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From the President



Kim Cooper, RN, MSN
President, Indiana State Board of Nursing

Greetings!

As I have pondered this quarter's submission, I have reflected at length about the belief that most all things exist along a continuum. The goal of the continuum in a profession is, in my belief, geared toward the continued development and purposeful growth of that profession. Nursing is no different. In years past, an article carried a tag line that has continued to rear its ugly head. From this article the phrase, "Nurses Eat Their Young" was born. Many nurses have worked tirelessly to change that perception. On the education front, schools have worked to expose students in capstone courses and

clinical offerings to the practice environment to best socialize them in preparation for that first nursing position. Partnerships between nursing programs and clinical agencies strive to welcome students to the field. Healthcare organizations have implemented nurse residency programs and expanded orientation to new employees. All of this has been done in an effort to ensure that incoming nurses are mentored and guided in their practice environment. Ideally, this then becomes an investment not just in that particular student or nurse engaged in the course or residency, but a longer term investment for those patients who will be cared for by that nurse, and also those healthcare team colleagues who will become a part of the fabric of the nurse's practice in the years to come.

As a result, many have noted that nursing has pulled together. This cohesiveness may not appear to those outside of nursing but it is indeed there. Nurses standing together is important in all practice settings. Recently this was noted when our integrity as a profession was seemingly challenged. We were deemed card players! In my

experience, no nurse in any practice environment has time to engage in a hand of "go fish" or "gin rummy". The response was quick and swift. This was similar to the outcry a few years prior when a celebrity asked why a nurse was using the "doctor's stethoscope." If we are reviewing cards at the work site, it is a related to perhaps medications such as "CARD-izem, CARD-ura or perhaps Pro-CARD-ia." As for those stethoscopes, we continue to use them with pride and purpose. Nurses will, and must, continue to stand tall and protect the reputation and ultimately the legacy of nursing.

In closing, it is important that nurses stand together when called upon. The protection of the profession is key. The responsibility to ensure that those outside of nursing are clear about the work we do and that no young are eaten rests with each of us. By doing our due diligence, we can certainly keep nursing as the #1 trusted profession.

Yours in service,

Kim Cooper, RN, MSN
President, Indiana State Board of Nursing

LICENSE RENEWAL NOTICE

- Your registered nurse (RN) license expires on October 31, 2019 at 11:59 pm. Your renewal will be processed online. Online renewal is faster and more accurate.
- The renewal notices will be sent out by email mid-July 2019.
- **CRIMINAL BACKGROUND CHECKS ARE NOT REQUIRED FOR RENEWAL AT THIS TIME.**
- Renew online 24 hours a day, 7 days a week. It only takes a few minutes and is QUICK & EASY.
- Acceptance by the system of your renewal fee does not guarantee renewal. Please check your license status approximately 24 hours after completing this process. At that time, if your license has not been renewed to active status, please call our office at (317) 234-2043.
- Renew at www.pla.in.gov and select the “Renew or Update Any License” link. If help is required in the instance the login ID or password is forgotten, you may use the links available on the page. You would complete 2 fields on the search page to locate your record and enter a new password.
- You can use your Discover, MasterCard or Visa credit card or debit card.
- You may update your address, email & phone number during the online renewal process.
- The renewal fee is \$50. Additional processing fees apply.
- If you have questions about the renewal process, contact the Board of Nursing by email at renewal2@pla.in.gov.
- If the Indiana Department of Revenue (IDOR) or the Internal Revenue Service (IRS) has placed a tax hold on your license for any reason, that hold must be released by that office before your license can be renewed. If this hold is not released before the October 31st deadline, your license will expire.
- **POCKET CARDS** – The Indiana Professional Licensing Agency no longer issues pocket license at renewal. To purchase or download a free copy of your updated license, please visit our website at <http://www.in.pla/3120.htm>. Before ordering a card, ensure the status and expiration date as has been updated at <http://www.in.gov/pla/3119.htm>. The hard copy will be mailed out to the address we have on file. It is the responsibility of the licensee to keep this information current. It may be updated at any time at the same site used to renew the license.
- **LATE FEES** – If you apply for renewal of your license after October 31, 2016 11:59 pm local time, you will be assessed a \$50.00 late fee in addition to the renewal fee. There are no exceptions – if you renew late, you must pay the late renewal fee in order to renew your expired license.





Best of Luck!

We Wish the Best of Luck

As the old saying goes, change is inevitable. We say a heartfelt thank you and goodbye to several members of the Indiana State Board of Nursing as they move on. Governor Eric Holcomb will appoint new Board members in the very near future.

Beth DeKoninck DNP, APRN-BC, NP-C was appointed to the Board by former Governor Mike Pence in July 2016. Dr. DeKoninck has been active in providing insight into both nursing education and advanced practice matters that come before the Board. Dr. DeKoninck has accepted a position as Assistant Dean of Graduate Programs at Averett University in Danville, Virginia. We wish Dr. DeKoninck the best of luck

in this new position.

India Owens MSN, RN, CEN, NE-BC, FAEN was appointed to the Board in July 2015 and has been an active member of the Board. Her professional and managerial perspectives have brought valuable insight to the Board. We wish Ms. Owens the best as she enjoys her long anticipated and well-earned retirement.

Sandra Bushman MSN, RN, FNP-C was appointed by Governor Eric Holcomb and has provided valuable insight into nursing advanced practice. Ms. Bushman will be leaving the Board when her term expires on July 31, 2019. We wish her continued success as she continues in her professional journey.

Karen Medernach completed her term

as the consumer member in May and will be missed. The consumer viewpoint is informative and important when the Board weighs the impact of licensure decisions. Ms. Medernach brought the consumer perspective to the Board with clarity and sincerity.

Welcome!!

Ms. Judy Hamblen LPN was appointed by Governor Eric Holcomb in May 2019 to serve a four year term. Ms. Hamblen fills one of the two vacant LPN positions on the Indiana Board of Nursing which are mandated by statute. Ms. Hamblen brings a wide range of experience ranging from long term care to leadership and management. We welcome Judy to the Board of Nursing!

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RENEWAL FRAUD

HONESTY IS THE BEST POLICY

As we approach summer of 2019, the biennial renewal cycle for licensed Registered Nurses in Indiana kicks into full gear. Every two years, nurses are required to answer certain questions in order to renew the license granted to them by the Indiana State Board of Nursing (“Board”). However, some nurses, whether on purpose or accidentally, answer those questions erroneously. When this happens, the nurse subjects himself or herself to possible sanctions against his or her license. This article will provide a brief overview of the renewal fraud statute, the questions on the renewal form, and situations before the Board involving nurses who were sanctioned after failing to answer renewal questions correctly. As will be seen, it is best to be upfront with the Board and answer the renewal questions appropriately.

When a nurse answers a question erroneously while renewing, a complaint can be filed against his or her license alleging renewal fraud. Indiana law states a nurse is subject to disciplinary sanctions if the Board finds he or she “has engaged in or knowingly cooperated in fraud or material deception in order to obtain a license to practice, including cheating on a licensing examination.” Ind. Code § 25-1-9-4(a)(1)(A). Because the Board holds each nurse responsible for the answers on his or her submitted renewal form, any erroneous response, whether intended to deceive the Board or by inadvertence, could provide the basis for sanctions under the above statute.

