recent data (2013a), there are 3,352,780 licensees (RN and LPN/VN) employed in the U.S. (U.S. Bureau of Labor Statistics, 2013a).

*Excludes Oklahoma, Alabama and Georgia.

Registered Nurses (RNs)

Table 1 illustrates the employment trends of RNs in the U.S. from 2000-2012.

Table 1. Total Number of Employed RNs: 2000-2012

	2000	2004	2008	2010	2011	2012
Number of Employed RNs*	2,201,813	2,442,593	2,596,399	2,655,020	2,724,570	2,633,980

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

See Figure 1 and Table 2 for a state-by-state depiction of the ratio of nurses per 100,000 capita.

As can be seen below, Idaho has the fewest number of RNs per capita, while the District of Columbia has the most.

Figure 1. The RN Workforce per 100,000 Population, by State (2008-2010)

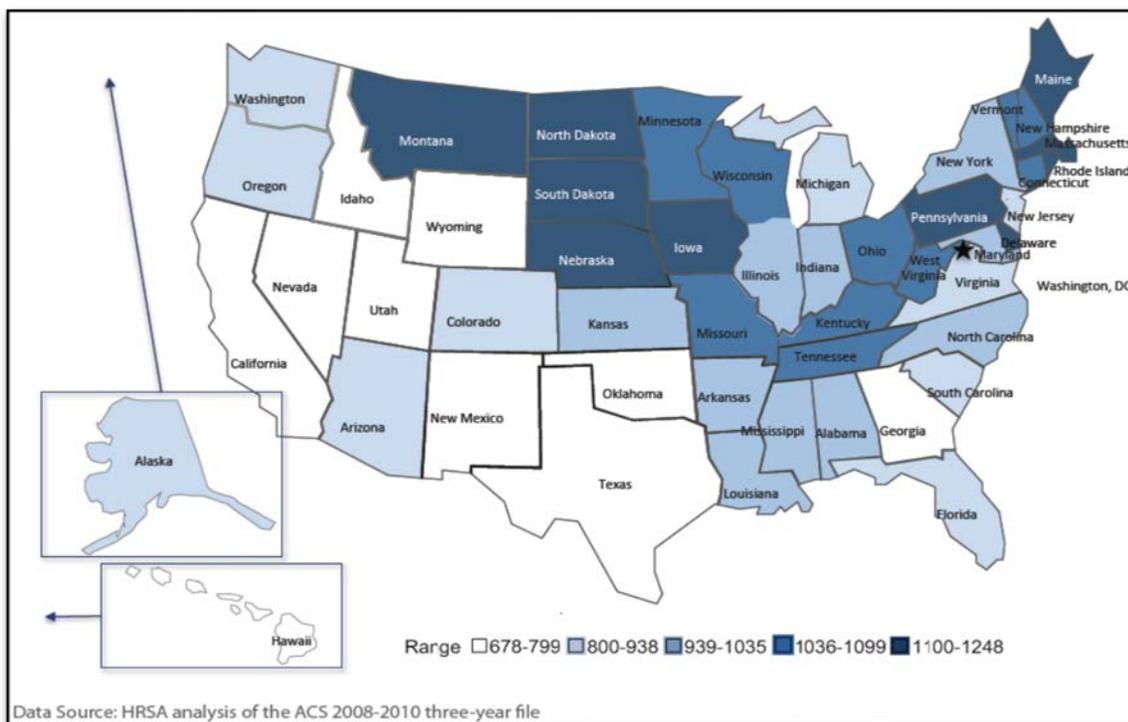


Table 2. The RN Workforce, by State, per 100,000 population

	RNs	Total Population	RNs per 100,000
Alabama	45,666	4,753,812	960.6
Alaska	5,605	700,113	800.6
Arizona	50,841	6,345,751	801.2
Arkansas	27,415	2,897,671	946.1
California	274,722	36,971,641	743.1
Colorado	43,480	4,970,333	874.8
Connecticut	37,555	3,561,486	1,054.5
Delaware	10,380	891,791	1,163.9
District of Columbia	9,869	592,306	1,666.2
Florida	167,476	18,674,425	896.8
Georgia	75,976	9,612,759	790.4
Hawaii	9,357	1,347,518	694.4
Idaho	10,527	1,553,404	677.7
Illinois	120,203	12,795,658	939.4
Indiana	63,655	6,458,253	985.6
Iowa	33,378	3,033,163	1,100.4
Kansas	28,556	2,833,318	1,007.9
Kentucky	44,755	4,317,738	1,036.5
Louisiana	42,856	4,490,487	954.4
Maine	16,153	1,329,222	1,215.2

Maryland	55,944	5,733,779	975.7
Massachusetts	80,725	6,514,611	1,239.1
Michigan	89,445	9,908,690	902.7
Minnesota	57,639	5,279,601	1,091.7
Mississippi	29,016	2,958,873	980.6
Missouri	63,756	5,960,413	1,069.7
Montana	11,172	983,863	1,135.6
Nebraska	22,260	1,813,164	1,227.7
Nevada	19,428	2,680,981	724.7
New Hampshire	13,860	1,316,255	1,053.0
New Jersey	75,269	8,756,104	859.6
New Mexico	15,701	2,037,799	770.5
New York	196,189	19,303,930	1,016.3
North Carolina	90,663	9,440,195	960.4
North Dakota	7,702	665,681	1,157.0
Ohio	126,582	11,526,823	1,098.2
Oklahoma	29,366	3,716,087	790.2
Oregon	32,113	3,805,432	843.9
Pennsylvania	140,077	12,662,926	1,106.2
Rhode Island	12,744	1,053,846	1,209.3
South Carolina	42,254	4,585,057	921.6
South Dakota	10,076	807,563	1,247.7
Tennessee	67,159	6,303,437	1,065.4
Texas	186,573	24,789,312	752.6
Utah	18,771	2,720,974	689.9
Vermont	6,528	624,976	1,044.5
Virginia	64,268	7,928,022	810.6
Washington	56,607	6,658,052	850.2
West Virginia	19,220	1,847,352	1,040.4
Wisconsin	60,813	5,667,100	1,073.1
Wyoming	4,296	556,787	771.6
U.S. TOTAL	2,824,641	306,738,434	920.9

HRSA (2013) reported that the RN workforce grew by more than 24 percent in the past decade. This outpaced the growth of the U.S. population. The number of RNs per 100,000 population increased by approximately 14 percent in the last decade.

Demographics

Table 3 indicates the top five industries with the highest levels of employment for RNs as of May 2013. As indicated, general medical and surgical hospitals continue to be the industry with the highest level of employment for RNs (U.S. Bureau of Labor Statistics, 2013a).

Table 3. Industries with the Highest Levels of Employment for RNs

Employment Setting	2012	2013
General Medical and Surgical Hospitals	1,556,930 (30%)	1,545,370 (29.5%)
Offices of Physicians	235,710 (10.1%)	177,190 (7.5%)
Home Health Care Services	156,730 (13.9%)	162,120 (13.8%)
Nursing Care Facilities	138,080 (8.3%)	139,440 (8.4%)
Outpatient Care Centers	95,180 (15.6%)	92,350 (14.4%)

The National RN Workforce Survey conducted by NCSBN and The National Forum of State Nursing Workforce Centers (2013) noted the following key findings about the supply of RNs:

- **Age:** The average age of responding RNs was 50 years old.
- **Education:** 61percent of respondents reported having a bachelor’s degree or higher (this includes non-nursing related degrees). The percentage of RNs holding bachelor’s degrees or higher is slowly increasing. HRSA (2013) found the percentage of the RN workforce holding a bachelor’s degree or higher increased 5 percent in the past decade.
- **Diversity:** The nursing population is slowly becoming more diverse. According to the U.S. Census Bureau (2013), individuals from ethnic and racial minority groups accounted for 37percent of the U.S. population in 2012. The workforce survey found that 19 percent of responding RNs were ethnic minorities. Of respondents licensed before 2000, 5 percent were male, while of those licensed between 2010 and 2013, 11 percent were male.

In a recent article, Buerhaus, Auerbach, Staiger, and Muench (2013) conducted a regional analysis of the state of the RN workforce. Results indicated significant differences in the age structure of the current RN workforce by region. Specifically, the South and Midwest regions of the country had a proportion of younger RNs (age 34 and younger), while the North and Northwest regions had a larger population of RNs (age 50 and older).

Licensed Practical Nurses/Vocational Nurses (LPN/VNs)

As of May 2012, there were 718,800 LPN/VNs employed in nursing (U.S. Bureau of Labor Statistics, 2013a). The LPN/VN workforce grew by 16 percent in the past decade. This exceeded growth in the U.S. population; specifically, the number of LPN/VNs per 100,000 population increased by approximately 6 percent (HRSA, 2013).

According to HRSA (2013) there were 690,000 LPN/VNs working in nursing or seeking nursing employment from 2008 to 2010. The per capita distribution of LPN/VNs varied substantially across states (see Figure 2 and Table 4).

As can be seen, Oregon has the fewest number of LPN/VNs per 100,000 capita, while North Dakota has the most.

Figure 2. The LPN/VN Workforce per 100,000 population, by State (2008-2010)

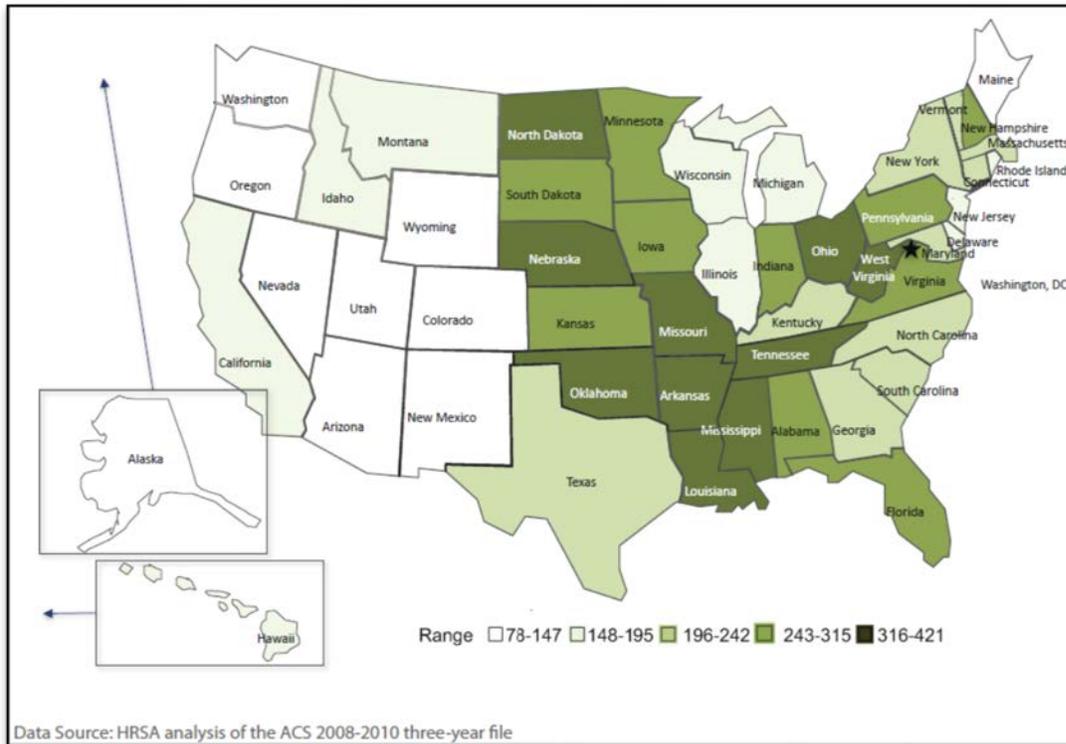


Table 4. The LPN Workforce, by State, per 100,000 population (2008-2010)

