



**TESTIMONY RE: Proposed Bill H.B.5275 AN ACT REQUIRING THE STATE BOARD OF
EXAMINERS FOR NURSING TO JOIN THE NURSE LICENSURE COMPACT**

PUBLIC HEALTH COMMITTEE

February 20, 2013

Good day Senator Garratana, Representative Johnson and esteemed members of the Select Committee on Children.

Thank-you for the opportunity to provide testimony on behalf of the Connecticut Nurses' Association (CNA) related to the Nurse licensure Compact. I am Mary Jane Williams Ph.D., RN current chairperson of Government Relations Committee for the Connecticut Nurses Association and professor emeritus from Central Connecticut State University. I speak in Opposition to implementation of the Nurse licensure Compact at this time.

The state of Connecticut has only recently begun to license Nurses electronically. The limited resources of the licensing agency makes the implementation of an electronic survey to gather data on licensees almost impossible and even if we collected the data we would still need more resources for analysis of the collected data. Therefore, Connecticut does not have the data necessary to assess the number, qualifications, age, experience, safety, competence etc of its Nursing workforce. The Nursing Community has for many years attempted to resolve this issue and as a result of the Institute of Medicine and the Robert Wood Johnson study and report on the "Future of Nursing" the "Connecticut Nursing Collaborative" has recently secured a Robert Wood Johnson Action Grant that will focus on Data Collection for the Nursing workforce. The projected

Data Collection and Analysis is a two-year project it will better define the workforce in Connecticut and address the needs of the state.

The argument that the state needs nurses does not hold in the current work environment. Currently we have newly licensed Nurses unemployed for 8 to 10 months and it is becoming more difficult for graduates to find employment in state. So our vital resource is moving out of state to find professional employment.

However, I see the major issue related to Interstate Licensure a safety issue. Who and how will we monitor practice, how will we assure competency and safety of licensees. I am not the expert so I have provided you with the resources developed by the American Nurses Association. The attachments ask and answer all the difficult questions about Interstate practice and the regulatory dilemma associated with this process.

At this time I believe we should proceed with caution for multiple reasons, however the most significant reason relates to protecting the public from harm. Changes to our licensing policy may not be prudent at this time as we struggle with the other issues facing our state.

Thank you

Mary Jane M. Williams PhD., RN

Interstate Nurse Licensure Compact

Historically in the U.S., regulation of health professionals has been a state-based function whereby each state or territory regulates the health care workforce within its geographic boundaries. Thus, health care professionals practicing within a state or territory are required to be licensed by the jurisdiction in which they practice. However, with the soaring popularity of telecommunication and other technologies being used to deliver health care services, practice is no longer limited by geographical boundaries. Telephone triage, telehealth consultation, and air transport nursing are just a few examples of how nursing practice is crossing state lines, either physically or via telecommunications technologies.

In 1997, the National Council for State Boards for Nursing (NCSBN), a private association of state regulatory agencies, proposed a mutual recognition model of nursing licensure, referred to as the Nurse Licensure Compact (NLC). The Compact is an agreement between two or more states to coordinate activities associated with nurse licensure. Although nurses are not usually schooled in the legal implications of interstate compact administration, it is imperative that all nurses understand the implications a regulatory change, such as a mutual recognition model of nursing licensure, may have on consumers, nurses and the profession.

The Compact concept was first introduced at ANA's 1998 House of Delegates (HOD) and resulted in a resolution outlining fourteen issues the HOD believed must be addressed for ANA to support the Compact model. Delegates reaffirmed their beliefs at the 1999 ANA House. Dialogue between ANA and NCSBN continued. Ongoing monitoring of states' experience and dialogue between ANA and NCSBN have led to dissolution of some of ANA's original concerns. For specifics, reference ANA's talking points (2011) □□**ANA Position**

At this time, ANA policy prohibits the association from fully endorsing the Nurse Licensure Compact (NLC); the most significant rationale is ANA's long standing policy stipulating the state of practice, rather than state of residence holds greater logic for licensure. Other concerns are the inconsistencies between states with differing requirements for licensure and re-registration: mandatory continuing education, criminal background checks, disciplinary causes of action, to name a few; all of which leads to confusion and the potential for varying standards for nurses employed in the same state. For a complete review of ANA's policy refer to "Talking Points"

(2011).

AMERICAN NURSES ASSOCIATION

THE NURSE INTERSTATE LICENSURE COMPACT

TALKING POINTS

(UPDATED MAY 2007)

BACKGROUND:

The National Council for State Boards for Nursing (NCSBN)'s Nurse Licensure Compact was first introduced at ANA's 1998 House of Delegates (HOD) and resulted in a resolution outlining fourteen issues the HOD believed must be addressed for ANA to support the Compact model. Delegates reaffirmed their beliefs at the 1999 ANA House. Dialogue between ANA and NCSBN continued. On February 24, 2005, members of the ANA Board of Directors Task Force related to the Compact, ANA staff, three compact administrators, and NCSBN staff participated on a conference call to discuss the ANA's remaining issues with the interstate compact model. Following a thorough review of the information provided by the NCSBN and thoughtful consideration, the task force recommended to the ANA Board that ANA maintain its' position on interstate practice.

POSITION:

Given that ANA and NCSBN continue to have philosophical differences related to the Compact model, the two organizations should "agree to disagree".