The renewal application consists of six questions for which a nurse must provide a “Yes” or “No” answer. All questions deal with the time period since your last

renewal of that particular license, which for most nurses who follow the regular renewal cycle would be the previous two years. Question 1 pertains to individuals who have had any professional license, certificate, or permit disciplined or have any pending charges in any state; this includes any Indiana licenses you may have, even those outside of nursing. Question 2 deals with any applications for a license, certificate, or permit that have been denied in any state. Again, this would include any denials that occur in Indiana for any license.

Question 3 focuses on criminally related activities that have occurred since you last renewed; it does not include minor traffic violations or any convictions that have been expunged by a court. You do, however, have to disclose any arrests, diversion agreements, convictions, guilty

pleas, or nolo contendere (no contest) pleas that have occurred in any state since you last renewed. Question 4 pertains to any malpractice judgments or settlements. Question 5 deals with your practice as a nurse or in any health care professional capacity. You must disclose any employment terminations, reprimands, disciplines, or demotions since you last renewed. If you are not sure about whether something falls under this question, call the Board or consult with a private attorney. Finally, Question 6 focuses on whether you have been excluded from being a Medicaid or Medicare provider.

Each year, the Office of the Attorney General (“OAG”) files numerous complaints alleging renewal fraud against the licenses of nurses who have answered renewal questions erroneously. The majority of renewal fraud cases stem from nurses who fail to disclose employment-related discipline reportable under Question #5. Often times, a complaint is filed by an employer based on the nurse’s actions and, during the course of the investigation, the OAG will discover the nurse failed to disclose terminations, suspensions, or other discipline by employers on either the current or previous renewal forms. A fair number of renewal fraud cases also involve nurses who fail to disclose discipline on licenses held in other states or who have been involved in criminal activity.

When the Board considers a case involving a nurse who has engaged in renewal fraud, it does not take the nurse’s actions lightly. The standard minimum sanction by the Board for a nurse who has answered a renewal question erroneously is a \$250 fine. This fine is applied for every instance of renewal fraud – that means every question on every renewal application that is answered erroneously. As you can imagine, the fines could add up quickly if a nurse is not forthright and has had multiple adverse employment actions or criminal actions over the years. For example, in a case before the Board in January 2013, a nurse failed to disclose an employment termination on her October 2008 renewal and then

When a nurse answers a question erroneously while renewing, a complaint can be filed against his or her license alleging renewal fraud.

failed to disclose another employment termination and a criminal conviction on her January 2011 renewal. These renewal fraud actions resulted in \$750 worth of fines (\$250 fine for each of the three questions answered erroneously) as part of the sanctions against her license.

If you do have to answer “Yes” to one of the renewal questions, it will not necessarily result in adverse action against your license. The Board will likely ask you for additional information to better understand the nature of your situation. The Board may renew your license based solely on your explanation of the events and require no further action. Sometimes, the Board determines the situation warrants a personal appearance before the Board. During these personal appearances, the Board will ask questions to determine the best course of action for your situation. This personal appearance may result in a renewal with no further requirements. However, the personal appearance may

result in your license being renewed with various restrictions, such as probation or participation in the Indiana State Nurses Assistance Program (ISNAP), depending on your history. Finally, the Board may renew your license as “Valid to Practice While Reviewed” and refer your situation to the OAG for further investigation. As long as you answer the renewal questions correctly, you will avoid being charged with renewal fraud.

As you fill out your renewal application this fall, remember that you alone are responsible for the answers provided no matter who fills it out (employer, spouse, family member, etc.). It is better to be upfront about a potential issue than wait for the Board or the OAG to find out and take action against your license. If you have questions about the renewal process or about whether something falls under a particular question, contact the Board or a private attorney to discuss your particular situation.

ALCOHOL to COPE WITH STRESS?

ISNAP is concerned about nurses. Why? Since July 1, 2018 ISNAP has served 625 nurses and too many have problems with alcohol. ISNAP was designed to assist nurses struggling with substance abuse issues and to provide evaluations, treatment recommendations and then enter treatment, if warranted, followed up by monitoring.

Despite the common myth, not everyone who comes to ISNAP has a Substance Use Disorder (SUD). Those individuals who are evaluated for a SUD and found not to meet the criteria for a SUD do not enter the monitoring program and the Board of Nursing is notified that nurse does not qualify for monitoring.

Why are these nurses referred to ISNAP in the first place? Often, the board recommendation comes after a nursing student applies for a license or a nurse completes the application

for license renewal and the applicant answers “yes” to one of the following questions on the renewal application.¹

1. Since you last renewed, has any health professional license, certificate, registration or permit you hold or have held been disciplined or are formal charges pending?
2. Since you last renewed, have you been denied a license, certificate, registration, or permit in any state?
3. Since you last renewed, and except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been

convicted of, pled guilty to, or pled nolo contendere to any offense, misdemeanor, or felony in any state?

4. Since you last renewed have you had a malpractice judgment against you or settled a malpractice action?
5. Have you been reprimanded, disciplined, demoted or terminated in the scope of your practice or as another health care professional?
6. Since you last renewed have you been excluded from being a Medicare or Medicaid provider?

Too often, the positive response is due to being arrested for an alcohol related offense such as an Operating While Intoxicated (OWI) or Driving While Intoxicated (DWI). The nurse



appears before the board of nursing and then may be instructed to make an appointment with ISNAP.

Why is ISNAP concerned about nurses and alcohol? Too many nurses are using alcohol to cope with the pressures and stress of being a nurse. Nurses go into the medical field to serve others! Many times, they beat all the odds against them to enter and to successfully graduate from nursing school. When they graduate the nurse then balances their school debt with the normal expenses of everyday living. Nurses juggle family life and work life in a work environment that demands a high level of commitment and professionalism, regardless of how their personal life is going that day. These dedicated and highly skilled healers who are called to be compassionate and caring are also human beings who sometimes need healing themselves.

Who helps the nurse? Often the nurse is the last one to receive help because family, friends, coworkers and even patients have come to depend upon the nurse to take care of them. The nurse's needs are overlooked. Some turn to alcohol to self-medicate the pressures and problems of the day. These individuals do not get up one day and say, "I think today I will go out and get a DUI (Driving Under the Influence) or get into trouble at work."

Nurses, like many others, do not realize how alcohol affects their bodies! For some nurses, in the beginning, they turn to alcohol to be that trusted confidant and friend to ease the problems of the day. As they continue using alcohol as a coping mechanism, tolerance for alcohol increases and they progress toward having a serious problem with alcohol. For other nurses, they have always balanced the stress of life and found other ways to cope with the pressures of the workplace. But then comes the holiday, cookout, wedding or birthday party and in the mood of celebration, the nurse consumes more alcohol than they realize and drive away from the party only to be arrested for driving under the influence. In both scenarios, the nurse was not aware of the effect of alcohol on the body. **Body weight and the type of alcohol being consumed are important in**



For some nurses, in the beginning, they turn to alcohol to be that trusted confidant and friend to ease the problems of the day.



understanding how alcohol effects our level of intoxication.²

Even after a nurse enters into a recovery monitoring agreement with ISNAP many continue to struggle with using alcohol as a means of coping or celebrating! From July 1, 2018 through April 15, 2019 ISNAP participants submitted 4,630 drug tests as part of their monitoring agreement. 225 of the drug screens were positive for a substance. This represents a positive rate of 4.85%. Of the 225 drug tests that were positive 140 or 62% were positive for alcohol! We forget that alcohol, although it is legal, is still America's number one substance related problem! If you are in a recovery monitoring agreement with ISNAP alcohol is not permitted.