	LPNs	Total Population	LPNs per 100,000
Alabama	12,297	4,753,812	258.7
Alaska	782	700,113	111.7
Arizona	7,853	6,345,751	123.8
Arkansas	10,734	2,897,671	370.4
California	54,817	36,971,641	148.3
Colorado	5,843	4,970,333	117.6
Connecticut	8,605	3,561,486	241.6
Delaware	1,679	891,791	188.3
District of Columbia	1,982	592,306	334.6
Florida	45,686	18,674,425	244.6
Georgia	22,076	9,612,759	229.7
Hawaii	2,107	1,347,518	156.4
Idaho	2,880	1,553,404	185.4

Illinois	20,949	12,795,658	163.7
Indiana	17,114	6,458,253	265.0
Iowa	7,397	3,033,163	243.9
Kansas	7,056	2,833,318	249.0
Kentucky	9,857	4,317,738	228.3
Louisiana	17,457	4,490,487	388.8
Maine	1,952	1,329,222	146.9
Maryland	11,733	5,733,779	204.6
Massachusetts	14,360	6,514,611	220.9
Michigan	19,196	9,908,690	193.7
Minnesota	15,462	5,279,601	292.9
Mississippi	9,719	2,958,873	328.5
Missouri	18,841	5,960,413	316.1
Montana	1,737	983,763	176.6
Nebraska	5,882	1,813,164	324.4
Nevada	3,101	2,680,981	115.7
New Hampshire	3,526	1,316,255	267.9
New Jersey	16,584	8,756,104	189.4
New Mexico	2,555	2,037,799	125.4
New York	46,063	19,303,930	238.6
North Carolina	20,535	9,440,195	217.5
North Dakota	2,802	665,681	420.9
Ohio	36,934	11,526,823	320.4
Oklahoma	13,335	3,716,087	358.8
Oregon	2,998	3,805,432	78.8
Pennsylvania	38,202	12,662,926	301.7
Rhode Island	1,735	1,053,846	164.6
South Carolina	10,149	4,585,057	221.3
South Dakota	2,149	807,563	226.1
Tennessee	23,373	6,303,437	370.8
Texas	58,189	24,789,312	234.7
Utah	2,728	2,720,974	100.3
Vermont	1,229	624,976	196.6
Virginia	22,276	7,928,022	281.0
Washington	8,226	6,658,052	123.5
West Virginia	6,346	1,847,352	343.5
Wisconsin	10,279	5,667,100	181.4
Wyoming	641	556,787	115.1
U.S. TOTAL	690,038	306,738,434	225.0

Table 5 indicates the top five industries with the highest levels of employment for LPN/VNs as of May 2013. As indicated, skilled nursing facilities is the industry with the highest level of employment for LPN/VNs (U.S. Bureau of Labor Statistics, 2013a).

Table 5. Industries with the Highest Levels of Employment for LPN/VNs

Employment Setting	2013
Nursing Care Facilities (Skilled Nursing Facilities)	213,180 (12.8%)
General Medical and Surgical Hospitals	124,400 (2.4%)
Offices of Physicians	90,160 (3.8%)
Home Health Care Services	77,990 (6.6%)
Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly	44,510 (5.7%)

Recent Studies

In a 2013 article, Auerbach, Staiger, Muench, and Buerhaus discuss the nursing workforce in the era of health care reform and the surprising turnaround in the supply of nurses over the last decade. The impending shortages that had been previously projected never reached the proportions predicted. The number of new RN graduates more than doubled from 2002 to 2010. The authors attributed this growth in the profession to the following: (a) The 2002 Johnson & Johnson campaign for nursing; (b) Development of state nursing workforce centers; (c) The sluggish recovery in overall employment following the recession coupled with growth in health care spending and jobs, causing an increase in the relative attractiveness of nursing; and (d) Growth in nursing education programs. The authors go on to say that four uncertainties threaten the current stability of the U.S. nursing workforce: (1) The number of individuals seeking nursing as a career in the future (entry into nursing must continue to grow over the next two decades at a rate of 20 percent per decade in order to meet demand); (2) Uneven distribution of the supply of nurses across the U.S.; (3) The national economy (uncertainty over the lingering effects of the recession and how this will affect licensees and their employment decisions); and (4) Uncertainty about the actual future demands for RNs.

NCSBN's Workforce Database: An Update

There are currently eight BONs providing data into NCSBN's nursing workforce database: Arizona, Arkansas, Maine, Minnesota, Nevada, New Hampshire, Ohio and Texas. Eight more BONs will enter data into the system in 2014: Connecticut, Georgia, Iowa, Kentucky, North Carolina, South Dakota, Washington D.C. and Wyoming.

The following BONs have sent NCSBN data that they have collected internally: Nebraska, New Jersey, North Dakota and Vermont.

Advanced Practice Registered Nurses (APRNs)

Many predict the ACA will have its greatest impact on APRNs. It is expected that the number of primary care providers will need to increase by 52,000 by the year 2025. (Pettersen et al., 2012). This may put pressure on states to pass legislation that grants independent practice and prescriptive authority for APRNs in order to maximize the number of providers available for meeting the population's health care needs.

The 2013 National Nursing Workforce Survey of Registered Nurses (NCSBN & The Forum of State Workforce Centers, 2013) found that 3,046 nurses, out of a sample of 42,294 RNs, identified themselves as APRNs. Since the last workforce study conducted by HRSA four years ago, these numbers represent a 29 percent increase in APRNs across all four roles.

The 2013 National Workforce Survey also indicated that the average age of APRNs is increasing; 63 percent of CNMs were age 50 or older compared with 55 percent in the 2010 HRSA survey. This trend was seen in the other three roles, with 40 percent of certified nurse practitioners (CNPs), 61 percent of certified nurse specialists (CNSs), and 36 percent of CRNAs being 55 or older.

The NCSBN Campaign for APRN Consensus

In 2010, more than 40 nursing organizations, including NCSBN, agreed to support the Consensus Model for APRN Regulation. These regulations, involving licensure, education program accreditation, certification and education, outline uniform requirements for all four categories of APRNs. In a major effort to move the progress of this important work forward, NCSBN initiated the Campaign for Consensus in 2011. For the latest and most comprehensive state-by-state data on the campaign's progress towards achieving the APRN Consensus Model requirements see NCSBN's Campaign for Consensus maps at <https://www.ncsbn.org/2567.htm>.

There are seven major elements that are part of the APRN Consensus Model and all are vital to public protection and access to care. These include title, the four roles, licensure, education, certification, independent practice and prescribing. Each legislative season, additional states and jurisdictions align with the requirements of the APRN Consensus Model. NCSBN supplies a variety of support, including legislative resources and consultation. Last August, NCSBN hosted a united legislative strategy meeting with BON members, APRN association representatives and other stakeholders to strategize the coming legislative session.

2013 Legislative Summary: APRN Consensus Model Elements

Seven states successfully passed legislation or adopted rules that further align the state nursing practice act and rules with the APRN Consensus Model.

- Arkansas, Nevada, Ohio and Rhode Island changed the title to advanced practice registered nurse (APRN).
- Rhode Island and New York now recognize the CNS role.
- Idaho came into full compliance with all conditions of the APRN Consensus Model by adopting a rule requiring graduate level education as a minimum standard.
- In Nevada, APRNs will be licensed, no longer certified.
- Nevada and Rhode Island expanded independent practice authority.
- In Oregon, CRNAs may deliver certain service without medical collaboration under certain circumstances
- Nevada and Rhode Island expanded independent prescriptive authority.

For additional APRN legislation passed in 2013, see Appendix 1.

Recent Studies

APRNs are regulated with greater uniformity and higher standards than ever before. Will the quality of their services be equal to the expectations placed on them? The newest systematic review, published in *The Journal for Nurse Practitioners* in September 2013, analyzed the findings of studies relative to certified nurse practitioner (CNP) outcomes from 1990-2009. Eleven outcomes were identified that were included in at least three of the studies reviewed and were carried out in a variety of patient care settings. The quality of each study was independently rated by two reviewers. Data indicated that care by NPs was comparable to that administered by physicians on measures of patient satisfaction with provider care, patient self-report of perceived health status and functional status, the number of unexpected emergency room visits, hospitalization rates, blood glucose, and blood pressure control. These conclusions support the premise that outcomes of NP provided care “are equivalent to those of physicians” (Stanik-Hutt et al., 2013).

Coupled with previous reports and studies demonstrating favorable outcomes for each of the roles, APRNs are well positioned to rise to the changing health care environment in the U.S. and to be a substantial part of the solution to health care improvements (Newhouse et al., 2011)

The Future Workforce

The former focus on a nursing shortage has shifted to an impending crisis of primary health care providers. This anticipated surge in the number of adult Americans that will be seeking health care services is due to the insurance expansion resulting from the ACA, an increase in chronic medical conditions, such as diabetes and obesity, and many more primary care physicians retiring than entering the profession. The most recent prediction estimates that by 2015, the shortage of physician primary care providers will exceed 52,000 (Pettersen et al., 2012). While many experts have recommended that NPs, physician assistants, RNs and even pharmacists can help aid this shortage of providers, Bodenheimer and Smith (2013), along with others such as Berwick and Hackbarth, state that the solution to the deficiency of providers is to not expand the number of providers, but instead, expand the capacity of providers by “reallocating clinical responsibilities—with the help of current technologies—to nonphysician team members and to patients themselves” (Bodenheimer & Smith, 2013, p. 1882). The health care delivery system will be restructured to rely on the following:

1. Expand the role of the licensed providers such as RNs, LPN/VNs, pharmacists and physical therapists. It is suggested that these individuals are not working to the full extent of their education and expanding their scope of practice is the answer.
2. Increase use of unlicensed personnel, such as medical assistants and other nonclinician team members. These individuals would have greater responsibility in providing clinical services through standing orders. Medical assistants would be empowered to provide care through “algorithm-based, periodic chronic and preventive care services.”
3. Patients can assist other patients with similar conditions by becoming “peer coaches.”
4. The expansion of telehealth services will continue and it is suggested that patients may not actually need a provider at all. One day there may be kiosks set up to assist patients who have simple medical conditions. The patient would answer questions and the kiosk would make a recommendation for treatment based on a programmed algorithm (Bodenheimer & Smith, 2013).

In another article, Kellerman, Saultz, Mehrotra, Jones and Dalal (2013) describe the role of a primary care technician to fill the primary care workforce gap. Similar to an emergency medical technician (EMT), the primary care technician would be a lay provider that would follow algorithms to provide care in homes or nearby clinics. It is envisioned that they would provide primary care, as well as stable chronic care. Education would take place over a period of a few months. In the article, the authors describe EMTs as having, “the cultural competence of community health care workers, the procedural skills of Pas [physician assistants], and ready access to the knowledge of NPs and primary care physicians. They should be easy to train, inexpensive to employ, and capable of working miles apart from their supervising providers” (p.1895).

While allowing licensed health care providers to work to the full scope of their ability is a positive intervention and will assist with the potential shortage of providers, many of the other recommendations including the expansion of services provided by medical assistants and other unlicensed personnel have broad implications for regulatory boards who should be watchful in the coming years that the desire to build capacity does not jeopardize the safety of patients.