The following represent the outstanding issues / concerns held by ANA in the form of seven talking points and related discussion:

TALKING POINTS (TP)

- 1. The state of practice rather than the state of residence holds greater logic for licensure, since licensure is intended to grant the nurse authority to practice while protecting the health and safety of the citizens of the state in which the license is held.**
- 2. There are many inconsistencies between states in relation to licensure / re-registration requirements, such as mandatory continuing education, criminal background checks, disciplinary causes of action, and evidentiary standards; all of which impede the states' ability to regulate practice in a constitutionally mandated manner and can create confusion for nurses and employers.**
- 3. The benefits of Compact entry have not been demonstrated to be commensurate with the associated costs to the states and resultant loss in revenue.**

4. **The Nurse Licensure Compact does not allow state regulators to identify everyone practicing in the state, not only limiting the states' ability to protect its' citizens from potential harm, but also making it impossible to collect workforce data to guide projections and determine needed strategies to ensure an adequate number of nurses for future.**
5. **There is a lack of clarity as to the Compact Administrators authority, related obligations, and processes used when communicating with Compact states.**
6. **There is significant risk the nurse's right to due process will be diminished.**
7. **The Compact model raises significant questions related to liability.**

TP 1. The state of practice rather than the state of residence holds greater logic for licensure, since licensure is intended to grant the nurse authority to practice while protecting the health and safety of the citizens of the state in which the license is held. The state of predominant practice should be the state of licensure; if the nurse is not practicing, the nurse should be licensed in his/her state of residence. (HOD Policy #8.13, paragraph 4.1)

TP 1. DISCUSSION:

The state's authority to regulate practice applies to other health care professions who possess licenses within that state and is consistent with state courts jurisdiction over actions taken only within the state.

A complaint against a nurse is most likely to be registered within the state of practice, with that state committed to aggressive investigation and appropriate action in order to fulfill its mission of protecting the public from harm. Crossing borders, with varying statutes, rules and regulations would inhibit the timely exchange of information for both the licensee as well as the complainant. And may even stop the sharing of information altogether. The nurse would be in a better position to defend against a complaint where practice occurred because of better access to witnesses and records.

Additionally, some employers, private and governmental have policies requiring licensure / current registration in the state of practice.

TP 2. There are many inconsistencies between states in relation to licensure / re-registration requirements, such as mandatory continuing education, criminal background checks, disciplinary causes of action, and evidentiary standards; all of which impede the states' ability to regulate practice in a constitutionally mandated manner and can create confusion for nurses and employers. Interstate practice must not be implemented in a way that allows persons to circumvent or contravene existing public policy as expressed by a state's laws or policies, including laws on the use of strikebreakers and striker replacement or initial and continuing licensure requirements. (HOD Policy #8.13, paragraph 4n.) Approaches to interstate advanced practice nursing should be addressed for consistency in connection with interstate practice for other RNs (HOD Policy #8.13, paragraph 4.i). The right of individual nurses to a fair hearing

of any disciplinary matter must be protected; and, no unfair or undue burden, financial or otherwise, should be placed on a nurse's exercising his/her right to a fair hearing; (HOD Policy #8.13, paragraph 4.h)
The rule-making process to implement any interstate practice legislation should be clearly spelled out in the legislation, and proposed implementation regulations for key provisions should be developed simultaneously with legislation; (HOD Policy #8.13, paragraph 4.b.)

TP 2. DISCUSSION:

The inconsistency of standards between states in such areas as continuing education requirements, timing for licensure re-registration, eligibility for practice by foreign educated nurses and licensee reporting requirements not only create confusion, but leads to the potential of nurses working side by side with different requirements for practice. Provisions in the Compact require Party states to unconditionally accept the licensure standards of other states which could lead to a "lowest common denominator" of state licensure standards. Remote states (Party states other than the Home state) do not have the ability to set licensure standards for nurses licensed in other states (Party states) but yet who are practicing in their state.

The interstate nursing compact structure mandating regulation based on state of residence, not practice, undermines the states' regulatory intent. Nurses with licenses in one state yet practicing in another state, can skirt the authority of the state of practice to regulate criminal behavior in licensees; and the interstate compact could have the perverse effect of allowing nurses who could not get licensed in the state of practice to practice under the Compact privilege.ⁱ Nurses who have questionable employment records or whose patterns of practice could signal aberrant, dysfunctional or criminal behavior, have options which allow them and their practices to remain outside of standard avenues of discovery. Although criminal background checks are performed by states participating in the Compact, associated laws and reporting requirements are inconsistent from state to state. With such variance in state criminal background check laws and statutorily-imposed limitations on licensure based on past criminal history, states have little authority to regulate practice in their constitutionally mandated manner.ⁱⁱ Again, those statutes were specifically designed to protect the public within that state. The nurse licensure Compact, in conjunction with criminal background check laws, could force nurses who obtained their education in one state to move to another border state for licensure, and then seek employment in the original state of education.ⁱⁱⁱ

A Party state could take action to limit the nurse's ability to practice in a Remote state, but if the Home state failed to take action against the nurse's license, the nurse would be free to practice in any other Party state without the board's knowledge. This limits the ability of the state to establish a regulatory means to protect the public, thus impacting state sovereignty.