So how does the new nurse, or the nurse renewing a license, avoid a positive response on the renewal application? By knowing how alcohol effects the body. In most states a blood alcohol concentration (BAC) of .08% means you are legally intoxicated. **A simple rule of thumb is it takes your body approximately one hour to metabolize one drink of alcohol. Another rule of thumb is for every drink allow one hour per drink to pass before you report to work or drive a car.**

Here is the part many nurses forget. **One drink is not always one drink! Just because it comes in one glass or one bottle and is considered "one drink" that may not be the case.**³ Today having a "drink" can vary depending upon what and how much you are consuming.

Alcohol by the Numbers – What equals one drink?

- 12 ounce can of 5% beer = 1 drink

- 8 to 9 ounces of 7% Malt Liquor = 1 drink
- 5 ounces of 12% table wine = 1 drink
- 1.5 ounces or one-shot glass of 80 proof Hard Liquor = 1 drink
- 6.1 ounces of Long Island Iced Tea = 4 plus drinks
- 5.5 ounces of Brazilian Monk = 2 drinks

And the kicker? When we are making our own mixed drinks how often do we ask for it to be made, "a little stronger?" That "little stronger" could represent an additional one or two more drinks. If we are drinking Bacardi 151 it is even stronger. Bacardi 151 is 75.5% alcohol per volume. This means one shot of 151 represents approximately two drinks unless you like it "a little stronger."

Let's take care of one another and reach out to our coworkers who may be struggling with alcohol before career, family and livelihood are put at risk. Let's take care of one another and support that coworker who is stressed out with the daily rigors of balancing work, family and life. As we approach the summer with graduation parties, weddings and July 4th celebrations let us not forget one drink is not always one drink.

1. <https://www.in.gov/pla/files/rn%20renew%20doc.pdf>
2. For more information on how our body weight effects blood alcohol concentration see <https://awareawakealive.org/educate/blood-alcohol-content>
3. Information adapted from www.USDTL.com



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A Call For TESTING REFORM

Nurse educators who teach pre-licensure students rely heavily on testing to assess student learning. There is a need to not only help students develop clinical decision-making and clinical judgement, but to function as nurses in complex professional settings. Additionally, educators are responsible for preparing students to be good test takers so they can pass the National Council Licensure Exam – Registered Nurse (NCLEX-RN) and obtain a nursing license. Because the NCLEX-RN is the gateway into nursing practice, faculty traditionally use NCLEX-RN style exams throughout their courses both to measure learning and to provide students with practice answering NCLEX-RN style test questions in a secure environment. Faculty face many challenges to produce NCLEX-RN style exams that include: finding or creating high-quality test questions, composing valid tests, post-test item analysis, academic integrity, and test security. In spite of this focus on testing, there is little evidence on which to base best practices.

Research has shown a lack of consistency with testing practices in programs nationwide (Bristol, Nelson, Sherrill, & Wangerin, 2018). An increase in test anxiety occurs when students are frequently exposed to inconsistent use of secure individual testing. In most schools of nursing, students must achieve a minimum average percentage on course tests in order to progress and graduate from the program. Test anxiety negatively affects student learning and performance (Gibson, 2014). To offset this problem, a mix of both high-stakes and low-stakes testing should be used in nursing courses (Duane & Satre, 2014).

Non-traditional approaches to testing are being used more frequently in higher education, backed by research in psychology, biological science, and healthcare education



(Jang, Lasry, Miller, & Mazur, 2017). Testing can be a great learner-centered tool for continuation of learning, and not for assessment only. Testing effect is a phenomenon where information better becomes a part of the student knowledge structure through retrieval. Knowledge retrieval makes learned information more accessible for future use, compared to traditional studying, or knowledge encoding, and has shown to have beneficial short- and long-term effects (Foss & Pirozzolo, 2017). Students who learn through testing demonstrate improved knowledge transfer across test formats, contexts, and domains. Improved learning is seen not only in information recall but also in situational application of knowledge, demonstrating students gain more than factual information through knowledge retrieval. They also gain an understanding of how that information can apply to real-life scenarios (Yang & Shanks, 2018). In a study involving fourth-year medical students, it was found that repeated testing enhanced clinical reasoning more than instructor led case studies

(Raupach et al., 2016).

There are some nurse educators who are turning their attention to developing testing best practices for schools of nursing (Sherrill, 2017). Many schools of nursing have not developed testing guidelines or policies, and sometimes the general academic integrity policy of the organization serves as the only guideline (Bristol, Nelson, Sherrill, & Wangerin, 2018). The Arizona Board of Nursing recently attempted to address this gap with the creation and adoption of a position statement on testing best practices (Arizona Board of Nursing, Education Committee, 2018). These types of position statements serve to guide faculty in the use of traditional individual testing, but do not address the potential use of non-traditional testing to increase learning and help students become clinical problem-solvers.

We need testing reform in schools of nursing. Nurse educators are needed to further the research on uses of testing in schools of nursing, and establish education best practices to guide faculty decisions. Without this evidence, faculty will continue

to make life-affecting student decisions based on tradition, trial and error, personal intuition, and authority. This approach violates what we know and teach our students about evidence based practice. Considering the changes that are taking place in nursing, anticipated changes in the NCLEX-RN, and the need to graduate future nurses with strong clinical reasoning skills, nurse educators must pursue every opportunity to improve educational practice. Please feel free to contact me for more information, or to discuss ways that nurse educators can work together to reform the use of testing in schools of nursing.

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Irene Coons, PhD, RN, CNE, FAADN
Professor, Department of Nursing

NURSING EDUCATION

Over the last 15-20 years, the number of new nursing programs within the U.S. has steadily increased (Buerhaus, Auerbach, and Staiger, 2016). Much of this is related to advances in technology (i.e., internet access), the ever-present nursing shortage and the call for better educated nurses (i.e., RN to BSN programs). During that same time period, multiple nursing schools established new campuses within the State of Nevada. It is important that those considering pre-licensure and/or post-licensure nursing education programs understand the type of institution they wish to enroll into and the type of curriculum (i.e., competency-based or outcomes-based) that will be taught. Those characteristics can impact not only tuition costs, but potentially a student's acquisition of knowledge and nursing skills. While there is much that can be written on the topic of classification of an institution, this article will attempt to provide a brief overview for the reader.

To begin with, most nursing education

programs are affiliated with colleges/universities that are classified as public or private and not-for-profit or for-profit (i.e., proprietary). Regardless of the classification, nursing students should, for the most part, select programs/institutions that are accredited by a regional organization as well as a nursing education accrediting body and approved by the state board of nursing (or similar). Otherwise, students may experience challenges when attempting to sit for their licensing exams, transfer credits into other systems of higher education (e.g., University of California System), and/or not be able to obtain a nursing license outside of the state where they completed their nursing program.

