

# Agenda Item #8.



BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

**BOARD OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS**  
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DATE: November 6, 2013

TO: Board Members

FROM:   
Teresa Bello-Jones, J.D., M.S.N., R.N.  
Executive Officer

SUBJECT: Multi - State Licensure Compact for California Nurses

On September 19, 2013, the Board received a telephone call from Nancy Sproull, representing an organization that desires California to participate in a multi – state licensure compact for licensed vocational nurses (LVNs). Since this issue had been considered by the Board years before, the Board President, at the Executive Officer's request, placed this issue on the agenda to inform Board Members of identified concerns. Ms. Sproull was asked to submit written information to the Board. That information was received on October 8, 2013 (see Attachment A).

In August 1997, the National Council of State Boards of Nursing, Inc. (NCSBN) adopted an optional multi – state compact model for state boards of nursing. Under that model, a license would be issued by the licensee's home state of residence; the licensee would be authorized to practice in any state in which a compact agreement had been executed without obtaining a license in the second state. The Board considered this issue in the late 1990's and declined to pursue participation due to its impact on California's ability to protect its consumers.

The following critical concerns are identified.

- **Practice Standards.** Standards for LVNs differ across Nurse License Compact states. Acts constituting gross negligence, incompetence, and unprofessional conduct in California do not constitute violations in other states. Some states allow LVNs to administer IV medications and blood transfusions, make decisions relative to the normalcy of client data, and independently plan and provide education to clients and their families. Others do not authorize such practice.
- **Criminal Background Checks.** The California Business and Professions Code requires individuals seeking initial licensure as LVNs and PTs to undergo a fingerprint criminal background check.

Currently, 15 of the 50 states do not require fingerprinting for licensure. Of the 24 Nurse License Compact states, five (5) do not require criminal background

checks for licensure (see Attachment B). Given the foregoing, implementation of the Nurse Licensure Compact would compromise the Board's ability to achieve its mandate to protect consumers against unsafe and incompetent practitioners.

- **Complaints and Disciplinary Action.** Existing statutes authorize the Board to implement disciplinary action against the licenses of individuals who have been found guilty of unprofessional conduct, gross negligence, or incompetence. This necessitates a thorough investigation of the alleged misconduct, collection of evidence, expert opinion, and often expert testimony.

If misconduct is alleged against an individual holding compact licensure from another state, California would incur substantial expense in investigating the alleged misconduct, collecting evidence, and prosecution as these actions would require travel to the state of licensure.

Further, if the misconduct is substantiated, based on legal counsel review, California would lack the authority to take administrative action against the out-of-jurisdiction licensee. California would have to rely on the out-of-state jurisdiction to take disciplinary action. While it could assist the other jurisdiction, that assistance would be expensive. As such, the Board's ability to achieve its mandate to protect California consumers against unsafe and incompetent practitioners would be seriously compromised.

- **Loss of Revenue.** The Board is classified by statute as a Special Fund Agency. As such, the Board is funded solely by the fees of applicants and licensees seeking initial and renewal of California licensure.

Additionally, applicants seeking California licensure based on licensure in other states are required to submit an application and pay the applicable fee. If a nurse license compact were implemented, individuals holding a compact license would be authorized to practice in California without meeting California's requirements for licensure. As such, implementation of the Nurse License Compact would result in a substantial loss of revenue for the Board.

- **Statutory Requirement.** Participation in such a compact would require statutory changes to the Vocational Nursing Practice Act.

## **RECOMMENDATION:**

No action is required at this time

Attachment A: Letter from Nancy Sproull, Dated October 7, 2013; Received October 8, 2013  
Attachment B: Nurse Licensure Compact States

# Attachment A

Multi-State Licensure for California Nurses Taskforce B V N P T

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October 7, 2013

Executive Officer, California Board of Vocational Nursing and Psychiatric Technicians  
Teresa Bello-Jones, JD, MSN, RN  
2535 Capitol Oaks Drive  
Suite 205  
Sacramento, CA 95833

Dear Ms. Bello-Jones,

I want to thank you for the opportunity to share the Coalition for Multi-State Licensure in California Nurses Taskforce's reasons for wanting California to join the multi-state compact. I am sending background information including the responses to the California Board of Nursing's concerns. As I mentioned, I am unable to attend your board meeting on November 22, 2013, I am pleased to let you know that Angie Macadangang, RN, BSN PHN Director of Patient Care Services Advanced Home Health, Inc. and Marilyn Edwards, RN, President of the California Coalition for Multi-State Licensure will attend and represent the coalition. The contact information is below.

The coalition supports multi-state licensure to support the safety and needs of the public through improved access to care. The current process of having to have a license in every state in case you should need it in order to support a patient and the patient's care givers is extremely limiting and leads to delays or fragmentation of care. Such delays and fragmentation add a needless financial burden to the healthcare system through increased hospital days and more direct costs to the nurses, employers and boards of nursing who duplicate efforts and expense.