States create administrative processes which vary drastically. The way in which investigations are conducted: informal or formal hearings and types of sanctions imposed such as censure/reprimand, limitation of licensure, suspension and revocation of licensure also vary widely.^{iv} State law determines the type of hearing utilized and the sanctions available. The hearing and sanction schemes have not been standardized.^v A failure to

standardize the disciplinary process leads to inequity in the adjudication process and the implementation of the NURSIS/CLIS reporting requirement, as some disciplinary actions that result in censure in one state (which does not require reporting) or may lead to suspension or licensure limitations in another state, which requires reporting of the disciplinary action and nurses' rights related information reported into the system has been compromised.^{vi} The distinctions are highlighted when viewed in the context of the Health Quality Improvement Act (and regulations) reporting requirements.^{vii}

There is also a lack of standardization in the drug diversion program discipline reporting process. In an effort to address diversion and treat diversion as an illness, many regulatory options have been developed.^{viii} Initially, diversion programs were designed to allow nurses to come forward, admit to addiction to obtain treatment. If the nurse successfully completed the diversion program and did not have subsequent lapses, the lapse would be expunged from the nurses' record. State laws have been changed to alter programs which require reporting of that information. Some states now require hearings on the diversion and a finding by the board prior to entry in diversion programs, which requires reporting of the administrative hearing finding into state and federal disciplinary databanks.^{ix} And, some states now treat administrative pleadings of nolo contendere as admissions of guilt in nursing licensure cases, which once again require reporting of the action to state and federal databases.^x These requirements were enacted because the states of enactment wanted additional protection for its citizens. Because the compact has been designed to regulate the state of residence, not of practice, these additional protections are not necessarily applied in a manner consistent to protect the desired constituency.^{xi} Also, the lack of uniformity in the law and process leads to inequitable application of the disciplinary provisions of state practice acts.^{xii} None of the literature prepared by the NCSBN nor the compact administrators has addressed this concern.

As a result of the variation in state laws, nurses may find themselves subject to multiple investigations and disciplinary proceedings arising from the same incident. The nurse could be required to bear the cost of investigation and disciplinary proceedings. Due process issues also arise when a nurse has to represent him/herself in multiple jurisdictions at one time. There are also conflicting evidence standards for jurisdictions. Information and case requirements in one jurisdiction may not withstand scrutiny in another jurisdiction.

It is not clear what the result of the availability of parallel disciplinary processes is likely to be. How much weight is afforded by a Remote state to an adverse action by the Home state -- by the Home state to an adverse action by a Remote state? What kinds of incidents lead a Remote state to "limit or revoke the multistate licensure privilege of any nurse to practice in their state"—will these be the same kinds of incidents that lead to suspension or revocation of licensure in the Home state? What is the relationship between the two kinds of actions?

The Compact authorizes state boards of nursing to recover from a nurse the cost of investigations and dispositions of cases resulting from any adverse action taken against

the nurse. This adds a financial burden to the nurse that is not the case with the current licensure system and is not required by other state licensing laws for any other occupation. And, it is questionable if this type of financial burden imposed by one state to address multiple state investigations violates due process. Again, it should be noted that neither NCSBN nor any other entity has conducted studies of the impact this cost has on licensure.

Establishing a separate compact for APRN practice poses important challenges for the continued development of both RN and APRN practice. The Compact model of APRN regulation is premised on the need to have a separate distinct license and a separate scope of practice. ANA has generally approached nursing as a continuum of practice and has rejected proposals to establish a separate, or "second" licensure for APRN practice. Policy on licensure development is premised on the need to create licensure classes. The presumption is addressed by determining whether or not the health or safety of the parties using the services of the professional class has been harmed by the lack of licensure. Although nursing groups are pushing for this new class, there are no data to show that APRNs disproportionately jeopardize the health and safety of their patients or their clients. Creation of a second class of licensure for APRNs discounts the nursing model in which all advanced practice nurses must possess RN licensure and experience prior to entering an advanced practice nursing program.

TP 3. The benefits of Compact entry have not been demonstrated to be commensurate with the associated costs to the states and resultant loss in revenue.

TP 3. DISCUSSION

Many states rely upon licensure fees to sustain their operating expenses.

In 1998, the Iowa Board of Nursing estimated that the Compact would decrease out-of-state licensure revenue by \$39,000., \$130,000 per biennium and approximately \$24,000 per year in license verification fees.

In 2003, the Virginia Board of Nursing estimated a loss of out-of-state nursing revenue of \$627,760 per biennium. Virginia estimated an additional loss of approximately \$135,000 biennium from license verification fees.

The Mississippi Board of Nursing saw endorsement revenue decrease by 51.4 % during the first year of the Compact (2004). The Board saw proportionate reductions in new and temporary licensure fees, which remain constant.

The Colorado Legislative Council estimated that the Board of Nursing would lose the following revenue in 2006/07: endorsement fees - \$3,500 and renewal fees - \$139,000. Since it is estimated that 12% of nurses hold multiple licenses, it could be argued that all nursing boards face an *average* of at least 12% reduction in revenue. And, if multiple nurses were to hold licensure in more than two states, that impact would be far greater.

In addition to a loss of revenue, states face an increase in expenses when joining the Compact. The NCSBN requires each state to comply with its hardware and software requirements for transmittal and receipt of interstate compact data. Review of state fiscal impact statements on Compacts costs and subsequent review of board finances have indicated that boards of nursing have not accurately determined the cost of complying

with software and hardware requirements associated with utilization of NURSYS. And, states have not included the costs of hiring staff for computer maintenance and upkeep. In addition to underestimated costs associated with computer upgrades, states have had added printing costs for board of nursing materials and brochures and expenses for legal counsel. For example, Colorado estimated that their entry into the Compact would cost \$327,461, with subsequent infrastructure and membership costs at \$85,539.