Traditionally, when one thought of "getting their degree", most probably thought of colleges/universities that were associated with a state system. For example, both the University of Nevada, Las Vegas and Great Basin College belong to the Nevada System of Higher Education (NSHE). Funds for degree

programs offered at public institutions are often provided by the state legislature and/or fees that students pay (e.g., differential fees) directly to the program. Benefits to attending these types of colleges/universities are tuition is typically lower in cost and there can be a variety of scholarship/grant opportunities available specifically to students attending public institutions (e.g., Millennium Scholarship/Promise Scholarship). In addition, there is often an on-campus culture such as a student run newspaper, student clubs, sports teams and possibly even a health center. Potential downsides to public institutions can be limited seats available to those interested in enrolling (e.g., nursing programs and/or competitive admissions), decreased funding due to legislative constraints, large class sizes, dealing with bureaucracy, and set enrollment dates (i.e., only spring/fall semester admissions) (Czarnecki, n.d.; Lopez, 2016; Neill, 2013).

Not-for profit institutions are those college/universities that charge students

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A close-up portrait of a young Paul George, looking directly at the camera with a neutral expression. He has short, dark, curly hair and is wearing a dark-colored shirt with a colorful patterned collar.

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tuition and use the funds collected to support the degrees/programs offered. Meaning, instead of using the profits made to pay investors, the funds are put back into running the institution (i.e., paying faculty, purchasing state of the art equipment for skills labs, and/or upkeep of buildings) Several, not-for-profit colleges/universities are affiliated with religious organizations. In addition, these types of institutions can also receive tax breaks due to the status of being a not-for-profit organization (AAU, 2018). Also, they may receive funds from specific grant programs and/or endowments (similar to public institutions). Benefits to a not-for-profit college/university can vary; depending on the institution selected, tuition may or may not be cheaper than that of what is charged at proprietary institutions, there may be various options for enrollment, course flexibility and reduced wait times for admission. Depending on the institution, a college culture may exist similar to that at a public institution. Potential downsides can vary as well. Funding is based on enrollment and can affect longevity of the school if student demand is not there. Examples of not-for-profit institutions include: Western Governors University, Stanford University, Roseman University and Grand Canyon University. These institutions vary greatly from one another in types of programs offered, research conducted, how courses are taught (i.e., on-line or competency based), admission criteria and tuition costs.

For-profit or proprietary institutions are those learning institutions that make money on educating students (Newton, 2018). Often times, they are owned and operated by a corporation. University of Phoenix (Apollo Education Group) and Capella University (Strayer Education Inc.) are examples of for-profit universities. Students may select proprietary institutions because of their lifestyle and an eagerness to obtain a degree quickly. The cost of tuition may not matter as much to students if they believe that they will graduate “sooner” and “get a well-paying job” before their counterparts who are attempting to enroll elsewhere and who were placed onto a waiting list. Profits are typically made from the amount of money students pay to the institution and through financial aid. Students not eligible for financial aid (as with any type of institution of higher learning) may take out loans, but

the amount of funds borrowed may be higher than if the student attended a public institution. Benefits to proprietary institutions include the fact that courses may be offered at a variety of times which allows the student to still work and/or tailor their courses around their personal commitments. Furthermore, for-profit schools led the way with popularizing on-line learning environments (Center for Online Education, n.d.). While it has been reported that there has been some enrollment slow down (overall) at private, for-profit institutions, growth of nursing programs at for-profit institutions increased “five-fold” 2007-2016 (Pittman, Bass, Han, Kurtzman, 2019). As with public and not-for profit schools, proprietary institutions also have potential downsides. According to the Center for Responsible Lending (2017), for-profit schools may be adversely affecting lower income students, minority students, and female students. First time pass rates on licensing exams have been found to be lower among graduates from some for-profit nursing programs (Pittman et al., 2019). In addition, a few of these types of schools have closed suddenly in Las Vegas and without notice (i.e., Brightwood and ITT Tech), leaving enrolled students without a completed degree.

So which type of degree is best for you? That depends on each person’s motivation and abilities (i.e., financial and personal). I, myself, graduated from a for-profit institution in 2001. I obtained my MSN and did incur student debt for nearly a decade, but obtaining my MSN did help me start my career in nursing education. Since schools can cost considerably more than public institutions, make sure the degree you are going to pursue is the degree you indeed want. Changing majors will only incur more cost to you and prolong your completion. When I decided to return for my doctorate, I considered several factors when selecting an institution. For example, reputation of the program, admission criteria, location, ease/ability to meet with faculty, and mode of content delivery (on-line versus face to face). Finishing “quickly” was not a priority for my doctorate since I was already a RN, but I did need a program with a part-time option. In the end, a public institution worked best for my lifestyle and my professional goals. Regardless of what type of program you

select, understand that the knowledge you acquire will be your foundation as you work as a nurse and/or advance your career.

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PURSUING COMPETENCE THROUGH CONTINUING EDUCATION

Health professionals have traditionally kept up-to-date with the latest medical and scientific knowledge and technologic advances in health care through a process known as continuing education (CE). However, comprehensive examinations of the current CE system have exposed weaknesses and vulnerabilities and raised questions about the relationship between CE and the professional competency of health professionals. This article reviews historical foundations of CE and its current state, and it projects future options of CE for health professionals.

If Florence Nightingale were a nurse in America today, she might be surprised by contemporary practice with its monitors, multifunction beds, and electronic medical records. But the need for continuing education (CE) would not surprise her. In 1872, she admonished probationer nurses in the School of St. Thomas' Hospital: "The progress you make in your year's training with us is as nothing to what you must make every year after your year's training is over" (Dossey, Selanders, Beck, & Attewell, 2005, p. 204).

In 2010, depending on the state where she practiced, Florence might be obliged to invest in educational offerings inside and outside of her work setting to satisfy licensure requirements. Also, her employer might require her to attend inservices, lectures, and conferences; complete computerized CE modules; and schedule time in a hightech simulation lab.

The scientist and statistician in Florence would look for evidence that these activities affected her competence, delivery of care, and patient outcomes. Would she find it? Could she conclude that the current CE models and systems live up to desired standards and stated intentions? If not, where do they fall short and what is the future of CE for healthcare professionals?

Traditional Approach to CE

Health professionals in the United States have traditionally kept up-to-date with the latest medical and scientific knowledge and technologic advances in health care through CE. Usually, CE is associated with didactic learning methods of lectures and seminars in structured settings such as the classroom and, more recently, the Internet. Although the concept of CE is global, each health profession may abide by a unique definition specific to its discipline. For

example, the Accreditation Council for Continuing Medical Education (ACCME), defines continuing medical education (CME) as educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical



sciences, the discipline of clinical medicine, and the provision of health care to the public (Accreditation Council for Continuing Medical Education [ACCME], 2010).

Likewise, the American Nurses Association's Scope and Standards of Practice for Nursing Professional Development defines continuing nursing education, as "systematic professional learning experiences designed to augment the knowledge, skills, and attitudes of nurses, and therefore enrich the nurses' contributions to quality health care and their pursuit of professional career goals" (American Nurses Association, 2000).