NURSING EDUCATION

As a result of the ACA a significant need may arise calling for increased numbers of nurses in the coming years. Attention will turn to educators to produce more nurses and in possibly shorter periods of time. In addition, recent reports are calling for a change in the U.S. model of education for health professionals that will better coordinate with the new delivery system emerging from the ACA. The following provides an analysis of the current status and outlook for nursing education.

Faculty

Annually, the NCSBN Environmental Scan reports on the findings of Fang and Li's *Special Survey on the Vacant Faculty Positions for Academic Year* (2013). This survey describes the current status and trends related to nursing faculty in baccalaureate or higher nursing education. The 2012-2013 survey had a response rate of 680 deans. Table 6 provides the 2013 data, as well as faculty trends from 2009 to present. As can be seen, the total number of budgeted faculty positions continues to increase, as does the number of faculty vacancies.

Table 6: Nursing Program Faculty: Recent Trends (2009-2013)

	2009	2010	2011	2012	2013
Total budgeted positions	12,184	12,783	14,166	15,574	16,444
Total number of full-time vacancies (National Vacancy Rate)	803 (6.6%)	880 (6.9%)	1,088 (7.7%)	1,181 (7.5%)	1,358 (8.3%)
Total number of filled positions	11,385 (93.4%)	11,909 (92.3%)	13,078 (92.3%)	14,393 (92.4%)	15,086 (91.7%)
Mean number of vacancies per school	1.4	1.6	1.8	1.8	2.0
Range of Vacancies	1-13	1-16	1-16	1-20	1-29
The number of schools with no faculty vacancies, but that need additional faculty	117	112 (20.1%)	104 (17%)	103 (17%)	98 (14.4%)
The number of schools with no faculty vacancies, and that do not need additional faculty	127	141 (25.4%)	145 (24%)	182 (30%)	168 (24.7%)

(Fang & Li, 2013; 2009, 2010, 2012 data from previous environmental scans)

2013 Faculty Data

According to Fang and Li (2013), there are several reasons nursing education programs are not hiring new faculty:

(n=98; schools that do not have vacant positions, but need more faculty)

- Insufficient funds (64.3 percent);
- Unwillingness of administration to commit to additional full-time positions (49 percent);
- Inability to recruit full-time faculty because of competition for jobs with other markets (38.8 percent); and
- Qualified applicants for faculty positions are unavailable in the geographic area (28.6 percent).

The most critical issues faced by schools related to faculty recruitment and retention include:

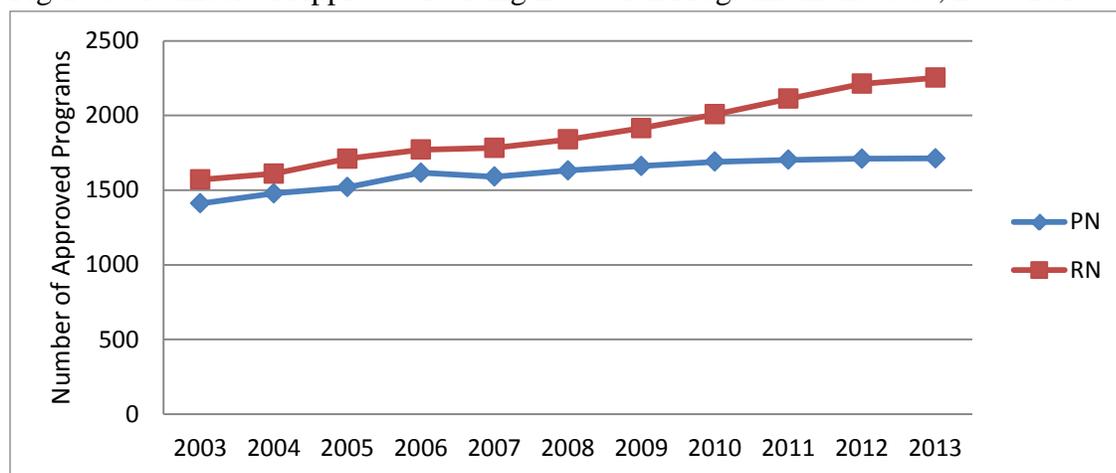
- Limited pool of doctorally prepared faculty (31 percent);
- Noncompetitive salaries (28.4 percent);
- Finding faculty with the right specialty mix (19 percent);
- Finding faculty willing/able to teach clinical courses (4.6 percent);
- Finding faculty willing/able to conduct research (4.4 percent); and
- High faculty workload (4 percent).

Nursing Education Programs

BONs report having increased enrollments in nursing programs of all levels¹. Florida, North Carolina, Ohio and Oklahoma report an increase in the number of new programs seeking approval; Alaska and Utah report, in particular, a rise in for-profit programs. California, which had previously enacted a moratorium on the approval of new programs due to a lack of education consultants, is now once again approving new nursing programs within the state. See Table 3 for national trends in new programs between 2003 and 2013.

¹ Updates provided by BONs at the 2013 NCSBN Annual Meeting.

Figure 3: Number of Approved Nursing Education Programs in the U.S., 2003-2013



(NCSBN NCLEX Program Code Database, 2013)

Because of the new programs, jurisdictions struggle to meet the demand for appropriate clinical sites and qualified faculty. Nevada has implemented a software-based clinical placement system to streamline this process. Idaho reports supplementing its faculty shortage by increasing adjunct faculty².

Another trend reported in jurisdictions is the increase in program noncompliance with approval standards. Arkansas, Connecticut, Delaware, Florida, New Hampshire, Ohio, Texas, and Virginia commented on this, with Virginia noting that the problem is becoming burdensome for their BON. Georgia, Indiana, Massachusetts, Minnesota, Missouri, North Carolina, Texas and the Virgin Islands have recently amended and streamlined their approval process for new and/or already approved programs; the Texas Board of Nursing describes its current initiative as a “site visit blitz,” having conducted more than 60 site visits since the initiative began in August 2012. Oklahoma is compiling a guide for programs that do not meet approval requirements³.

Tables 7 depicts a three-year trend in candidate numbers and pass rates of first-time U.S. educated students taking the NCLEX-RN® and NCLEX-PN® Examinations. Note the increase in the number of first-time RN test takers and the increased pass rate. However, the LPN/VN pass rates have decreased slightly since 2010, and the numbers of test takers are also down.

² Id.

³ Id.

Table 7: Three Year Trend in NCLEX® Candidate Numbers and Pass Rates

	January-December 2010	January-December 2011	January-December 2012
Number of first time U.S. educated students taking the NCLEX-RN	140,889	144,583	150,266
Number of first time U.S. educated students taking the NCLEX-PN	66,831	65,334	63,350
NCLEX pass-rates first time RN test takers	87.41%	87.89%	90.34%
NCLEX pass-rates first time PN test takers	87.05%	84.83%	84.23%

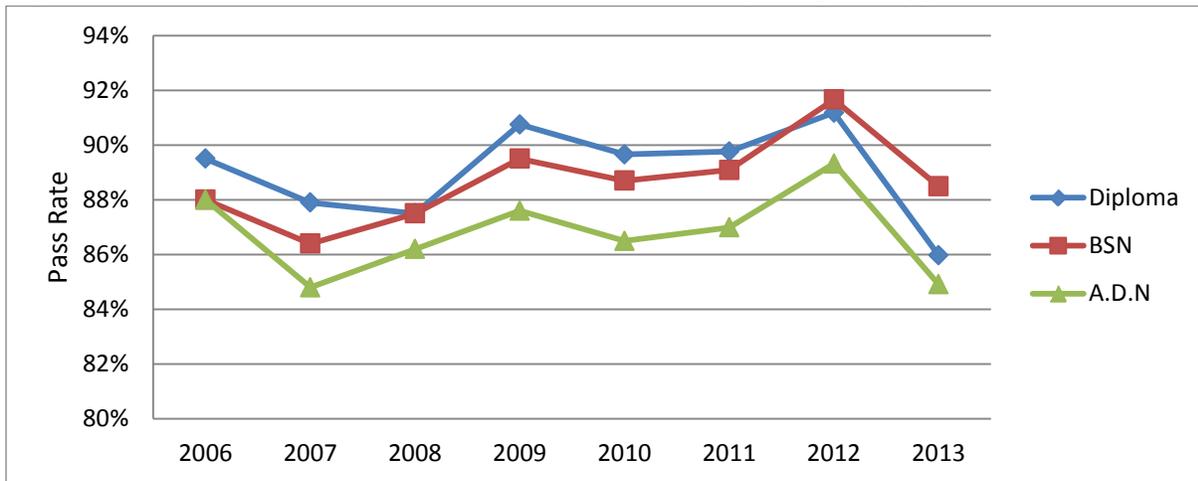
Table 8 shows a three-year trend of the breakdown of NCLEX® test takers according to program type. As expected, associate degree in nursing (ADN) graduates still comprise the largest number of nursing program graduates. The number of diploma graduates has decreased over the three-year period, while the number of baccalaureate graduates has increased at a rate higher than the ADN graduates.

Table 8: Three Year Trend in NCLEX® Test Takers According to Program Type

	2010	2011	2012
Diploma	3,753	3,476	3,173
Associate Degree	81,618	82,764	84,517
Baccalaureate	55,414	58,246	62,535
Unclassified or special codes	104	97	41
Total	140,889	144,583	

The new NCLEX-RN passing standard went into effect April 1, 2013, and as is seen every time a passing standard is raised, there is a slight decrease in pass rates in the testing periods following it.

Figure 4: NCLEX First Time U.S.-Educated Pass Rates by Program Type



The BONs and the nursing education community have been following the National League for Nursing’s (NLN) and National League for Nursing Accrediting Commission’s (NLNAC) differences. In response to the litigation, NLNAC renamed its accrediting agency the Accrediting Commission for Education in Nursing (ACEN). On Aug. 2, 2013, the New York Supreme Court upheld the NLN’s position with regard to the bylaws and NLNAC’s request to void the longstanding contracts between NLN and NLNAC (ACEN). NLN is currently developing a national nursing accrediting agency, which means that there will be three national nursing accrediting bodies: the ACEN, the Commission on Collegiate Nursing Education (CCNE) and the new NLN accrediting body.

New Graduate Employment

In January 2013, the National Student Nurses Association (NSNA) released the results of its fifth annual survey of new graduate nurses. Though surveys through 2010 showed a decline in entry-level positions for new graduates, the 2011 survey had shown an improvement in new graduate employment (Mancino, 2011). The 2013 data showed that this trend continued. Employment rates stayed steady or improved for new graduate nurses in every type of nursing program, and the overall hire rate for new graduates increased by 2 percent between 2011 and 2012 (Mancino, 2013).