Although the NCSBN believes that the electronic database NURSYS would provide adequate information to other states related to discipline, there has been no data collection on the cost of preparing a case for discipline in multiple states or on the amount of recovery of these costs by Compact states. With the responsibility to discipline, comes the responsibility and the financial burden of monitoring the multi-state discipline. This would be done in an environment where boards are faced with declining budgets as states seek to resolve budget deficits, compounded by less revenue from nurse licensure fees.

TP 4. The Nurse Licensure Compact does not allow state regulators to identify everyone practicing in the state, not only limiting the states' ability to protect its' citizens from potential harm, but also making it impossible to collect workforce data to guide future projections and determine needed strategies to ensure an adequate number of nurses. Mechanisms should be in place to ensure that a board of nursing knows who is practicing in its state under authority of a license granted by another state or through an interstate practice agreement; (HOD Policy #8.13, paragraph 4.k)

TP 4. DISCUSSION

The NCSBN contends that the Compact neither enhances nor detracts from the board of nursing's ability to identify and track nurses, yet nursing organizations and entities continue to hear complaints about boards of nursing not knowing who and how many nurses have entered the state to practice under the Compact. The Registrar of the Alberta, Canada Association of Registered Nurses (Board of Nursing) outlined the difficulties encountered when trying to verify practice of nurses in the United States. Alberta requires a nurse to verify practice in all regulated jurisdictions where she/he has worked. When working under the Compact, the boards of nursing (in states other than the Home state) do not know if a nurse has practiced in their state and cannot verify the practice. This requires the Home state to sign off on all practice jurisdictions which has lead to delays in confirming practice for nurses who want to practice in Alberta and has increased the administrative burden for the Home state and the Alberta licensure board.

Compact proponents have indicated that the existing regulatory process does not allow state boards of nursing to identify all parties practicing in the state because most states enacted an exemption of federal employees working in federal facilities. This exemption was created to allow the military to provide federal health benefits and services to military employees, under the war powers provision of the federal constitution. Thus, those nurses working in federal enclaves are providing federal services. Federal (VA) nurses who provide care outside of their employment are required to give notice and get approval for temporary services, a temporary or permanent license. To address concerns related to their practice, federal rulemaking was adopted to mandate the reporting of federal employees to state boards of nursing when the employees violated the state scope of licensure. Although the state does not have an actual count of all nurses practicing in

federal facilities, those facilities and parties are bound by state law to report infractions. This regulation protects the state; and combined with the limitations on practice does mandate notice of licensed nurses who are providing private or state-related services. The compact allows individuals who are not regulated through state or federal law to practice within the state. How does this unregulated practice provide states with tools to protect the needs of its citizenry.

It is believed that only 12% of nurses practice in more than one state, but practicing in a participating Compact party state makes the percentage more difficult to pinpoint. Many states are increasingly working to determine nursing supply and demand requirements especially related to the nursing shortage. Since a Remote state nurse is not required to register with the board of nursing, the state will not be aware of the actual number of nurses working in the state making workforce projections even more difficult to determine.

TP 5. There is a lack of clarity as to the Compact Administrators authority, related obligations, and processes used when communicating with Compact states.

TP 5. DISCUSSION: Articles of the Nurse Licensure Compact grant authority to the Compact Administrators to develop uniform rules to facilitate and coordinate implementation of the Compact, but they do not set out the notice requirements and process. The nurse licensure compact does not reconcile the requirements associated with state notice and comment requirements related to the rulemaking process.

TP 6. There is significant risk the nurse's right to due process will be diminished.

TP 6. DISCUSSION:

The Nurse Licensure Compact is the first compact to address licensure of individuals. Typically, compacts address environmental, correctional or safety issues; and compact administrators develop rules which may or may not require administrative review and approval. The Compact does not adequately provide opportunity for those regulated to participate in the rulemaking process.^{xiii} The rules are developed by the compact administrators and published in state registers or other authorized publications. While the public is given notice and an opportunity to comment, the standard for amending the rules is so high it is virtually impossible. Amendment of the proposed rules, as such, would require all states who are parties of the compact to republish or conduct added administrative review. The practical effect of the process is to deny the public the opportunity to participate in rules development.

Additionally, hearings are not conducted in multiple settings or venues that would allow nurses to hear or participate in the public hearing process. ANA believes that little legal analysis or review has been directed to this due process consideration.

TP 7. The Compact model raises significant questions related to liability.

TP 7. DISCUSSION:

Boards of nursing protect the public not only through licensing and disciplinary functions, but also through interpreting and enforcing the state nurse practice acts. Working with the Compact model impedes the boards' ability to perform these vital functions. This raises questions such as, "Who, then is liable for failure to practice within state standards or within recognized state scope: the nurse, employer, the state in which the nurse is licensed or the state board of nursing in which the nurse is practicing?"