Although the first recorded continuing nursing education course was in 1894 (Institute of Medicine [IOM], Committee on Planning a Continuing Health Care Professional Education Institute, 2010, p.13), today's construct began in 1967, when the National Advisory Committee on Health Manpower recommended that professional associations and government regulatory agencies take steps to ensure that health professionals maintain competence (IOM, Committee on Planning a Continuing Health Care Professional Education Institute, 2010, p. 21). During the 1970s, various states rallied around this objective and began to mandate CE for health professionals. However, these requirements were not applied uniformly across the United States, creating disparities in CE that are still apparent. For example, only 32 states and the Commonwealth of Puerto Rico require ongoing CE for nursing licensure. In addition, requirements involving the timing, the number of CE units (contact hours) per license period, and even subject areas vary from state to state. As inconsistencies evolved, observers argued for a change in the CE system and asked questions that still resonate (IOM, Committee on Planning a Continuing Health Care Professional Education Institute, 2010, p. 21):

Are mechanisms available to accurately assess the learning needs of healthcare professionals?

How can these learning needs best be met?

How many annual contact hours are needed to ensure competence?

Can CE even guarantee competence?

Calls to Improve Practice

Along the way, important groups, including the Pew Taskforce on Health Care Workforce Regulation (1995), the Citizen Advocacy Center (1995), and the Institute of Medicine (IOM), have debated the best ways to ensure the continuing competence of health professionals (IOM, Committee

on Planning a Continuing Health Care Professional Education Institute, 2010, p. 21). In June 1998, the IOM's Committee on the Quality of Health Care in America assembled to develop strategies to improve healthcare quality. In 1999, the IOM's stunning report, *To Err is Human: Building a Safer Health System*, sounded the call to improve quality and patient safety. The committee's second and final report, the 2001 *Crossing the Quality Chasm: A New Health System for the 21st Century*, called on health professionals to provide care that is safe, effective, patientcentered, timely, efficient, and equitable (IOM, Committee on Quality of Health Care in America, 2001, pp. 5–6). As a central theme, these IOM reports cited the need to improve the quality of the health

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professional workforce.

In June 2002, in response to the Quality Chasm report, IOM's Committee on the Health Professions Education convened a multidisciplinary summit of leaders in health professions to develop strategies for restructuring clinical education across the continuum of education (IOM, Committee on the Health Professions Education, 2003, p. 3). The committee's report stated that health professionals are not adequately prepared—in either academic or CE venues—to address shifts in the nation's everchanging patient population. The committee observed that practicing health professionals tend to work in interdisciplinary teams, yet they are not educated together or trained in teambased skills. And although clinicians should make evidencebased decisions, they are not consistently taught how to search and evaluate evidence or how to apply evidence to their practice (IOM, Committee on the Health Professions Education, 2003, p. 2).

Defining competencies as the “habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice,” the resultant 2003 IOM report, *Health Professions Education: A Bridge to Quality*, details five core competencies necessary for all health professionals (IOM, Committee on the Health Professions Education, 2003, pp. 3–4):

- Patientcentered care
- Interdisciplinary teambased care
- Evidencebased practice
- Quality improvement strategies
- Use of health informatics

Historical review demonstrates “the components of CE—the CE research system, regulatory and quasiregulatory bodies, and financing entities—are currently ill equipped to support these core competencies consistently” (IOM, Committee on Planning a Continuing Health Care Professional Education Institute, 2010, p. 21). The Committee on the Health Professions Education believed integration of a shared set of core competencies into the health professions oversight spectrum—accreditation,

certification, and licensure—would provide the most leverage in reforming education for the health professions (IOM, Committee on the Health Professions Education, 2003, p. 4).

Analyzing CE

These calls for change have gone unanswered. In particular, CE has developed without sufficient structure to ensure appropriate outcomes. Historical perspectives and still relevant questions have prompted astringent evaluations of the current CE system by leading experts. Despite many differing opinions, most experts agree that a well-educated professional workforce is critical to the discovery and application of healthcare practices that promote wellness, prevent disease, and increase the overall quality of the public's longterm health (IOM, Committee on Planning a Continuing Health Care Professional Education Institute, 2010, p. 11). The results of recent evaluations focus on future efforts to create a more responsive and comprehensive CE system.

In 2007, the Josiah Macy, Jr. Foundation (JMF) convened a conference, *Continuing Education in the Healthcare Professions: Improving Healthcare Through Lifelong Learning*, where 36 leaders in medicine, nursing, and education gathered to examine CE in multiple health professions, focusing mainly on accredited CE for medicine and nursing. They examined commissioned background papers covering a wide range of CErelated topics; reviewed how physicians and other health professionals learn; and examined the role information technology, financing, and certification plays in CE (Hager, Russell, & Fletcher, 2007, p.14).

Participants acknowledged that a good deal of learning takes place informally and outside accredited formats. They also found that current systems of CE do not meet the needs of health professionals as well as they should. Participants reached these conclusions (Hager et al., 2007, p. 14):

Too much CE relies on a lecture format and counts hours of learning rather than improved knowledge, competence, and performance.

Too little attention is given to helping individual clinicians examine and improve their own practices.

Insufficient emphasis is placed on individual learning driven by the need to answer questions that arise during patient care.

CE does not promote multidisciplinary collaboration, feedback from colleagues and patients, teamwork, or efforts to improve systems of care—activities that are key to improving performance by health professionals.

CE does not make adequate or creative use of Internet technology, which can help clinicians examine their own practice patterns, bring medical information to them during patient care, and aid them in learning new skills.

Too little high quality scientific study of CE exists.

After days of discussion, participants concluded that the performance of individual health professionals profoundly affects the quality of patient care and that maintaining professional competence is a core responsibility of each health professional, regardless of specialty, type of practice, or discipline. Their final recommendations included a desire to see CE shift from excessive reliance on presentation and lecturebased formats to practicebased learning and lifelong learning throughout the early, formal stages of education in health professions. Perhaps the most intriguing recommendation was the creation of a national interprofessional CE institute to advance the overall science of CE. They envisioned this institute promoting the discovery and dissemination of more effective methods of educating health professionals throughout their professional careers. The institute would foster the most effective and efficient ways to improve knowledge, skills, attitudes, practice, and teamwork in health professions (Hager et al., 2007, p. 21).

In response to this landmark conference, the JMF asked the IOM to review issues related to the CE of health professionals and to consider the establishment of a national interprofessional institute whose focus would be improving CE. The IOM accepted the challenge, and the

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Committee on Planning a Continuing Health Care Professional Education Institute undertook the task of reviewing issues in CE for health professionals. Exploration into the development of a national CE institute and guidance on establishing and operating it were part of the committee's work (IOM, Committee on Planning a Continuing Health Care Professional Education Institute, 2010, p. 1).

Because the effectiveness of CE has been discussed, researched, and debated for decades, a thorough review of the evidence was essential in evaluating contradictory statements and historical findings. Although the committee recognized the importance of the full spectrum of health professional learning, for the purposes of this project, it only focused on postlicensure learning. The committee's literature review involved synthesizing results from more than 18,000 articles that dealt with CE, knowledge translation, interprofessional learning and practice, and faculty development. In three rounds, the committee systematically assessed each study's design, method, outcomes, and conclusions. Their analysis included 62 studies and 20 systematic reviews and metaanalyses relevant to CE methods, costeffectiveness, or educational theory. Studies from a variety of health professions were also included (IOM, Committee on Planning a Continuing Health Care Professional Education Institute, 2010, pp. 27–28).