Table 9: Percentage of New RN Graduates Employed by Type of Nursing Program

Degree Type	2011		2012	
	Total Graduates	Percent Employed*	Total Graduates	Percent Employed*
Associate Degree	1,407	61% (864)	1,580	61% (966)
Diploma	169	69% (117)	125	70% (87)
Baccalaureate Generic	1,681	68% (1,150)	1,900	72% (1,361)
Baccalaureate Accelerated	377	54% (200)	374	58% (218)
Total	3,634	64% (2,331)	3,979	66% (2,632)

* Reflects employment status 3-4 months post-graduation

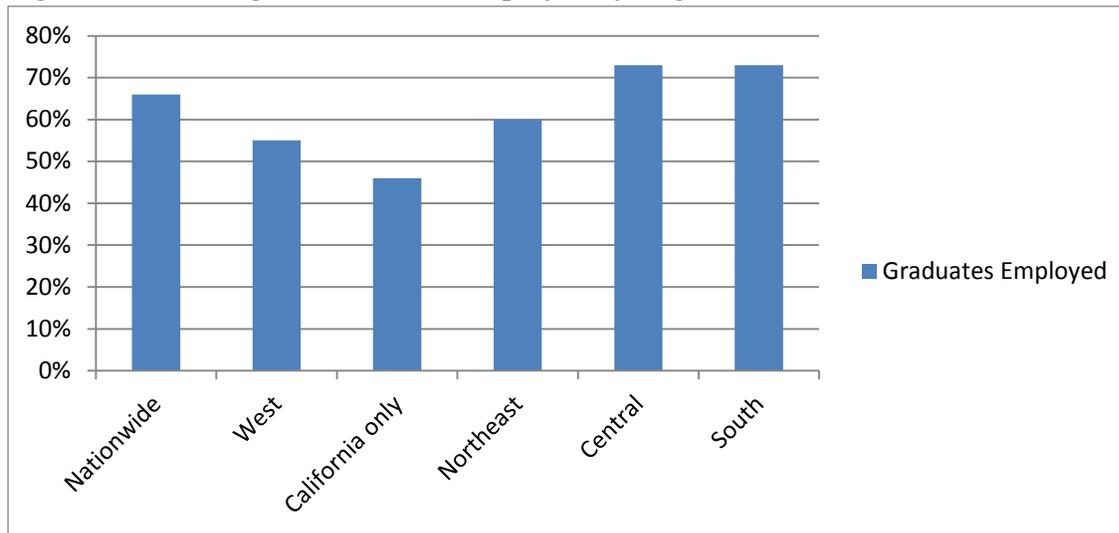
(Mancino, 2011; 2013)

Using the 2013 NSNA new nurse employment data (Mancino, 2013), Stone and Feeg (2013) report that the four most frequently cited reasons for a lack of jobs included:

- The market's need for more experienced nurses;
- An overabundance of new graduates in the area where they graduated;
- The recession of the local economy; and
- The lack of respect for new graduates.

The NSNA survey does reveal some concerns about the true nature of the nurse hiring shortage. There is the perception that certain regions may actually be experiencing an overpopulation of new graduate nurses rather than a shortage (Mancino, 2013). See Figure 5 for a breakdown of new graduate employment by region.

Figure 5: Percentage of Graduates Employed by Region



(Mancino, 2013)

According to the NSNA employment survey (Mancino, 2013), new graduates cited the following factors as contributing to their difficulty finding employment:

- Employers are filling positions with experienced RNs (76 percent);
- Older RNs are not retiring (70 percent);
- Too many new graduates (63 percent);
- Hiring Bachelor of Science in Nursing (BSN) graduates over ADN graduates (69 percent);
- RNs working full time are taking additional part-time positions (56 percent);
- Nurses are hired per diem without benefits (52 percent);
- RNs currently employed are working harder (51 percent);
- Part-time nurses are being hired full time (50 percent);
- Hospitals are hiring travel and agency nurses (44 percent);
- Long-term care facilities are hiring new graduates (44 percent);
- Hospitals are creating residency programs (41 percent);
- Hiring freezes (34 percent);
- Sub-acute facilities are hiring new graduates (29 percent);
- Home care/community health agencies are hiring new graduates (27 percent);
- Hospitals are discontinuing orientation and residency programs (25 percent);
- Hospitals are closing departments (20 percent); and
- RNs are being laid off (16 percent).

Distance Education

Distance education is becoming a mainstream of higher education, with an unprecedented 6.7 million students taking at least one online course annually and 32 percent of all students in higher education taking at least one online course (Allen & Seaman, 2013). Distance education is making it easier for a larger, more diverse group of students to receive quality education, particularly in remote areas of the country where there are few nursing education programs. No definitive data could be found on the number of online programs in nursing.

Jurisdictions report increased inquiries⁴ into their requirements for distance education, as well as issues and concerns with licensure requirements and faculty qualifications for such programs. Hawaii, for example, is currently finalizing language to address prelicensure distance programs. Alaska, Louisiana, Oregon, South Dakota, and Washington report that they are examining the problem of out-of-state programs requesting clinical experiences, impacting the availability of clinical experiences for in-state students. Washington and Oregon have now put official protocols in place to approve these placements.

In April 2013 the Commission on the Regulation of Postsecondary Distance Education finalized a document titled *Advancing Access through Regulatory Reform: Findings, Principles, and Recommendations for the State Authorization Reciprocity Agreement (SARA)*. This document provides recommendations for interstate reciprocity (voluntary participation) for governing the regulation of distance education programs. Nursing regulation of programs, however, is not a part of this agreement. That is still up to the individual BONs.

International Clinical Experiences

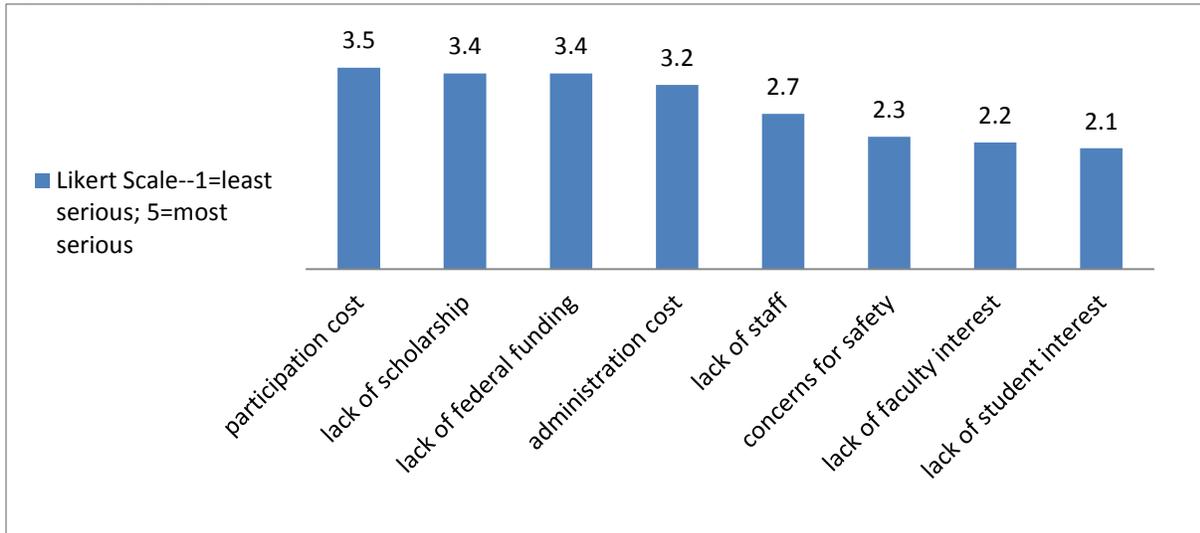
As nursing programs endeavor to become more globally diverse, they are offering more international clinical experiences. Further, with the limited availability of clinical sites in some areas of the U.S., international clinical experiences can provide diverse experiences. While fewer than 50 percent of schools of nursing currently offer international study abroad or service learning programs (McKinnon & McNelis, 2013), the trend of higher learning institutions to focus globally and the perceived value to participants drive increased interest in such programs.

A 2013 NLN survey of schools of nursing (n=487) examined the major obstacles for international service learning programs (see Table 10 for these findings). Other notable obstacles mentioned were that a rigid nursing program design or BON regulations might make participation in such programs difficult; likewise, that practice restrictions in other countries might relegate the students to mere observers and diminish the value of the clinical experience. Gains in cultural competency and civic engagement, which result in improved quality of care,

⁴ Id.

might supersede these challenges for some institutions. NLN also perceived a possible trend wherein the attractiveness of an international program is inversely linked to the institution's population diversity (McKinnon & McNelis, 2013).

Table 10: Perceived Seriousness of Obstacles to Implementing International Nursing Clinicals by Nursing programs (N=487)



(McKinnon & McNelis, 2013)

Regulatory issues related to this include oversight by faculty from the program, and the question of whether the BON is aware of the international facilities being used for student clinical experiences and whether they meet state requirements.

Virtual Community Clinic Learning Environments (VCCLEs) and Massive Open Online Courses (MOOCs)

Nursing programs are beginning to use more innovative technology as they move to the future. One such innovation is the VCCLEs. These are asynchronous, immersive environments where students interact with virtual patients. At East Carolina University College of Nursing in North Carolina, faculty have developed and implemented a VCCLE for APRN students (East Carolina University, 2013). In this particular program APRN students navigate the VCCLE as avatars, interacting with the patients and preceptors, thus developing critical thinking skills through the diagnostic sequence. This technology, using standardized, virtual cases, enhances traditional hands-on learning.

Another emerging model in distance education is MOOC, which is creating a buzz in higher education. MOOCs are courses for delivering content online to virtually anyone who wants to take the course. For example, one course at Stanford drew 100,000 learners (Educause, 2011). This model bears watching as it may be one avenue for meeting the Institute of Medicine's

(IOM) recommendation of advancing nursing education. For example, Skiba (2013) asserts that perhaps 650 introductory courses on various subjects, such as research, pharmacology or pathophysiology, are not needed. Could MOOCs be an answer for these courses? Skiba also queries whether MOOCs could be used to offer accelerated graduate degrees in nursing.

Johns Hopkins School of Nursing offered two MOOCs in fall of 2013. The courses addressed global tuberculosis, and the care of elders with Alzheimer's disease and other neurocognitive diseases. MOOCs provide excellent opportunities to students and life-long learners, particularly during these times of massive student loan debts. However, this model is not without pitfalls, including incidents of cheating; course variability; and lack of adequate completion rates, ability to assess student learning and a cost model to demonstrate revenue generation (Skiba, 2012).

Advancing Nursing Education

BONs, working with state action coalitions, are rising to meet the challenge of converting 80 percent of their workforce to BSN-educated nurses by 2020. Indiana, Vermont and Washington noted the increase in demand for RN to BSN programs within their states. Other states are tackling the challenge in a variety of ways: Wyoming recently enacted a statewide curriculum for RN to BSN programs; Iowa convened a task force to meet the directive; and Montana is applying Robert Wood Johnson Foundation (RWJF) grant money to the initiative. Four additional Oregon community colleges have joined the Oregon Consortium of Nursing Education (OCNE), where there is co-admission with ADN and BSN programs to streamline the RN to BSN process. In South Dakota, Maine and Vermont, major ADN programs have been converted into BSN programs⁵. A survey of BONs, with a 64 percent response rate, showed that 29 percent have articulation agreements for seamless advancement of nursing education.

In 2012 NCSBN's Nursing Education Committee recommended that all BONs require nursing accreditation by 2020 for continued approval of nursing programs. A recent survey, with a BON response rate of 47 percent, reports on the progress of that recommendation:

- 29 percent reported requiring accreditation now, or by some future date.
- Of the remaining BONs, 35 percent reported either having written rules to require accreditation or having serious discussions about it.

While there is work to be done in achieving this recommendation, there has been significant movement toward requiring accreditation.

The NSNA employment survey (Mancino, 2013) provides insight into how new graduates in nursing are planning to advance their education. See Table 11 for these data.

⁵ Id.

Table 11: Career Advancement Plans of New Graduate Nurses, 2012

Degree Level	Number of graduates planning to pursue this degree level
Baccalaureate	13% (500)
MS in Nursing	53% (2,053)
DNP	26% (1,001)
PHD	6% (246)

(Mancino, 2013)

Certain BONs imply⁶ there is a potential trend in decreased interest in LPN/VN programs, possibly related to the recommendation to increase the education of nurses. Idaho noted reduced admissions to LPN/VN programs; the District of Columbia reports the voluntary closure of one of its LPN/VN programs due to lack of enrollment. In accordance with this, on NCSBN's monthly education calls, there have been discussions of LPN/VN programs not being allowed clinical experiences in pediatrics, obstetrics or acute care and what kinds of skills LPN/VNs should be taught. It may be a time for a national meeting on the future of the LPN/VN.