Insurance is a state-based function. The underwriting of insurance is based on an actuarial assessment of risk for practice within the state of practice, with the assumption that the state of licensure is the state of practice. This assumption allows the insurer to develop certain factors for evaluating and assessing risk. How does a state-based insurance underwrite the practice of nursing by out-of-state licensees? What benchmarks should be utilized to determine competence to practice in another compact state, and the type of risk of suit the insured is incurring by practicing outside of the state of licensure without direct regulation? If the state of practice has a continuing education requirement or additional training/education requirements for certain practices and the state of licensure does not, how is the insurer to factor in the differences in failure to comply with state of practice licensing requirement?

SUMMARY

Between 1998 - 2006, 21 states (AZ, AR, DE, ID, IA, IN, ME, MD, MS, ND, NE, NJ, NM, NC, ND, NH, SD, TN, TX, UT, VA, WI) have enacted compact legislation/regulation with only 19 being eligible. IN was ejected from the Compact because of incompatible language that required nurses to register with the Indiana Board of Nursing every two years and pay a \$25 fee. New Hampshire was ejected from the Compact because of incompatible language that required nurses to register with the board of nursing and undergo criminal background checks. New Jersey has yet to set a date to implement the compact. UT became the first state to enact the APRN Compact and with IA implementing the APRN Compact in 2006.

Since the first state entered into the Compact in 1998, there has been minimal formal evaluation of the Compact model. In December of 2003, NCSBN provided an impact evaluation of the compact which included information from eleven boards of nursing in compact states. The boards were asked about numbers of multi-state and active licenses, revenue and expenses, and discipline-related information; 156 employers from thirteen Compact states were surveyed to determine if the Compact had made an impact on the hiring and retention of nurses they employed, while 655 nurses from thirteen Compact states were surveyed to determine the impact of the Compact on their practice.

The evaluation provided some early data on the Compact, but failed to address many of the underlying issues raised by the ANA HOD resolution: licensing a nurse in the state of residence, rather than the state of practice; overriding of state laws related to licensure requirements; requiring a separate and distinct license for APRN practice; failing to

require a board to identify which nurses are practicing in their state; and the need for collecting more specific information related to protecting the right of individual nurses to a fair hearing process.

While the Optional Enabling Act Provisions of the Interstate Nurse Licensure Compact would require the nurse licensing board to participate in a Compact Evaluation Initiative to evaluate the effectiveness and operability of the Compact by 2005, not every state has included this provision in their legislation.

ⁱ See Michigan Nurses Association Position Paper on Bill 5493, February 14, 2006.

ⁱⁱ American Nurses Association, Background: Criminal Background Checks (2005).

ⁱⁱⁱ American Nurses Association, ANA Analysis and Comparison Chart: Evaluation of the American Nurses Association's 1998 House of Delegate's 14 Points on Interstate/Multistate Practice (updated 2000), found at: <http://www.nursingworld.org/gova/charts/intrst.htm>

^{iv} Allison M. Sulentic, "Crossing Borders: The Licensure of Interstate Telemedicine Practitioners" 25 J. Leg. at 35-36 (1999).

^v Nancy Brent, Standards of Proof in Cases Involving Nurses, Nursing Spectrum online at http://www.nursingspectrum.com/StudentsCorner/StudentFeatures/StandardOfProof_stk.htm
See also *In re: Trudy J. Smith*, 97-417 (Washington Sup.Ct. 1998) and compare the evidentiary standard utilized in *In re: Sharon E. MacBride*, NU23-1004 (Vermont Board of Nursing, October 13, 2005).

^{vi} Virginia Multi-State Nurse memo includes summary of **Memorandum from John Hoff, Attorney at Law, to Debra Hardy Havens, March 11, 1998**. The Hoff memo states:

"There is no provision for informing a nurse when information about her has been submitted to CLIS, unlike the protections under the NPDB. Also unlike the NPDB, there is no provision for the nurse to query the CLIS to learn what information it holds about her, or to correct any erroneous information. The CLIS also does not place limits on who may receive the information and how it may be used. For example, information from the CLIS may be a source of information for plaintiff's attorneys. Although the CLIS apparently accepts reports from non-Compact states, those states cannot be required to report. Thus, information about a nurse who moves around will be incomplete."

^{vii} Title IV of P.L. 99-660, Health Care Quality Improvement Act of 1986, as amended is the statutory authority for the National Practitioner Databank. The Health Insurance Portability and Accountability Act of 1996 authorized the creation of the Healthcare Integrity and Protection Data Bank (HIPDB).

See also Legislative and Policy Issues Related to Interstate Practice: NAPNAP Letter (April 8, 1998) http://www.nursingworld.org/ojin/tpclg/leg_7b.htm; Catherine Becker, AORN Journal: A license without borders (April 2006) <http://www.aorn.org/journal/2006/Aprilhpi.htm>
See also Sulentic, *ibid*.

^{viii} On drug diversion programs, Ky statute allows the board to set up an authority to address drug and alcohol abuse; and mandates nurse submission to the board's authority for examination, which allows the Board of Nursing to compel going into diversion and if one refuses to do so, then the Board makes the nurse go through the disciplinary process. Ky Code §314.171. See the Ky BON case study on diversion <http://kbn.ky.gov/conprotect/casestudy2.htm>

See also Michigan Nurses Association Position Paper on Bill 5493, February 14, 2006.
See also the California backgrounder on their drug diversion program, which provides absolute confidentiality. <http://www.rn.ca.gov/div/div-faqs.htm#DIV2>

Pennsylvania and Arkansas treat drug diversion as a disciplinary action and one's nursing license is revoked if the nurse is found guilty of or pleads guilty or nolo contendere to any drug offense. Arkansas allows the nurse to request and the board to grant a waiver, which would allow the board to waive the nolo contendere plea as a bar to licensure. See Arkansas Code §17-87-309(b) and get PA code cite.