Key Conclusions

The committee concluded that although CE research is fragmented and tends to focus too heavily on learning outside clinical settings, some evidence supports the overall effectiveness of CE in specific instances. However, the committee did not find enough evidence to make a compelling case for the effectiveness of CE under specific circumstances (IOM, Committee on Planning a Continuing Health Care Professional Education Institute, 2010, p. 28). Finally, the committee's review, like other reviews on CE effectiveness, provides limited conclusions about the effectiveness of specific CE methods. Still, the committee offered these tentative insights (IOM,

Committee on Planning a Continuing Health Care Professional Education Institute, 2010, p. 29):

Interactive techniques, such as academic detailing and audit/feedback, generally seem effective.

Simulations appear to be effective in some instances, but not in others. Simulations to teach diagnostic techniques are generally more effective than simulations to teach motor skills.

Elearning offers opportunities to enhance learning and patient care; however, without a comprehensive body of evidence, judging the effectiveness of elearning is difficult. The committee also found that the CE literature does not identify the most effective mix of CE methods and the amount of CE needed for continued competence and improved clinical outcomes. The literature, however, does offer some guidance for improved learning: CE guided by needs assessments, interactivity, diverse learning opportunities, and multiple methods of education. Finally, the committee recommended the development of a comprehensive research agenda, stating it should identify theoretical frameworks, determine proven and innovative CE methods and the degree to which they apply in various contexts, define CE outcome measures, and determine influences on learning (IOM, Committee on Planning a Continuing Health Care Professional Education Institute, 2010, pp. 34–35).

The resultant 2010 IOM report, *Redesigning Continuing Education in the Health Professions*, showcases the accumulation of knowledge obtained from previous IOM reports, research on CE, and perspectives and public statements obtained from stakeholders in the health professions and regulatory bodies. The report provides overviews of five broad messages (Table 1) and presents detailed recommendations for the development and implementation of a new national system on a broad scale—across disciplines and governmental agencies—to improve the continuing professional development of health professionals and adequately serve the best interests of health professionals, patients, and the nation (IOM, Committee on Planning a Continuing

Health Care Professional Education Institute, 2010, p. 10).

Continuing Professional Development

Improvements to the CE system will require change beyond conventional boundaries. An emerging concept, called continuing professional development (CPD), already used in the United Kingdom, other countries in the European Union, New Zealand, and Canada, includes components of traditional CE but incorporates a broader focus. The central themes of the CPD concept are teaching health professionals how to identify problems and apply solutions; tailoring the learning process, setting, and CE curriculum to enable individual clinicians to be architects of their own learning; and stretching health professionals' learning opportunities from the classroom to the point of care. In addition, information technologies are embraced to provide health professionals with greater learning opportunities. The Committee on Planning a Continuing Health Care Professional Education Institute concluded that a CPD institute offers the most promise for addressing the flaws in the current approach to CE (IOM, Committee on Planning a Continuing Health Care Professional Education Institute, 2010, p. 4).

Requirements in British Columbia

In British Columbia, legislation mandates all regulated health professions to have a continuing competence program that incorporates the elements of CPD. The College of Registered Nurses of British Columbia (CRNBC) requires practicing registrants—nurses, nurse practitioners (NPs), and certified nurses—to renew their registration annually (College of Registered Nurses of British Columbia [CRNBC], 2010a), while completing continuing competence requirements as outlined in the Registration Standard: Continuing Competence for Registered Nurses (CRNBC, 2009). The CRNBC defines competence as “the integration and application of knowledge, skills, attitudes and judgment required to perform safely, ethically and appropriately within an individual's nursing practice or in a

designated role or setting” (CRNBC, 2009). In addition to meeting minimum practice requirements of 1,125 hours in the preceding 5 years, registered nurses (RNs) must complete a Personal Practice Review as part of their yearly renewal. In the year immediately preceding their renewal, RNs must meet these requirements (CRNBC, 2009):.

Complete a selfassessment of their practice based on the CRNBC’s Professional Standards for Registered Nurses and Nurse Practitioners (CRNBC, 2008a) and, where relevant, review the Scope of Practice Standards to identify additional learning needs. Obtain peer feedback.

Develop and implement a learning plan based on self assessment and peer feedback.

Evaluate the impact of the learning on their practice. Selfassessment is the most important step in the nursing professional’s learning and growth process because it facilitates selfreflection and guides nurses as they develop their learning plan and subsequent activities. Nursing professionals complete the Personal Practice Review by answering specific questions on the registration renewal form each year. However, the documents they use to complete their review are for their own use and remain confidential. Nurses are advised to keep their documents for 5 years in case of an audit. The CRNBC website provides guidance for completing outlined requirements using PDF documents, online tutorials, and continuing competence videos.

NPs must meet these additional requirements (CRNBC, 2010b):

- Have an onsite peer review of their practice, including a chart audit, within the first 2 years of registration and, subsequently, at least once every 5 years as part of a quality assurance program.
- Meet practice hour requirements 900 practice hours in the immediate 3 years preceding renewal.
- Complete an NP selfassessment, which includes a practice component and a substantive evidencebased client documentation review.

Have peer feedback of their practice by another NP or physician, preferably in the same practice specialty. This process

includes the NP and the peer reviewing areas identified as a priority for the NP’s professional development and learning enhancement.

Develop a learning plan subsequent to their selfassessment and peer feedback according to six categories of professional development learning activities.

Evaluate their learning plan in relation to their professional development and the overall quality and effectiveness of their practice.

Operating with the fundamental belief that nursing professionals work in everchanging environments with evolving technologies for treatment and care, the CRNBC believes nurses must continue to develop their knowledge and competence throughout their careers (CRNBC, 2008b). The CRNBC’s current structure supports the philosophy that individual nursing professionals are suited to judge their practice, identify their own learning needs and, with feedback from professional colleagues, design their own continuing competence plan. Movement in the United States.

Efforts to support the CPD philosophy are already underway in the United States. Professional organizations, such as the American Medical Association and the Accreditation Council for Pharmacy Education (ACPE), have recognized the broader learning opportunities CPD offers and have adopted the concept as a guide. Since 1998, three national accrediting bodies—ACCME, the American Nurses Credentialing Center (ANCC), and the ACPE—have been working together on ways to align their requirements and systems. In March 2009, these efforts came to fruition with the announcement of their collaboration to offer, Accreditation of Continuing Education Planned by the Team for the Team. This joint accreditation is designed to support healthcare teamfocused education that improves patient care while streamlining the accreditation process. Joint Accreditation for the Provider of Continuing Education for the Healthcare Team is now available for organizations already accredited by at least two of the three national accrediting bodies—ACCME, ACPE, and ANCC (American Nurses Credentialing Center, 2009).

At the same time JMF funded the IOM study, it approved two other grant proposals. The first grant was awarded to the Association of American Medical Colleges, in collaboration with the American Association of Colleges of Nursing (AACN), to focus on recommendations from the 2007 JMF conference related to the delivery of CE and the development of lifelong learning skills in health professionals (American Association of the Colleges of Nursing [AACN], 2010, p. 9). The AACN 2010 report, Lifelong Learning in Medicine and Nursing: Final Conference Report, is the product of cooperative efforts from a large number of stakeholders (Expert Panel) who represent a wide range of perspectives, including medicine, nursing, basic and undergraduate education, CE, and practice and regulatory arenas (AACN, 2010, p. 9).