⁶ Id.

Education of the Future

In response to the ACA, new models of health care delivery are being proposed. It is suggested that the education of health professionals is also in need of redesign. Six areas are highlighted as being necessary for the health care professional of the future;

- Interprofessional education;
- New models for clinical education (care outside the hospital in communities, and allowing students to form relationships with patients and families to fully understand the impact of chronic illness);
- New content to complement the biological sciences, including ethics, quality improvement, patient safety, population health and the social determinants of disease;
- New educational models based on competency. Students advance according to their level of competency;
- New educational technologies, including learning the electronic medical record, and less time in the classroom, in addition to more time being devoted to team building, mastering competencies and honing of skills; and
- Faculty development for teaching and educational innovation; institutional and public policies need to support these innovations. There also needs to be a closer integration of education reform and health care delivery reform (Thibault, 2013).

POLITICAL AND ECONOMIC ISSUES

Looking forward to 2014, the following section describes the broader political climate in the U.S. Understanding the current political environment and its potential implications on nursing regulation can enhance a BON's ability to more effectively operate and make strategic decisions.

Partisan Composition of State and Federal Government

The political composition and ideology of the country's lawmakers potentially have significant implications for nursing regulation, particularly impacting the likelihood that a proposed legislative agenda passes or fails. Beginning in 2014, the composition of the U.S. Congress is:

The U.S. House of Representatives	U.S. Senate
200 Democrats	53 Democrats
231 Republicans	45 Republicans
0 Independents	2 Independents

In 2014, governors in all 50 states and five U.S. territories have the following political affiliations:

2014 Governors- 50 States	2014 Governors- Five U.S. Territories
21 Democrats 29 Republicans 0 Independents	2 Democrats 1 Republicans 1 Independents

Beginning in 2014, 26 state legislatures will be Republican, 19 Democrat and 3 legislatures are divided. The Nebraska Legislature is nonpartisan (Office of the Clerk of the U.S. House of Representatives, 2013; United States Senate, 2013; National Governors Association, 2013).

Political Issues

Political observers have noted elevated levels of party polarization in Congress in recent years. This polarization has been attributed to a variety of factors, including redistricting, primary elections and ideologically focused mass media.

The Cook Report recently deemed 83 percent of Congressional seats in the House as noncompetitive, a result of political gerrymandering designed to distort the popular vote (Picard, 2013). In 34 states Congressional district boundaries are crafted through a highly politicized and partisan process under the control of state legislatures and governors. Without competition, these districts often produce highly partisan elected officials and thus, increasing polarization in America’s governing bodies (Picard, 2013).

Like redistricting, political primaries can lead to more extreme political discourse. Primaries determine who will compete in the general election. However, primaries are often decided by highly partisan voters who show up to vote and select more conservative or liberal candidates. This dynamic forces general election voters to choose between more extreme candidates that do not necessarily fit their political beliefs and ultimately results in more polarized legislative bodies.

State-Federal Relations

Regardless of its root cause, the increasing polarization in American politics continues to accentuate intergovernmental conflict and affect state-federal relations. For example, in recent years, lawmakers in many states have introduced anti-federal government bills, including measures to authorize state nullification of federal laws. These nullification efforts illustrate how some lawmakers use state power to express discontent and partisan opposition in today’s polarized political environment (Kincaid, 2013).

In 2013, there was an ongoing series of federal budget crises that had a significant impact on state governments. Congress was embroiled in bitter budget debate involving a 2011 deal between the president and Congress to invoke dramatic spending cuts, known as "the sequester", unless policymakers agreed on a plan to reduce the federal deficit. Congress could not agree to the necessary policy interventions and the sequester occurred on March 1, 2013, complicating budget making for states by putting sizeable dents in programs involving some vital state and local functions. Governors across the country pleaded for discretion in spending federal dollars (Kincaid, 2013).

On Oct. 1, 2013, the federal government began a 16-day shut-down resulting from an impasse in congressional spending-bill negotiations. This was the first federal shutdown in 17 years. Like the sequester, the federal shutdown hampered state governments by denying federal money for certain state programs and services.

The State of the States

Overall, the nation's economy is slowly rebounding after one of the worst recessions in U.S. history. The period of resurgence that marked other post-recession economies has been remarkably diminished when compared to the past. Unemployment remains high and states have been financially challenged by cut backs in funding from the federal government due to sequestration and directly, by increased costs that resulted from the troubled economic environment of past years. One example of this is the increased spending that resulted from a higher number of Medicaid recipients (National Governors Association & National Association of State Budget Officers, 2013).

On the horizon, however, is an improvement in state revenue and the ability of states to close budget gaps. The \$146.3 billion reported in state budget gaps during 2011 and 2012 is improving. There were 18 states that closed \$33.3 billion budget gaps in fiscal year 2013, and higher revenue and decreased expenditures are closing the gaps in 2014. Most states (46) begin their fiscal year in July. Alabama and Michigan begin their fiscal year in October, New York in April and Texas in September. Twenty-one states have a biennial fiscal cycle (NGA & NASBO, 2013).

The largest amount of state spending goes to the state Medicaid program. In 2012, almost 24 percent of the state budget (23.9 percent) went to funding Medicaid (the last year for which data are available). Enrollment in Medicaid is expected to significantly increase in states that have decided to expand Medicaid under the ACA. In the state budgets recommended for 2014, it was projected that Medicare enrollments would increase by 6.3 percent and this is expected to continue to rise. In 2013, the Center for Medicare and Medicaid Services (CMS) Office of the Actuary estimated that 8.7 million individuals were enrolled in the Medicaid program in 2014 and will rise to 18.3 million by the year 2021 (NGA & NASBCO, 2013).

The largest state health care expansion outside the ACA is the movement toward community-based long-term care in lieu of institution-based care. Fourteen states took action in this direction in 2013 and another 14 states appropriated funding for 2014.

IMPORTANT LEGISLATIVE, SOCIAL AND PRACTICE ISSUES

Veterans

In February, the White House released a report titled, *The Fast Track to Civilian Employment: Streamlining Credentialing and Licensing for Service Members, Veterans and Their Spouses*, encouraging states to support legislative efforts that will transition veterans into the civilian workplace. The White House initiative focused on a number of professions, including nursing. NCSBN joined these efforts by conducting an in-depth analysis of the health care specialist (medic), corpsman and airman curricula, and compared these with a standard LPN/VN curriculum. This resource has been widely distributed. NCSBN was invited to speak at a White House meeting to discuss licensure issues related to this initiative and continues to work with a number of government departments and agencies, along with the National Governors Association (NGA), to bring its expertise to the table on this important matter.

In October, NGA announced that six states will participate in the Veterans' Licensing and Certification Demonstration Policy Academy to assist veterans' transition from military service to civilian employment. The six participating states include Illinois, Iowa, Minnesota, Nevada, Virginia and Wisconsin. Arizona and Michigan have already enacted bridge programs. Each state will develop a plan to help separating service members obtain the necessary state-level credentials in three of five occupations, including truck drivers, police officers, EMTs/paramedics, LPN/VNs, plus one health care occupation of the state's choosing based on its particular needs. All participating state elected to focus on LPN/VNs as part of the Veterans' Licensing and Certification Demonstration. Iowa selected RNs as their health care occupation of choice.

Social Media

Social media continues to affect the culture of nursing, both as a new way to provide outreach and quality care, and as a potential pitfall for boundary, privacy and/or confidentiality violations.

As social media platforms continue to grow in popularity, health care providers increasingly see them as a means of spreading information about upcoming events and important medical topics, as well as receiving feedback and improving patient satisfaction. More than 1,500 U.S. hospitals now maintain a social media presence; 84 percent of them favoring social networking site Facebook (Mayo, 2013). Additionally, 14 BONs (or their umbrella agencies) maintain a social media account of some sort, reaching an audience of more than 1.15 billion active users on Facebook (Facebook, 2013) and 218 million on Twitter (Twitter, 2013).

BONs should be aware, however, of issues that may arise from the implementation of a social media presence. Legal cases regarding employee behavior on such sites are becoming more and more regular, and lawsuits concerning state use of social media are expected to continue to increase (Clark, 2013). The National Association of State Chief Information Officers (NASCIO) recommends that states adopt broad social media policies that explicitly address such issues as privacy and terms of use (2013). A useful resource for BONs wishing to implement such a policy may be found at

www.nascio.org/publications/documents/NASCIO_2013SocialMediaIssueBrief.pdf.

Many nurses are turning to the social networking site LinkedIn as an opportunity to grow their careers and develop interprofessional connections; health care recruiters praise the site as a means of finding job candidates (Potempa, 2012). In April, LinkedIn reported surpassing a combined total of 1 million doctors and nurses signed up for the service. As of October 2013, the largest nurse networking group on the site, The RN Network, had more than 30,000 members (Zhang, 2013).

Mobile devices have also been a benefit to nurses and patients alike. Smart phones have been increasingly adopted as a means of accelerating communication, both interprofessionally and between care providers and patients. Handheld mobile devices are also seeing use as bedside reference tools, and applications for gathering and managing patient information are constantly evolving. More than 3,800 hospitals have implemented meaningful use of electronic health records as of April 2013 (HHS, 2013a). While some institutions see the benefits outweighing the drawbacks, debate continues over the potential distractions of handheld devices, as well as the unintentional spread of both patient information and infection that may be caused by their use (Guglielmi et al., 2013).

With increased social media use comes an increased potential to violate patient privacy. In an NCSBN survey conducted in 2013, of the 32 responding BONs, 19 reported receiving complaints about nurses who shared sensitive information via social media. More than half of these complaints name Facebook as the medium of the violation.

BONs are beginning to combat the growing problem with increased education and the development of resources. Both the Massachusetts and Virginia BON responded to increased violations of the nurse practice act related to the use of social media. Massachusetts created a tool to assist board members and staff in the evaluation of social media related complaints. Virginia developed a guidance document related to social media, which clearly identifies potential violations of the nurse practice act related to social media and the resulting consequences for that violation.

NCSBN surveys taken in 2010, 2012 and 2013 (Table 12) show an overall decrease in reports of social media related violations. Over that period, the number of jurisdictions with established

social media guidelines more than tripled, with 32 percent of BONs reporting that they would either develop their own policies, or refer to NCSBN’s or American Nurses Association’s (ANA) guidelines.