^{ix}Ibid.

^xIbid.

^{xi}Sulentic discusses at length scope of practice issues related to interstate practice models and notes: Even Allison M. Sulentic, "*Crossing Borders: The Licensure of Interstate Telemedicine Practitioners*" 25 J. Leg. 1 (1999) if non-physicians were made the subject of individualized special purpose licensure regulation, the wide variation between scope of practice rules in different states would have to be addressed through special safeguards. As discussed above, a health care professional's scope of authorized practice varies dramatically between states. **n158 A state which elects to rely on the entry-to-practice standards applicable to nurses in their home states may find some difficulties in coordinating the scope of practice. If the state's scope of practice statute is broader than that of the nurse's home state, there is a risk that a person would be permitted to engage in activities via telemedicine that he or she simply would not be permitted to do in person in his or her home state.** If the state's scope of practice regulations are more narrow than those of the nurse's home state, both the state and the nurse must be vigilant to ensure compliance with the state's expectations regarding scope of practice. (emphasis added)(p. 26)

^{xii} Barbara J. Safriet on "Health Care Dollars & Regulatory Sense: The Role of Advanced Practice Nursing", Yale Journal on Regulation, Vol., No. 2, p. 447. The Report of the Taskforce on Health Care Workforce Regulation, Dec. 1995, The Pew Health Professions Commission.

^{xiii} Articles 6D and 8C of the Nurse Licensure Compact grant authority to the Compact Administrators to develop uniform rules to facilitate and coordinate implementation of the compact, but they do not set out the notice requirements and process. The nurse licensure compact does not reconcile the requirements associated with state notice and comment requirements related to the rulemaking process with the omnibus authority granted to the Compact Administrators to promulgate substantive rulemaking.

**THE AMERICAN NURSES ASSOCIATION
PROPOSED LICENSURE MODELS
TO FACILITATE NURSING PRACTICE ACROSS STATE LINES AS
REQUESTED BY THE 1999 ANA HOUSE OF DELEGATES**

**MODEL #1 - FACILITATION OF PHYSICALLY PROVIDING NURSING SERVICES ACROSS
STATE BOUNDARIES**

RAPID ENDORSEMENT	
Components	Comments
<ul style="list-style-type: none"> • A set of common data elements is identified; • The model nurse practice act would be the basis of licensure uniformity; • Consistency in causes of action would be applied; • A central disciplinary bank would be available and would be connected to the electronic verification system; • Technology would be utilized to reduce processing time and; • A current license to practice would be required in each state where practice occurs. 	<ul style="list-style-type: none"> • Allows each state to retain their traditional power to set and enforce standards that best meet the needs of the local population. • Requires minimal legislation for implementation; • Builds upon the existing regulatory structure and concepts; and • Assures consumer protection.
SPECIAL SITUATIONS	
<p>A. Trauma nurses and educators</p> <ul style="list-style-type: none"> • Provides an exemption for nursing practice that is intermittent, infrequent, limited in number of visits and does not create an ongoing nurse/patient relationship. 	<ul style="list-style-type: none"> • Based upon uniformity of state law and facilitates the provision of care that is infrequent yet it still gives recognition within the practice act for possible disciplinary action as required.
<p>B. Disaster nurses</p> <ul style="list-style-type: none"> • Would include nurses who provide emergency nursing care in a state where the governor has declared a state disaster; • Would require nurses to register (in oral or written form) with the board of nursing in the state of licensure and include information such as name, licensure number, home address and phone number. 	<ul style="list-style-type: none"> • Establishes accountability of out-of- state providers; and • Assures consumer protection.

<p>The board of nursing would provide the registration information to the board of nursing in the disaster state.</p>	
---	--

MODEL #2 FACILITATION OF PROVIDING NURSING SERVICES ACROSS STATE BOUNDARIES THROUGH THE USE OF TELEHEALTH

REGISTRATION	
Components	Comments
<ul style="list-style-type: none"> • Allows the state to identify who is providing telehealth service; • Out-of-state provider is accountable to the board of nursing; • Authorizes the provision of services and discipline of provider; • Creates additional jurisdiction over provider in the registration state that can accept or prohibit practice; • Provides a mechanism for communication between the board and provider; • A central disciplinary data bank would be available and would be connected to the electronic verification system and • Registration would include name, address, state of licensure, phone number, license number, affidavit acknowledging any pending disciplinary causes of action and criminal causes of action and includes submission of jurisdiction to the state of registration. 	<ul style="list-style-type: none"> • Maintains strong presence of the board of nursing; • Administrative ease; • Accountability required of out-of-state providers; • Requires no new regulatory scheme; • Builds upon current licensure system; • Assures consumer protection; and • Meets the criteria set forth in the ANA Core Principles of Telehealth.