Focusing on the value and purposes of CE and continuous learning, the Expert Panel emphasized the role of CE in these areas (AACN, 2010, p.16): perspectives, including medicine, nursing, basic and undergraduate education, CE, and practice and regulatory arenas (AACN, 2010, p. 9).

Focusing on the value and purposes of CE and continuous learning, the Expert Panel emphasized the role of CE in these areas (AACN, 2010, p.16):

- Validating individual practice and competence
- Engaging learners in new knowledge and skill acquisition for practicesetting application
- Reducing or closing practitioner identified performance gaps
- Improving patient care outcomes
- Affording the opportunity to integrate knowledge, performance, competence, and judgment

Generating professional satisfaction and identity, potentially preventing or decreasing burnout The Expert Panel’s Finalized Key Constructs diagram (Figure 1) clearly demonstrates their vision of a continuum of health professional education from admission into a health professional program to retirement that values, exemplifies, and assesses lifelong learning skills; emphasizes interprofessional and teambased education and practice; employs tested, outcomesbased continuing education methods; and links health

Continued from next page >

professional education and delivery of care within the workplace (AACN, 2010, p. 4).

The second JMF grant was awarded to the Institute for Health Policy at Harvard University to conduct economic modeling for alternative financing models for CME (IOM, Committee on Planning a Continuing Health Care Professional Education Institute, 2010, p. 17). The commercial funding of CE continues to raise concerns about conflicts of interest and whether companies use CE to influence health professionals to promote specific products. In 2008 alone, the total income for ACCME-accredited CE activities in medicine was \$2.4 billion. Commercial support from pharmaceutical and medical device manufacturers accounted for about 44%, or \$1.35 billion, of the total (ACCME, 2008). This relationship has led to discussion about whether industry sponsorship leads to overemphasis on sponsor-related products, such as medicines, medical devices, and diagnostic tests, thereby biasing the selection of CE topics and presentation curriculum regardless of importance to improving patient care (Steinbrook, 2008, p. 1060).

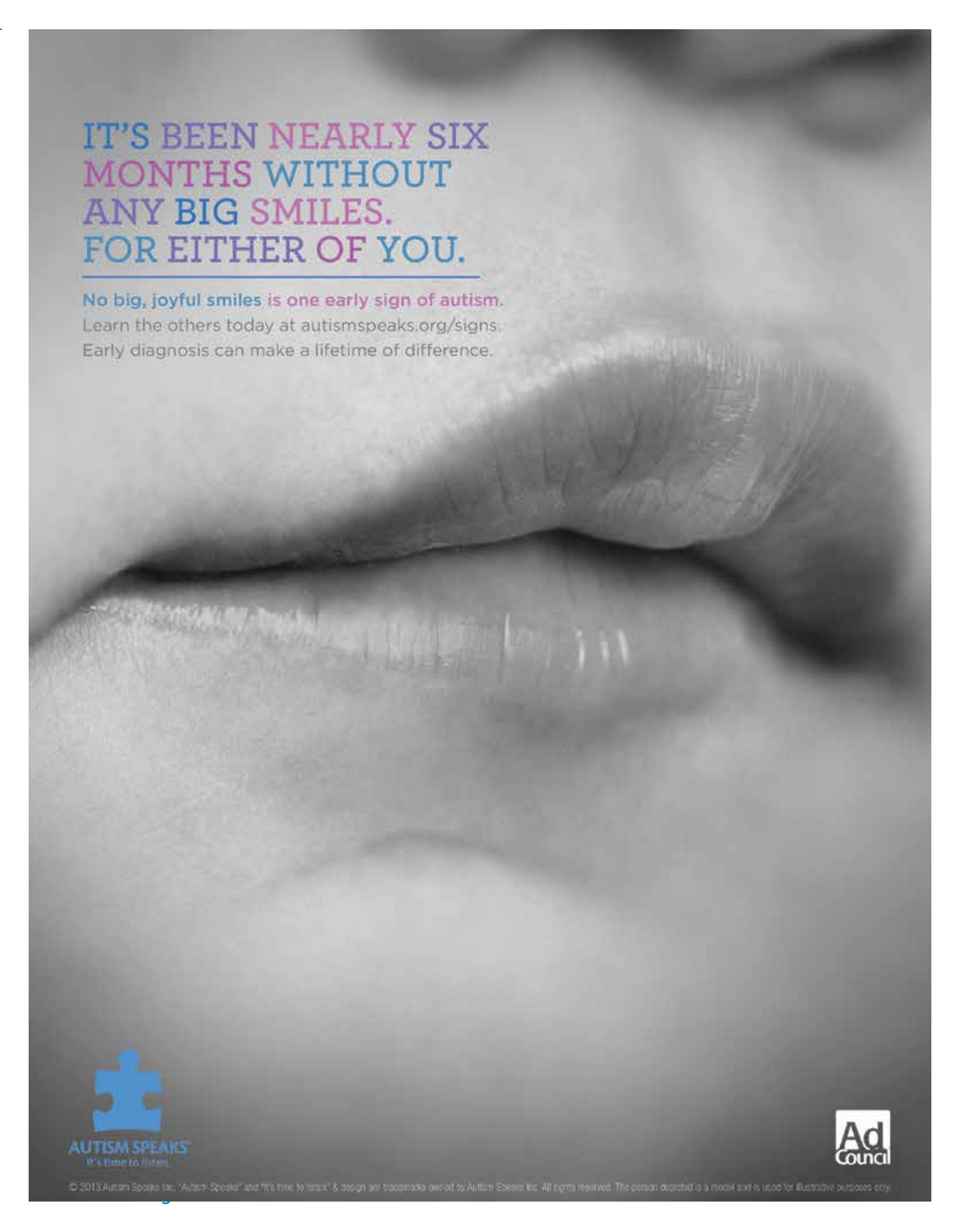
The Future is Now

One thing is certain: CE will be a mainstay in the CPD of health professionals. The question is, will CE continue on its current path? Or will the way CE is conducted, financed, regulated, and evaluated be transformed, repackaged, and directed by a joint venture of private industry and a government regulatory committee? More importantly, will changes advance the professional development and competency of health professionals and ultimately improve patient safety and patient outcomes?

If Florence Nightingale were alive, she would be in the middle of the debate that may lead to the best healthcare education and practice environment to date—one that supports a philosophy of shared educational framework, true multidisciplinary collaboration in the educational and practice arenas, and lifelong learning for the continuing professional development of all health professionals. In the distance, Florence's Grecian lamp just may glow a little brighter.

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Disciplinary Actions

Indefinite Suspension—Indefinitely prohibited from practicing for a specified minimum period of time.

Indefinite Probation—License is placed on probation for a specified minimum period of time with terms and conditions.

Renewal Denied—The nurse's license will not be renewed, therefore, she/he does not have a license to

practice in Indiana.

Summary Suspension—Immediate threat to the public health and safety should they be allowed to continue to practice. Issued for a period of ninety (90) days but can be renewed with Board approval.

Letter of Reprimand—Letter issued by the Board to the nurse indicating that what she/he did was

wrong.