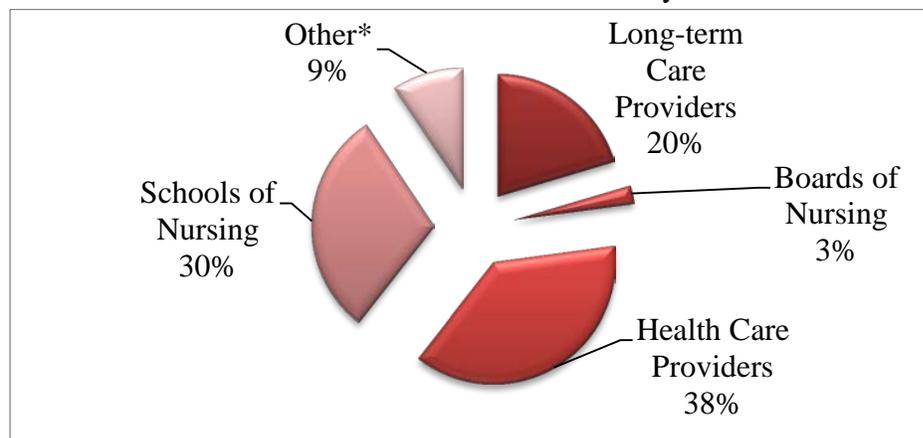
Table 12: BONs and social media-based privacy violations, 2010-2013

	2010 N=46	2012 N=30	2013 N=32
Percentage of BONs reporting social media based complaints	72%	60%	59%
Percentage of BONs taking disciplinary action based on social media complaints	57%	50%	50%
Percentage of BONs with guidelines in place for social media use	7%	20%	31%

(NCSBN, 2010; 2012; 2013)

NCSBN disseminates information on social media use to as many nurses as possible. As of December 2013, almost 500,000 free brochures on the subject were sent to a variety of institutions. The brochure, “A Nurse's Guide to the Use of Social Media,” has been downloaded digitally more than 5,000 times. The NCSBN video, “Social Media Guidelines for Nurses,” has accumulated a total of more than 53,000 views.

Table 13: Distribution of Social Media Literature by NCSBN



*includes insurance companies, law firms, the military, other health care disciplines, etc.

Unlicensed Personnel and Medication Administration

In August 2013, the California Supreme Court unanimously ruled that trained unlicensed school personnel could administer insulin and other prescription medication to students. It remains uncertain whether the state legislature will pass legislation establishing standards of training for unlicensed personnel. Nursing advocates may consider an appeal to federal court.

In May 2013, the Iowa Supreme Court upheld two administrative rules permitting advanced registered nurse practitioners (ARNPs) (Iowa title/credential for APRNs) to supervise technicians during fluoroscopy. Several physician associations, including the Iowa Medical Society, argued that the Iowa Board of Nursing (IABON) and the Iowa Department of Public Health (IDPH) exceeded their authority in approving the rules to allow the supervision. The court concluded that regulatory judgments fall within the scope of the authority of the IABON and IDPH. The court upheld the administrative rules, reasoning that the IABON did not irrationally, illogically or wholly unjustifiably promulgate rules for the ARNP supervision of technicians during fluoroscopy.

In 2013 there were a number of legislative efforts related to care for students with diabetes in schools. These efforts coincide with an initiative by the American Diabetes Association to target state laws or policies requiring that only licensed school nurses provide diabetes care in school. The American Diabetes Association's Safe at School Campaign advocates for allowing unlicensed school staff volunteers to receive training in routine and emergency diabetes care, such as administration of insulin and glucagon.

Addressing the Prescription Drug Abuse Epidemic

The Centers for Disease Control (CDC) reports a 300 percent increase in painkiller prescriptions in the U.S. Furthermore, data indicate that in 2008, nearly 15,000 people died from a painkiller overdose (Wilson, 2013). In reaction to these startling statistics, the Federal Drug Administration (FDA) announced its intention to submit an official proposal to the HHS to reclassify hydrocodone combination products to a more restrictive schedule. In order to finalize the rescheduling, the HHS must accept the FDA's recommendation, and the Drug Enforcement Administration (DEA) would then adopt and enforce it.

The DEA has long supported such a policy change. However, the FDA recommendation comes after nearly 14 years of urging from the House and Senate to reclassify the hydrocodone drugs from a Schedule III drug to a more restrictive Schedule II, along with other painkillers, such as morphine, fentanyl and oxycodone, which require a written prescription.

Nearly every state has introduced prescription drug monitoring program to help identify "prescription shoppers," problem prescribers and individuals in need of treatment. Only Missouri and the District of Columbia do not currently have active monitoring programs (Levi, 2013).

The Rise of Retail Clinics and Efforts to Expand APRN Scope of Practice

Drugstore retail clinics run by NPs have become popular in recent years as a convenient and cost-effective way to treat relatively minor illnesses. Analysts predict that there will be more than 5,000 retail clinics in the U.S. by 2015. Research shows that visits to retail clinics translate into lower costs per health care episode, compared to health care episodes that do not begin with a retail clinic visit. Moreover, the health care costs were even lower when NPs, who are often the primary providers in retail clinics, were allowed to practice independently (Spetz, 2013). The positive outcomes data arising out of this successful and expanding business model has helped drive efforts to broaden the scope of practice for APRNs.

Retail clinics are now expanding the scope of services they provide from basic primary care to the management of chronic conditions. This initiative has sparked controversy as many believe this will fragment care and draw patients away from a primary care provider. Retail clinics believe they are increasing access to much needed services and improving population health (Stempniak, 2013).

Telehealth

The influence of telehealth has grown significantly over the last two decades. In 2013, efforts to expand the practice of telehealth continue at various levels of government, including state and federal legislative initiatives, and other regulatory or agency-level policy shifts. This year, Congress introduced several bills intended to facilitate telehealth:

The TELEmedicine for MEDicare Act (TELE-MED Act), House Bill 3077, would enable health care providers to treat Medicare patients in other states via telehealth without separate licenses for each state. The bill was introduced on Sept. 10, 2013, in the House by Rep. Devin Nunes (R-Calif.) and Rep. Frank Pallone (D-N.J.). The bill's sponsors seek to update current licensure laws to address technological advances in medicine, and reduce what they perceive as bureaucratic and legal barriers between Medicare patients and their doctors.

The Veterans E-Health and Telemedicine Support (VETS) Act (H.R. 2001) was also introduced this year. This bill would enable providers affiliated with the Department of Veterans Affairs (VA) to deliver telehealth services across state lines, eliminating a requirement that the providers hold licenses in the same state as their patients. This bipartisan legislation aims to make it easier for health care providers to reach distant and remote veterans who are dealing with mental health issues and do not want to travel to a VA clinic.

The Telehealth Enhancement Act of 2013 was introduced in the House on Oct. 22, 2013, by U.S. Rep. Gregg Harper (R-Miss). This bill builds on existing payment innovations and, among other reforms, adjusts Medicare home health payments to account for remote patient monitoring and expands coverage to all critical access and sole community hospitals. The bill also covers home-

based video services for hospice care, home dialysis and homebound beneficiaries. States will have the option of setting up high risk pregnancy networks within their Medicaid programs. Interestingly, the bill includes language defining the site of care for health care liability as the “distant site,” the site at which the physician or practitioner is located at the time the service is provided, as opposed to the “originating site,” the site at which the patient is located.

Several regulatory and policy changes have also occurred in a number of federal programs related to telehealth:

- The VA has dropped co-payments charged to veterans for telehealth consultations and is setting a goal of providing 200,000 remote consultations by the end of 2013 (up from 140,000 in 2012).
- The VA announced the launch of the \$15 million, three-year Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO) program, designed to help rural healthcare providers receive training and assistance in delivering telehealth services to veterans (Wicklund, 2013).
- In July, CMS proposed a rule that would increase the number of beneficiaries eligible for telehealth by modifying their urban/rural definitions and proposes several new reimbursable telehealth services.
- There are now 24 states that have legislative mandate for private coverage or Medicaid coverage of telehealth (American Telemedicine Association, 2013). The following states had successful legislation pass during the 2013 legislative session:
- Arizona requires telehealth services in rural areas of the state to be covered by health insurance. Beginning in 2015, insurers must cover services provided through the telehealth service programs if the insurers pay for those same services when they are provided in a traditional clinic or hospital setting.
- Montana requires insurance coverage of telehealth services if the services are otherwise covered.
- New Mexico requires that coverage for health care services provided through telehealth in a manner consistent with coverage for health care services provided through in-person consultation.
- In Mississippi, a new law requires health insurance plans to provide coverage for telehealth services to the same extent that the services would be covered if they were provided in-person.

This year, the Federation of State Medical Boards (FSMB) announced that its House of Delegates approved a resolution calling for a formal study of the practical implications of a medical licensing compact to help facilitate telehealth, multistate practice and ensure that state boards retain individual authority for discipline and oversight (FSMB, 2013).

The 2012 NCSBN Environmental Scan reported 75 organizations had signed the telehealth petition on Fixlicensure.com. As of November 2013, 85 organizations had signed.

BOARDS OF NURSING

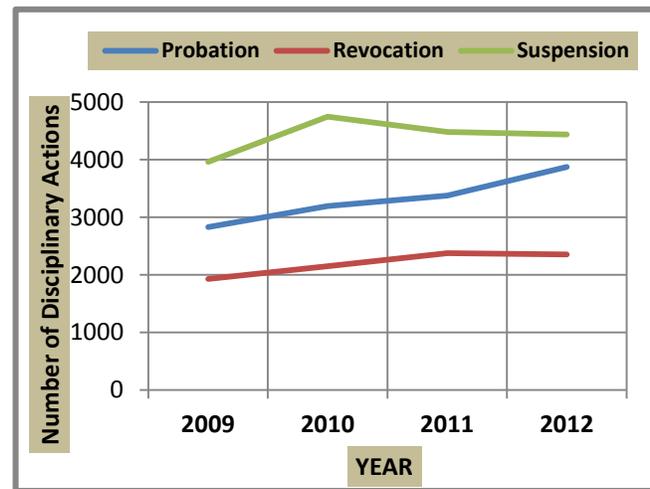
Discipline

The past several years demonstrated an increase in the volume of disciplinary complaints to BONs. However, in 2013 some jurisdictions note stabilization in the number of complaints, while others report the volume continues to increase. The plateau in the number of nurses joining the workforce may contribute to the stabilization in the number of complaints for some states.

Of states reporting frequency of violations in the NCSBN BON Updates (2013) and BON Annual Reports (2012 and 2013), the largest categories of violations of the nurse practice act were substandard nursing practice, drug diversion and criminal convictions. Some jurisdictions note an increase in the use of fraudulent supporting documents or fraudulent answers to licensure applications questions, as well as unlicensed practice or imposters. Cases related to substance use disorder and social media continue to challenge many BONs.

Table 14 Trends in Disciplinary Actions for RN & PN across All Jurisdictions

BON actions range from nondisciplinary consent orders to revocation of license. The most frequent disciplinary action mentioned in the NCSBN BON Updates (2013) and BON Annual Reports (2012 and 2013) is reprimand. Probation, revocation and suspension disciplinary actions trends are noted in Table 14.



The National Nursing Database, 2013

The majority of disciplinary cases are settled without a formal hearing. At least 12 percent of BON seek to recoup the costs of investigation and enforcement from the licensee (NCSBN, 2013; and BON Annual Reports, 2012 and 2013)

BONs continue to develop innovations to assist in the disciplinary review and sanctioning processes. Maryland, New Hampshire and Washington report new processes or systems that move complaints more expeditiously through the investigation, board action and sanctioning processes. Montana has developed a Sanction Matrix and Complaint Review Tool to enhance the consistency of disciplinary evaluation. The District of Columbia initiated a board discipline subcommittee with authority to make final disciplinary decisions. These innovations seek to streamline the disciplinary processes, as well as provide consistency in evaluation as board member terms expire and board staff turnover. Additionally, the Texas legislature removed the pilot designation from the Texas BON deferred discipline option, making the deferred discipline option permanent.

NCSBN piloted the Regulatory Action Pathway (RDP) and, after collecting data and revising the instrument based on BON needs, disseminated it for use by BONs. This tool, incorporating the principles of Just Culture, assists BONs in making consistent decisions regarding nursing practice errors and unprofessional conduct cases. The tool is being used across the U.S. and in Canada.