MODEL #3 FACILITATION OF PROVIDING NURSING SERVICES ACROSS STATE BOUNDARIES THROUGH THE USE OF TELEHEALTH

SITE OF PROVIDER	
Components	Comments
<ul style="list-style-type: none"> • Provision of services would be defined as the site of the provider when practicing via telecommunication technologies; • Site of provider determination assumes uniform licensure laws; • A central disciplinary bank would 	<ul style="list-style-type: none"> • Requires no new regulatory scheme; • Reflects the federal reimbursement model that defines site of services as the site where the provider is practicing - i.e. Transports the patient to the provider; • Expands the current licensure system

<p>be available and would be connected to the electronic verification system;</p> <ul style="list-style-type: none"> • Site of provider determination creates a blanket authority to practice telehealth however, individual providers would not be identified; and • Site of provider determination reinforces authority of the state where the provider is located. 	<p>by defining the practice of telehealth while the board of nursing would retain the same jurisdictional authority;</p> <ul style="list-style-type: none"> • Would require only one license; and • Could be burdensome to the consumer and might not assure consumer protection.
---	---

Other opportunities for expansion of work on this issue include:

- Development of a model informed consent to be utilized by current nurse providers of telehealth services. This is related to liability and protection for the provider.
- Development of a questionnaire to be sent to each individual board of nursing to determine how long it takes for endorsement of licensure to occur. Explore their temporary licensure system.
- Development of telehealth systems guidelines including equipment, imaging, lines etc. to assure care can be delivered safely with quality transmissions ensuring accurate diagnosis and assessment.
- Implement the model nurse practice act in all states to ensure uniformity of licensure laws.

**THE AMERICAN NURSES ASSOCIATION
PROPOSED LICENSURE MODELS
TO FACILITATE NURSING PRACTICE ACROSS STATE LINES**

Evaluated using the House of Delegates 14 Points

THE HOUSE OF DELEGATES 14 POINTS	Model #1 - Physically practicing across state boundaries RAPID ENDORSEMENT (meets all 14 points articulated by ANA HOD)	Model #2 - Practicing via Telehealth REGISTRATION (meets all 14 points articulated by ANA HOD)	Model #3 - Practicing via Telehealth SITE OF PROVIDER (meets 9 of 14 points articulated by ANA HOD)
<p>A. Interstate practice legislation should clearly define key terms and be precisely drafted to ensure that the primary objective to be accomplished by interstate practice is achieved, i.e., asserting jurisdiction over out-of-state nurses practicing in a state;</p>	<p>Key terms have been defined by ANA. Those definitions may be used. Endorsement as a regulatory model utilizes existing definitions which are known and recognized by BON and nurses.</p> <p>This model requires licensure wherever the nurse practices.</p>	<p>Utilizes definitions which already exist in ANA model practice act and are known and recognized by BON and nurses.</p> <p>This model requires one license and registration in states where other sites of practice exist.</p>	<p>Utilizes definitions which already exist in ANA model practice act and which are known and recognized by BON and nurses.</p> <p>This model incorporates a reliance on a federal HCFA definition of jurisdiction recently enacted 11/2/98. Statutory and case law defining jurisdiction for appellate review would have to be changed.</p> <p>This model requires one license, but does not preclude multiple licensure in other sites where one may physically practice.</p>
<ul style="list-style-type: none"> The rule-making process to implement any interstate practice legislation should be clearly spelled out in 	<p>Rule making process would remain the same as existing process and is clearly spelled out in state administrative procedures act.</p>	<p>Rule making process would remain the same as with existing law and it is not envisioned that additional definitions which would require additional rule making.</p>	<p>Rule making process would remain the same as existing process and is clearly spelled out in state administrative procedures act.</p>

<p>the legislation, and proposed implementation on regulations of key provisions should be developed simultaneously with any legislation;</p>			
<p>C. Clear parameters should be established related to the confidentiality of any information shared with other states as well as who shall have access to such information;</p>	<p>Confidentiality would be controlled by state and federal law. State law varies with jurisdiction, but all are written to provide protection to nurses while disciplinary actions are pending. Final actions would be reportable.</p>	<p>Confidentiality would be controlled by state and federal law. State law varies with jurisdiction, but all are written to provide protection to nurses while disciplinary actions are pending. Final actions would be reportable.</p>	<p>If the licensee is licensed in more than one state, the model does not clearly indicate that all states of licensure would be required to share information; and information may be limited to the state where practice occurs without granting access to such information in the state where the licensee resides.</p>
<p>D. The sharing of any information related to disciplinary matters, other than final orders and emergency suspensions, should be prohibited unless there is a clear and convincing need to do so to protect the public;</p>	<p>Confidentiality would be controlled by state and federal law. State law varies with jurisdiction, but all are written to provide protection to nurses while disciplinary actions are pending. Final actions would be reportable.</p>	<p>Confidentiality would be controlled by state and federal law. State law varies with jurisdiction, but all are written to provide protection to nurses while disciplinary actions are pending. Final actions would be reportable.</p>	<p>If the licensee is licensed in more than one state, model does not clearly indicate all states of licensure would be required to share information; and information may be limited to the state where practice occurs without granting access to the state where licensee resides.</p>
<p>E. The process for selecting an entity to conduct data collection or provide other services related to implementation of interstate practice shall be open and competitive;</p>	<p>The selection process would remain open and competitive, however any entity selected would have to adhere to state and federal confidentiality requirements.</p>	<p>The selection process would remain open and competitive, however any entity selected would have to adhere to state and federal confidentiality requirements.</p>	<p>The selection process would remain open and competitive, however, there would be questions about how the state would assure accurate and unduplicated information on licensees. Other</p>