Revoked—An individual whose license has been revoked may not apply for a new license until seven (7) years after the date of revocation.

CEUs—Continuing Education Credits

Fine—Disciplinary fee imposed by the Board.

Censure—A verbal reprimand given by the Board.

January 17, 2019 Board Meeting

NAME	License #	Board Action Taken
Carol Fuldford	27062455A	Probation
Jessica Sadler	28197421A	Probation
Wendy Cox	27053816A	Letter of Reprimand/Fine
Clay Dorsey	27042187A	Probation
Deanna Hembree	28126104A	Suspension
Michele Peconge	28103682A	Probation
Teri Lightner	28186207A	Letter of Reprimand/Fine
Tankia Williams	28190118A	Probation
Carol Lyons	28142591A	Suspension
Kelsi West	28210091A	Suspension
Cynthia Gilliom	28204258A	Probation
Jacob Hemming	28226820a	Probation
Megan Spikermans	28221517A	Probation
Dana Ames	28157106A	Letter of Reprimand
Heather Borst	28165548A	Probation
Randall Fillmore	28229697A	Suspension
Janet Leos	27056608A	Suspension
Bianca Brown	28228792A	Probation
Miranda Davenport	27061728A	Summary Suspension
Erica Weiss	27059674A	Summary Suspension
Jessica Ben Lamine	28179807A	Probation
Christopher Surface	28190985A	Revocation
Megan Nagel	28191012A	Revocation
Melissa McAtee	28140324A	Summary Suspension
Kelly Rice	27027447A	Summary Suspension

February 7, 2019 Board Meeting

NAME	License #	Board Action Taken
Jessica Roberts	28201965A	Probation Withdrawn
Phyllis Ungerank	27060469A	Probation Withdrawn
Sherlita Clemons	27064760A	Probation Withdrawn
Melissa Murphree	28196497A	Probation Withdrawn
Lisa Tomlinson	28145918A	Probation Withdrawn
Amy Hogan	28157679A	Probation Withdrawn
Mary Carter	28140183A	Probation Withdrawn
Brooke Bozarth	28178182A	Reinstated on Probation
Jason Riley	27040346A	Reinstated on Probation
Mary Avery	28129810A	Reinstated on Probation
April Anderson	28214568A	Revocation
William Demyan	28219561A	Suspension
Valerie Singleton	27072647A	Suspension
Hilary Kirk	27054526A	Suspension
Norma Shafer	27029190A	Suspension
Nicole Cameron	28207572A	Suspension
Allison Flaherty	28191964A	Suspension
Brandy Purdue	27066921A	Revocation

NAME	License #	Board Action Taken
Cori Atkinson	28155386A	Revocation
Christina Ramon		Renew on Probation
Dawn Gruell		Renew on Probation
Gina Salinas		Renew on Probation
Debra Thompson		Renew on Probation

February 21, 2019 Board Meeting

NAME	License #	Board Action Taken
Angel Boren	27063087A	Probation
Tonni Drake	28206392A	Probation
Leanna Sharrett	28163101A	Probation
Travis Karn	28194636A	Fine
Jennifer Gaines	28077701A	Revocation
Amanda King	27067965A	Probation
Christina Peal	27058968A	Probation
Karie Velasquez	28221405A	Probation
Annette Washington	27062337A	Probation
Melinda Hettmansperger	28148738A	Probation
Sean-Michael Selig	28201525A	Suspension
Charolette Martin	27069331A	Suspension
Jameka Kennedy	28219189A	Suspension
Michelle Murray	28212754A	Reinstated
Judy Cottrell	28135028A	Revocation
Shannon Powers	28204488A	Revocation
Rebecca Wyeth	28198295A	Suspension
Brittany Stofel	28208260A	Suspension
Regina Dennison	27056902A	Suspension
Shannon Bhatt	27047954A	Suspension
Chrisphter Hunt	28202511A	Suspension
Deborah Chandler	27039082A	Revocation
Renetta Dixon	27069220A	Summary Suspension
Susan Smitka	28176128A	Summary Suspension
Shawna Asher	28237750A	Summary Suspension
Angela Schutte	28156729A	Summary Suspension
Diana Juarez	28222407A	Summary Suspension
Ashlynn Racine	28183564A	Summary Suspension
Jennifer Siert	28222750A	Summary Suspension

March 7, 2019 Board Meeting

NAME	License #	Board Action Taken
Chelsea Freyberger	28238628A	Probation Withdrawn
Cynthia Kirton	28231820A	Probation Withdrawn
Alisa Griffin	28233270A	Probation Withdrawn
Karen Adkins	28170658A	Probation Withdrawn
Mark Hopster	27037467A	Probation Withdrawn
Emily Gardenour	28152950A	Probation Withdrawn
Andrea Detamore	28198394A	Probation Withdrawn

NAME	License #	Board Action Taken
Debra George	28137026A	Probation Withdrawn
Christine Heckman	28181134A	Probation Withdrawn
Karen McNeely	28104985A	Probation Withdrawn
Vanessa Berlin	28110885A	Probation Withdrawn
Nicole Williams	28175832A	Probation Withdrawn
Taunya Hughes	28063175A	Probation Withdrawn
Ashley Wilson	27062130A/ 28213807A	Reinstated on Probation
Joshua Metiever	28216308A	Suspension
Suzanne Fait	28164128A	Suspension
Edward Van Arsdall	28110734A	Suspension
Alicia Grist	28196006A	Suspension
Janie Secrest	27041912A	Suspension
Paige Krumma		License issued on Probation
Keyauna Bowman		License issued on Probation
Adura Isaac		License issued on Probation
Danishia Smith		License issued on Probation
Cara Baringer		License issued on Probation

March 21, 2019 Board Meeting

NAME	License #	Board Action Taken
Lois Crosby	28160742A	Renew on Probation
Grace Wyatt	28240276A	Probation
Ashley Hobbs	28201010A	Hobbs
Michael Smith	28221463A	Suspension

NAME	License #	Board Action Taken
Teena Fitchpatrick	27025414A	Letter of Reprimand/Fine
Kelsey Brunofsky	27074363A	Suspension
Teena Roberts	28233008A	Fine
Jayn Laws	27023251A	Probation
Sherry Bowacki	27067870A	Renew on Probation
Christopher McLoughlin	28195703A	Suspension
Aaron Haupricht	28227883A	Suspension
Tracy Jordan	27064495A	Revocation
Casey Elliott	28193475A	Suspension
Hanah Keener	28205585A	Suspension
Tina Klinedinst	28133813A	Suspension
Amy Blair	27060757A	Suspension
Melissa McAtee	28140324A	Suspension
Stefani Houston	27050532A	Suspension
Kaci Jacob	28210355A	Summary Suspension
Jill Kane	28143650A	Summary Suspension
Melissa Omlor	28169795A	Summary Suspension
Jennifer Lewellyn	27060225A	Summary Suspension
Kimberly Lakin	27052314A	Summary Suspension
Kamau Mosley	28224883A	Summary Suspension
Carol Sanders	28156959A	Summary Suspension
Misty Snitchler	27054635A	Summary Suspension
Sarah Phillips	28194677A	Summary Suspension
Kasey Travis	28199066A	Summary Suspension



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