Idaho recently initiated the Practice Remediation Program, an alternative to discipline program for nurses whose practice deficiencies do not rise to the level of substantial risk to the public. Similarly, Pennsylvania developed the Practice, Education and Remediation Collaboration (PERC) program. Disciplinary sanctions in these voluntary recovery programs are deferred and ultimately dismissed, as long as the nurse meets the requirements of that program. Additionally, Vermont is investigating a practice remediation program.

The California RN BON reports recent collaboration with Immigrations and Customs Enforcement, Homeland Security Investigations, Internal Revenue Service, U.S. Attorney's Office and local district attorneys to investigate the increased perpetration and sale of fraudulent nursing licensure documents.

Participation in Nursys enhances communication between BONs regarding discipline and licensure. All 59 BONs participate in discipline data collection via Nursys. Additionally, Connecticut and Pennsylvania joined 52 other BONs as participants in licensure data collection via Nursys. Georgia has signed an agreement to become a Nursys licensure data participant in 2014. Forwarding disciplinary data between BONs enhances the timeliness of BON awareness of licensees who may pose a serious threat to patient safety.

Nursys also serves as the agent to the National Practitioner Data Bank (NPDB) for 47 BONs. In that role, Nursys is the reporting agent for disciplinary actions, as well as agent for various compliance activities with NPDB. All 18 states that participated in the 2013 compliance audits

by NPDB received a “compliant” status. This status signifies that 100 percent of public disciplinary actions from 2010 through 2011 determined reportable by NPDB were indeed reported to NPDB by BONs.

Criminal Background Checks (CBCs)

In 2013, Minnesota successfully enacted legislation authorizing the BON to conduct CBCs. Over the course of the next year, the Minnesota BON will continue to prepare for implementation in 2015.

NCSBN’s CBC Call to Action Initiative continues to work with states currently moving towards adoption of CBC requirements. There are 14 states that do not require CBCs as part of the initial licensure application process.

NCSBN will continue to support states by preparing informational resources, facilitating dialogues among states and stakeholders, visiting BONs interested in learning more about CBC requirements, and otherwise meeting the needs of BONs moving forward on this important mechanism of public protection. In 2013, NCSBN staff presented on the importance of CBCs to the Nurse Licensure Compact Administrators (NLCA) during its annual meeting and to the Pennsylvania, Washington, Wisconsin and Vermont BONs.

Scope of Practice

Legislative Changes

During 2013, a substantial number of states made advancements in expanding APRN scope of practice.

- In Alabama, CRNP and CNMs can prescribe certain schedules of controlled substances. This law calls for written collaboration with a physician and designates the Board of Medical Examiners as the certifying board for the registration and approval of a CRNP or a CNM in obtaining or renewing a Qualified Alabama Controlled Substances Registration Certificate. The BON remains the sole licensing and disciplinary authority for CRNPs and CNMs.
- California also passed legislation describing the creation of the Medi-Cal health home program for enrollees with chronic conditions. The program is consistent with medical home descriptions in the ACA and is inclusive of NPs.
- California also removed the requirement that a licensed midwife practice under physician supervision while attending cases of normal birth and pregnancy. The new law requires the midwife to transmit prenatal records upon hospital transfer and to communicate with a physician about the status of labor. It allows licensed midwives to purchase supplies and order tests within the scope of their practice, removing some questions raised by suppliers and laboratories asking for a physician to be listed.

- Maine now allows family or pediatric NPs to serve as health care providers in schools.
- In Ohio, APRN prescribers may prescribe Naloxone, but are not permitted to “personally furnish” Naloxone to patients. Current law only allows APRN prescribers to “personally furnish” certain prescription drugs in certain settings.
- Missouri waves a proximity requirement for physicians and collaborating APRNs under certain circumstances for rural health clinics.
- In Illinois a new law was passed that creates more flexibility for collaborating APRNs. APRNs can now sign a written collaborative agreement with a physician located anywhere in Illinois, and can provide services the physician provides or doesn’t provide. The law also states that an APRN may provide primary health care treatment. In other words, if an insurance provider or payer recognizes APRNs as the primary providers, the APRN will be paid as such. Absent an employment relationship, a written collaborative agreement may not limit the types of provider payments the APRN chooses to accept, may not restrict the categories of care the APRN provides or limit geographic area of practice.

Practice

The following position statements, clinical practice advisories, advisory rulings/opinions, and interpretive guidelines were issued or revised by BONs in 2013:

Arizona

- RN and LPN roles in abandonment of patients
- RN role in bone marrow aspiration (BMA) and biopsy
- RN and LPN roles in conservative sharp wound debridement
- RN scope of practice in intra-aortic balloon removal
- RN role in critical care setting to remove Pulmonary Artery catheters
- RN and LPN roles in providing fluids and medications via subcutaneous infusion
- RN role is supervising unlicensed nurse externs
- LPN role in changing low profile gastrostomy tubes or other types of gastrostomy feeding tubes
- RN scope of practice in inserting an esophageal temperature probe in the management of hyperthermia therapy

Kentucky

- Role of nurses in psychiatric-mental health nursing practice
- Cardiopulmonary/respiratory nursing practice, school nursing practice
- Removal of arterial and venous access devices (sheaths) and use of mechanical compression devices by nurses

- RN or LPN scope of practice – the dispensing of medications in a correctional facility

Louisiana

- It is not within the scope of practice for RN to perform soft chamber/mild/low pressure hyperbaric oxygen therapy

Massachusetts

- Withholding initiation of cardiopulmonary resuscitation (CPR) in long-term care facilities
- LPNs in the charge or supervisor nurse role
- Role of the licensed nurse as trainer or consultant for the Department of Public Health Medication Administration Program
- Administration of medications for sedation/analgesia

Nevada

- Amniotomy practice decision rescinded so the BON is no longer taking a stance on whether or not amniotomy is within the scope of practice for an RN

New Hampshire

- It is within APRN scope of practice to provide deep sedation
- It is not within the licensed nursing assistant (LNA) scope of practice to:
 - Empty supra-pubic catheter; clamp nasogastric (NG) tube or perform other functions associated with NG tubes based on need for assessment
 - Insert rectal tubes
 - Collect flu swabs and rapid Strep swabs
 - Administer percutaneous tibial nerve stimulation
 - Accept or sign for meds delivered to facility by pharmacy without medication nursing assistant (MNA) certification
 - Operate a cough assist machine or vest therapy as nursing assessment is required
 - Perform any tasks that involve medication handling
- It is within LNA scope to:
 - Apply intermittent pneumatic devices to lower extremities with education, competency and delegation by licensed nurse
 - Perform heel sticks with competencies
 - Apply orthotic braces with training and competency
 - Insert contact lenses
- It is not within LPN scope of practice to
 - Pronounce death
 - Administer monoclonal antibodies

- Perform x-rays
- It is within LPN scope of practice to:
 - Administer percutaneous tibial nerve stimulation
 - Apply and change vacuum-assisted closure (VAC) dressings with education and competencies
 - Perform deep suctioning
 - Perform venipuncture with intravenous (IV) certification
 - Mix and perform allergy testing provided competencies are met
 - Run a flu clinic
 - Administer epinephrine in an emergency
- It is not within RN scope of practice to:
 - Dispense emergency contraception
 - Flush epidural line
 - Directly inject narcotic into epidural line
 - Inject neuroaxials directly into epidural line of post-partum surgical patient or post-surgical patient
 - Perform needle thoracotomy to emergently relieve tension pneumothorax
- It is within RN scope of practice to:
 - Perform x-ray with proper education, training and competency
 - Administer anesthesia drugs
 - Monitor/administer narcotics via established epidural catheter utilizing pump with training and competencies
 - Prepare bone marrow biopsy blood smear slides while in performance of patient care
 - Insert advanced airway into adult, adolescent and pediatric patients
 - Perform rectal dilation in home setting
 - Insert central venous catheter (CVC) under ultrasound with training and competency
 - Administer percutaneous tibial nerve stimulation
 - Cannulate external jugular, subclavian or femoral veins
 - Start vecuronium drip provided there is a protocol in place and patient is intubated
 - Perform needle decompression
 - Draw therapeutic phlebotomy from vascular access device (VAD) for treatment of hemochromatosis; insert coude catheter with training and competency

North Dakota

- Role of the RN in administration of anesthetic agents
- Safety to practice

Ohio

- Role of the RN in monitoring obstetrical patients receiving epidural infusions; guidelines for monitoring and management of epidural infusions
- Licensed nurse's role in the care of patients receiving intramuscular, subdermal or subcutaneously injected medications for cosmetic/aesthetic treatment
- RN performance of a patient health history and physical examination for purposes of providing nursing care

Oklahoma

- Continuing Qualifications for Practice for License Renewal Guidelines
- CRNA Inclusionary Formulary
- Employment of nursing students or nonlicensed graduates
- Issuance of temporary licenses for RNs and LPNs
- Refresher course policy

South Carolina

- Joint advisory opinion issued by medical examiners, nursing and pharmacy regarding over-the-counter (OTC) meds in schools
- Assisting with meds in school settings, competency in the school setting for unlicensed assistive personnel (UAP)
- Intrathecal nerve therapies
- Nursing tasks (UAP)
- Peripheral IV therapies (RN)

Vermont

- Developed new position statement on the Role of the RN in Obtaining Informed Consent for a Treatment or Procedure
- Role of the nurse in delegating nursing interventions plus Decision Tree
- Role of the nurse in administration of homeopathic drugs, herbal medicine products and dietary supplements
- Role of the nurse in an immunization clinic
- Responsibilities of the nurse in providing complementary and alternative medicine interventions

Virginia

- Nursing Employment Practice under Orders of Probation
- Guidance on the Use of Social Media

- Disposition of cases against certified nursing assistants (CNAs), registered medical assistants (RMAs) and certified medication technicians (CMTs) for practice with expired registrations or certificates
- Prescription drug administration training program for child day programs
- Continuing competency and practice agreement requirements violations for NPs
- Attachment of scalp leads for internal fetal monitoring
- Administration of OTC drugs by CNAs

Washington

- RN first assistant and camp nursing

Wisconsin

- Pain management
- Patient abandonment
- Use of social media by nurses
- Telephone triage
- Use of nurse technicians

Wyoming

- CNA role
- CNA II role
- IV administration of ketamine for intractable pain in adults
- LPN IV therapy scope of practice
- Medication assistant-certified (MA-C) role
- Nitrous oxide administration

The following are nurse practice trends or issues nationally and internationally, as reported by NCSBN Member Boards and Associate Members:

- Alabama is seeing increasing attempts to expand the scope of practice of RNs into that of advanced practice registered nurses.
- Alaska employers prefer to employ baccalaureate prepared nurses. There is an increase in foreign educated nurses, especially from the Philippines. The number of LPNs is generally decreasing. Medical assistants are replacing LPNs in doctor's offices.
- Delaware is receiving more inquiries about telehealth and laser hair removal.
- District of Columbia reported that employment opportunities for LPNs tend to be in community settings, such as home care and clinics. Due to a change in regulatory requirements, nursing homes are hiring more RNs for patient care.