			models provide better methods for tracking conduct which warrants discipline.
F. Before any immunity from liability is extended to non-governmental entities, there should be careful scrutiny to ensure those entities are appropriately accountable for their actions;	Liability from immunity would not be extended to non-governmental entities.	Liability from immunity would not be extended to non-governmental entities.	Liability from immunity would not be extended to non-governmental entities.
G. Mechanisms should be established to ensure that the process used by any entity collecting data be reconciled with state law and procedures regarding collecting, maintaining and distributing licensure and disciplinary information;	Using existing regulatory structure, state law would govern the procedures related to collecting, maintaining and distributing licensure and disciplinary information. Like existing model, could identify all states of practice.	Using existing regulatory structure, state law would govern the procedures related to collecting, maintaining and distributing licensure and disciplinary information. Registry allows identification of all states of practice.	Unless all states accept this model there would be problems with duplication of information and assuring accuracy of one national database. Other models provide better mechanisms for tracking practice.
H. The right of individual nurses to a fair hearing of any disciplinary matter must be protected; and, no unfair or undue burden, financial or otherwise, should be placed on a nurse's exercising his/her right to a fair hearing;	As this disciplinary process expands existing law, there is a retention of the right to due process and fair hearing.	Using a registry, the state of practice would have the right to prohibit practice by the nonresident nurse, and the affirmative obligation to send information to the state board of licensure related to discipline. State board of licensure would be responsible for discipline.	The licensee would retain the right to due process and a fair hearing, but there is the issue of whether there can be comprehensive investigation of actions which occur outside of state of the provider. The consumer, a nonresident, may have the right but not easy access to participate in the disciplinary hearing and investigation process. This regulatory structure allows licensees practicing in the same state to be disciplined differently -- both are held to the standards of their place of licensure (which are often different)

			although they are practicing in same state.
I. Approaches to interstate advanced practice nursing should be addressed for consistency in connection with interstate practice for other RNs;	Building on existing regulatory model, consistency would be possible.	Registry allows same treatment of LP/VN, RN and APN.	Building on existing regulatory model, consistency would be possible.
J. Mechanisms should be in place that ensure nurses have ready and ongoing access to practice-related information, including current board of nursing policies;	With expedited licensure, the affirmative obligation to know and understand the law of state of licensure.	With registry, BON of state of practice would know who is practicing in the state and could mandate through affirmation upon registration knowledge of law of state of practice.	This model requires knowledge of state law where licensee is located. State where the licensee is practicing gives blanket permission for entry into the state by out-of-state providers. State cannot identify who is actual providing care through telehealth measures within its boundaries.
K. Mechanisms should be in place to ensure that a board of nursing knows who is practicing in its state under authority of a license granted by another state or through an interstate practice agreement;	This expanded use of exist(g law would assure knowledge of those practicing in state.	Registration was designed to assure knowledge of those practice in state. Telehealth permit option would provide knowledge of those practice in state.	State where the licensee is practicing gives blanket permission for entry into the state by out-of-state providers. State cannot identify who is actual providing care through telehealth measures within its boundaries.
L. The state of predominant practice should be the state of licensure; if the nurse is not practicing, the nurse should be licensed in his/her state of residence;	This expanded use of existing law could be structured to assure that predominant place of practice would be state of licensure.	This expanded use of the registry existing law could be structured to assure that predominant place of practice would be state of licensure. Telehealth permit option would clarify temporal nature of practice.	The dominant practice could be accomplished with this model, but additional language would have to be included in act to clearly define "predominant practice" and provide alternative methods for allowing one to practice outside the area of predominant practice.
M. Employers must be held accountable for ensuring that they	Additional statutory authority would be created with this model to hold	Additional statutory authority would be created with this model to hold	No additional duty has been created to assure knowledge of state law

<p>utilize staff who are licensed (or otherwise authorized to practice) under state law;</p>	<p>institutions responsible for using staff licensed or appropriately registered in the state of practice. Additionally, BON can use existing authority to challenge institutional licensure process when inappropriately using unlicensed staff. Additional staff work is needed on informed consent models to provide protection to nurses who practice across state lines.</p>	<p>institutions responsible for using staff licensed or appropriately registered in the state of practice. Additionally, BON can use existing authority to challenge institutional licensure process when inappropriately using unlicensed staff. Additional staff work is needed on informed consent models to provide protection to nurses who practice across state lines.</p>	<p>where consumer/patient is located.</p>
<ul style="list-style-type: none"> Interstate practice must not be implemented in a way that allows persons to circumvent or contravene existing public policy as expressed by a state's laws or policies, including laws on the use of strikebreakers and striker replacement or initial and continuing licensure requirements. 	<p>Expedited licensure does not circumvent or contravene existing public policy related to use of strikebreakers or strike replacements. The nurse may obtain a license, but the institution has affirmative obligation to comply with antistrike breaker law.</p>	<p>Registration does not circumvent or contravene existing public policy related to use of strikebreakers or strike replacements. The nurse may obtain a license, but the institution has the affirmative obligation to comply with antistrikebreaker law.</p>	<p>Site of Provider determination does not circumvent or contravene existing public policy related to use of strikebreakers or strike replacements. The nurse may obtain a license, but the institution has the affirmative obligation to comply with antistrikebreaker law.</p>