- Florida continues to receive consistent inquiries from nurses and medi-spas regarding the use of Botox, dermal fillers and other injectables. In Florida, only NPs with proper education, training, and experience may perform these cosmetic procedures under protocol with a supervising physician. RNs and LPNs may not perform these procedures as they are considered to be medical acts, not the administration of medication.
- Idaho is seeing emerging health care roles such as anesthesia technicians and non-nurse midwives. It is also reporting more complex care is being provided in community settings, including schools, families and group homes.
- Indiana is seeing a trend of military applications without U.S. nurse education equivalency and international transcripts without U.S. nurse education equivalency.
- Louisiana had legislation pass regarding diabetes management in schools. RN oversight, delegation, training and competency validation is required for unlicensed persons.
- Massachusetts identified unintentional consequences of electronic medical records and electronic communication, such as documentation by proxy, medication reordering and other scope of nursing practice issues.
- New Hampshire is seeing an increase in nurses considering cosmetics as their focus for employment.
- New Zealand is seeing more acute/high dependency patients, especially in the community.
- North Carolina is seeing many acute care agencies preferentially hire BSN prepared nurses. New nurse graduates continue to have difficulty finding employment in some parts of the state. The North Carolina BON will be carefully examining the issue of allowing RNs to administer deep procedural sedation in emergency room settings.
- Northern Mariana Islands reports that 90 percent of their nursing workforce is from the Philippines. The Commonwealth Board of Nurse Examiners is discussing strategies to increase local nurses for sustainability.
- Nova Scotia has seen an increase in the number of LPNs and a loss of RN positions in acute care settings due to changes in various care delivery models. Collaborative Emergency Centres (CECs) have been implemented in small rural emergency centres in order to prevent closure of the emergency centres. This new collaborative model involves RNs and paramedics working together with a centralized emergency oversight physician.
- Ontario has new processes in place to support transition to practice for new graduates.
- Saskatchewan has increasing concern about role and scope confusion of LPNs and RNs in long-term care facilities.
- Texas is reporting that employers are hiring LVNs without appropriate supervision and are unaware of the licensure laws requiring a directed scope of practice.
- Utah is seeing a push toward BSN hiring. Additionally, some clinical placement sites are basing acceptance of a school's students on NCLEX scores.
- Virginia is seeing an increase in procedural/conscious sedation inquiries.

- Wyoming is receiving frequent practice questions involving delegation, utilization of medical assistants and Botox injections by RNs.

Licensing

- Alabama now requires each applicant or licensed nurse to submit proof of citizenship or legal presence at least once prior to issuing or renewing a license.
- California is now required to deny applications for licensure of any applicant and suspend licenses of licensees who have outstanding tax obligations of more than \$100,000. California is finding other countries where theoretical instruction and clinical practice are not completed concurrently, specifically China and Mexico. There are difficulties authenticating academic records for schools in Sierra Leone.
- British Columbia reported an increased number of LPNs.
- Delaware and Indiana experienced increasing numbers of licensees overall.
- Florida reported an increased number of exam applicants due to an increased number of new education programs. They are not authorized to issue exemptions for a licensee or applicant for licensure who has certain felony convictions and it has not been three years since their probation or sanctions ended. New legislation went into effect requiring all nursing applicants to have a Florida/national background check by Live Scan.
- Idaho reported an increase in the number of international applicants.
- Iowa reported an increase in endorsements due to telenursing practice.
- Minnesota reported an increase in fraudulent licensure applications.
- Nevada is now requiring that endorsing applicants who graduated from international nursing programs be licensed in the country they were educated in. Additionally, the Nevada BON requires an English proficiency exam if internationally educated applicants have been licensed in the U.S. for five years or less.
- New Zealand reported an increase of international applicants, predominantly from India and the Philippines.
- North Carolina expanded Live Scan for CBC to include all in-state applications for examination, endorsement and reinstatement.
- North Dakota is issuing temporary licensure for those military spouses who come to the state fully licensed from another state. There is an expedited process to obtain full licensure.
- Northern Mariana Islands are receiving applications from foreign graduates of ADN and LPN programs asking to sit for the NCLEX. The BON voted not to allow them to sit for the NCLEX.
- Oklahoma implemented federal national CBC for all initial licensure applicants instead of simply requiring a state-based CBC.

- South Dakota completed a project titled Virtual Nursing Care for Children with Diabetes in the School Setting. During the project, more than 5,400 doses of insulin were administered by trained unlicensed providers under the supervision of an RN. No adverse outcomes were reported.
- More BONs have moved to online systems for licensure renewal, endorsement and/or initial application.

KEY FINDINGS OF THIS REPORT

- The ACA has the potential to not only increase the number of health care consumers over the next few years; it also may critically change the health care delivery system.
- The ACA places a major emphasis on quality outcomes, but also dramatically changes the payment structure for hospitals. If indeed there are 32 million enrollees into the health care system by Jan. 1, 2014, if they have not been counted among health care consumers of the past and if they seek medical care in sync with one another or with any frequency, the current system may be taxed by consumers and there will not be enough providers. Another nursing shortage may be on the horizon.
- Other predictors which may influence and create shortages are the growing number of older adults reaching an advancing age. If their health care needs become greater as they get older, this also may increase the number of nurses necessary for safe delivery of care. The U.S. Bureau of Labor Statistics (2013b) Employment Projections 2010-2020 predict that 711,900 additional RNs will be needed by 2020 to meet job growth and replace RNs leaving the field.
- Revisions to the current system of delivery are being proposed that bring both opportunities and challenges. One opportunity is for APRNs to fill the predicted shortages. Literature has shown they can provide the same quality care as physicians at a cost savings. However, many predict that there will not be enough primary care NPs or physician assistants and the system will need to train and use unlicensed personnel in ways beyond what their current role and education allows.
- Among the new roles being suggested to fill an expected shortage of primary care physicians is the role of a primary care technician. This individual would receive a few months of training and administer primary care and care for stable chronic conditions in the community via algorithms.
- Distance education is rapidly expanding beyond state to international borders.
- RN programs continue to rise, especially in for-profit institutions. There is a concerted effort towards advancing education with many states being involved in initiatives that promote BSN education. Some states report a decrease in LPN programs.
- Bridge programs are being developed by educators to assist veterans and enlisted personnel with health care experience (e.g., medics, corpsman and airmen) in transitioning to civilian careers in nursing.
- Telehealth continues to expand and extend its capabilities. Facilitating the licensing of health care providers in telehealth is a major focus of both state and federal legislators.

CONCLUSION

The U.S. is currently on the brink of changes that could have a dramatic impact on health care delivery, education and regulation as it is now known. Conversely, the changes may be so incremental, there may be minimal impact to BONs. Regulators need to be vigilant and ready to appropriately act and respond to preserve state-based regulation and maintain public protection.

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Appendix A

State Decisions For Creating Health Insurance Marketplaces	
Location	Marketplace Decision
United States	17 State-based Marketplaces; 7 Partnership Marketplaces; 27 Federally-facilitated Marketplaces
Alabama	Federally-facilitated Marketplace
Alaska	Federally-facilitated Marketplace
Arizona	Federally-facilitated Marketplace
Arkansas	Partnership Marketplace
California	State-based Marketplace
Colorado	State-based Marketplace
Connecticut	State-based Marketplace
Delaware	Partnership Marketplace
District of Columbia	State-based Marketplace
Florida	Federally-facilitated Marketplace
Georgia	Federally-facilitated Marketplace
Hawaii	State-based Marketplace
Idaho	State-based Marketplace
Illinois	Partnership Marketplace
Indiana	Federally-facilitated Marketplace
Iowa	Partnership Marketplace
Kansas	Federally-facilitated Marketplace
Kentucky	State-based Marketplace
Louisiana	Federally-facilitated Marketplace
Maine	Federally-facilitated Marketplace
Maryland	State-based Marketplace
Massachusetts	State-based Marketplace
Michigan	Partnership Marketplace
Minnesota	State-based Marketplace
Mississippi	Federally-facilitated Marketplace
Missouri	Federally-facilitated Marketplace
Montana	Federally-facilitated Marketplace
Nebraska	Federally-facilitated Marketplace
Nevada	State-based Marketplace
New Hampshire	Partnership Marketplace
New Jersey	Federally-facilitated Marketplace
New Mexico	State-based Marketplace ⁴
New York	State-based Marketplace
North Carolina	Federally-facilitated Marketplace

State Decisions For Creating Health Insurance Marketplaces	
Location	Marketplace Decision
North Dakota	Federally-facilitated Marketplace
Ohio	Federally-facilitated Marketplace
Oklahoma	Federally-facilitated Marketplace
Oregon	State-based Marketplace
Pennsylvania	Federally-facilitated Marketplace
Rhode Island	State-based Marketplace
South Carolina	Federally-facilitated Marketplace
South Dakota	Federally-facilitated Marketplace
Tennessee	Federally-facilitated Marketplace
Texas	Federally-facilitated Marketplace
Utah	Federally-facilitated Marketplace
Vermont	State-based Marketplace
Virginia	Federally-facilitated Marketplace
Washington	State-based Marketplace
West Virginia	Partnership Marketplace
Wisconsin	Federally-facilitated Marketplace
Wyoming	Federally-facilitated Marketplace

Source: Henry J. Kaiser Family Foundation. (2013). State decisions for creating health insurance marketplaces. Retrieved from <http://kff.org/health-reform/state-indicator/health-insurance-exchanges/>

Status of State Action on the Medicaid Expansion Decision, as of Nov. 22, 2013	
Location	Current Status of Medicaid Expansion Decision
United States	26 Moving Forward at this Time; 25 Not Moving Forward at this Time
Alabama	Not Moving Forward at this Time
Alaska	Not Moving Forward at this Time
Arizona	Moving Forward at this Time
Arkansas	Moving Forward at this Time
California	Moving Forward at this Time
Colorado	Moving Forward at this Time
Connecticut	Moving Forward at this Time
Delaware	Moving Forward at this Time
District of Columbia	Moving Forward at this Time
Florida	Not Moving Forward at this Time
Georgia	Not Moving Forward at this Time
Status of State Action on the Medicaid Expansion Decision, as of Nov. 22, 2013	
Location	Current Status of Medicaid Expansion Decision

Hawaii	Moving Forward at this Time
Idaho	Not Moving Forward at this Time
Illinois	Moving Forward at this Time
Indiana	Not Moving Forward at this Time
Iowa	Moving Forward at this Time
Kansas	Not Moving Forward at this Time
Kentucky	Moving Forward at this Time
Louisiana	Not Moving Forward at this Time
Maine	Not Moving Forward at this Time
Maryland	Moving Forward at this Time
Massachusetts	Moving Forward at this Time
Michigan	Moving Forward at this Time
Minnesota	Moving Forward at this Time
Mississippi	Not Moving Forward at this Time
Missouri	Not Moving Forward at this Time
Montana	Not Moving Forward at this Time
Nebraska	Not Moving Forward at this Time
Nevada	Moving Forward at this Time
New Hampshire	Not Moving Forward at this Time
New Jersey	Moving Forward at this Time
New Mexico	Moving Forward at this Time
New York	Moving Forward at this Time
North Carolina	Not Moving Forward at this Time
North Dakota	Moving Forward at this Time
Ohio	Moving Forward at this Time
Oklahoma	Not Moving Forward at this Time
Oregon	Moving Forward at this Time
Pennsylvania	Not Moving Forward at this Time
Rhode Island	Moving Forward at this Time
South Carolina	Not Moving Forward at this Time
South Dakota	Not Moving Forward at this Time
Tennessee	Not Moving Forward at this Time
Texas	Not Moving Forward at this Time
Utah	Not Moving Forward at this Time
Vermont	Moving Forward at this Time
Virginia	Not Moving Forward at this Time
Status of State Action on the Medicaid Expansion Decision, as of Nov. 22, 2013	
Location	Current Status of Medicaid Expansion Decision

Washington	Moving Forward at this Time
West Virginia	Moving Forward at this Time
Wisconsin	Not Moving Forward at this Time
Wyoming	Not Moving Forward at this Time

Source: Henry J. Kaiser Family Foundation. (2013). Status of state action on the Medicaid expansion decision, as of November 22, 2013. Retrieved from <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>