An example of such a situation occurred for a registered nurse in California who was hired to find a solution for an infant who lived in a rural community in Nevada. The mining community's resources for care included an EMT and a Veterinarian. The child had spent most of her life in the hospital at UCSF. She had transposition of the great vessels, meaning that the major vessels going to and from her heart were reversed. She needed surgery in a year. The family had not had the opportunity to really bond and support the child in anything resembling a normal environment. The cost to the health care system is approximately \$5,000 - \$15,000 per day in the hospital. The nurse case manager had to obtain a Nevada license and proceeded to create a plan of care with the physician, family and identified resources to support this baby at home. The plan at a high level involved DME, round the clock LVNs in the home, and adding lighting to a small airport to support night time evacuation if needed. The child went home for the year without any hospitalizations during that time and successfully had the surgery. This example

may seem extraordinary, but it really is not. Patients come to acute hospitals every day from other states who will return to their home state or will live with their care givers in other states post discharge. The case manager's responsibility includes assessing the needs for follow up care, the availability of those resources, and the coordination of care. The Interpretive Guidelines for the Medicare Conditions of Participation for acute care hospitals was issued May, 2013 and became effective immediately. Specifically, Standard 482.43(b) addresses if the hospital is one with specialized services that attract a significant number of patients who will receive their post-hospital care in distant communities, the hospital is expected to take reasonable steps to identify the services that will be available to the patient. The flip to that statement is that the distant community has to assess the patient remotely in order to determine the safety of the discharge to their care as well as initial care plan. Nurses in California find themselves needing to make these assessments and initial care plans in nursing homes, rehabilitation facilities, home health agencies, insurance companies and managed care groups.

The advances in technology support increased nursing care at the right time and the right place. This expansion of technology supports patient care and saves resources. The cell phone, often the only phone puts nurses at risk for their license. It is not possible to know what state or physically where the patient is during this call. Telehealth makes it possible to hear and see a patient in their environment and support nursing assessment and education. Telehealth is easily practiced across state lines.

The driver's license is the model for multi-state nursing licensure supporting one license that allows you to drive in other states while requiring the driver to abide by the rules of that state. In addition, Federal agencies such as the military and the VA only need one license in the US to practice in that setting. Unfortunately, military spouses do not receive the same benefit.

We acknowledge that there are concerns but feel that benefits outweigh the risk.

We look forward to meeting with your board. If you have any specific concerns that you would like addressed at that meeting, please contact Angie Macadangdang at 916-978-0844. We would very much like to receive support from the California Board of Vocational Nursing and Psychiatric Technicians California Board of Nursing as we progress through the legislative process.

Contact information:

Angie Macadangdang  
[amac@ahhsac.com](mailto:amac@ahhsac.com)  
916-978-0744

Marilyn Edwards  
[MSL-4-CA-Nurses@hotmail.com](mailto:MSL-4-CA-Nurses@hotmail.com)  
916-764-6816

Nancy Sproull  
[nsproull@hotmail.com](mailto:nsproull@hotmail.com)  
916-752-6857

Sincerely,



Nancy Sproull, RN, MA, CCM

Concerns expressed by Louise Bailey, Executive Director California Board of Registered Nurses and responses following discussion with the National Council of State Boards of Nursing (NCSBN) representative for the Nurse Licensure Compact (NLC).

1. Educational requirements are not the same in each state as is required to obtain a license in California. Excelsior College in New York City only requires one weekend of clinical experience. Excelsior sued CA for not accepting their credential. CA won the suit and appeal.

**Response:** It is true that different states have different educational requirements. This is not surprising given that such requirements are state-by-state decisions. The basic requirements that all states have in common include graduation from an accredited school of nursing, passing the exam, and checking for previous disciplinary actions by other boards. Different states do have additional work or preceptor hour requirements for Excelsior College in New York City including states in the NLC. The impact according to the NLCA is minimal and does not outweigh the need for licensure portability.

2. The continuing education requirement is variable among states. Some do not even require it.

**Response:** There is no agreement or evidence in the literature to support the best indicator of competency between continuing education or active practice experience. Professional nurses as well as employers play a role in ensuring that the nurse providing a specific procedure is competent to do so, particularly in the acute hospital setting.

There is no evidence that continued education equates to competence. Research does not show that nurses that don't obtain CEUs are more prone to disciplinary action.

Both the employer and the Board have a stake in a nurse's competency. For some competency issues, the employer is better able to detect and monitor the nurse than the Board. The nurse is under the employer's supervision on a day to day basis.

The variations in the requirements referenced above and the resulting discussion issues are not unique to the NLC. The NLC is a state-based system that is recognized nationally but enforced locally. The NLC does not require all states to function identically. In fact, that would defeat the concept of a state-based system. It does require that the party state recognize the licensure decisions of other party states. The statutes and rules that govern the NLC define which licensure requirements must be uniform. Mandatory continuing education is a continued competence methodology. Continued competence is also demonstrated by other methods such as employment in nursing for a specified number of hours or a portfolio process. There is no consensus on which method is the most effective measure. The nurse is required to meet the continued competence requirements in the home state. Nurses working side by side will have met core licensure requirements of graduation from an approved education program, successful

completion of the NCLEX and licensure by a state board of nursing. The only variation will be the method in which they demonstrate continued competence for licensure renewal.

3. Fourteen states do not mandate fingerprinting and background checks. California requires both CA and FBI checks.

**Response:** The Nurse Licensure Compact (NLC) supports fingerprint-based criminal background checks (CBCs) as a Uniform Licensure Requirement. Fingerprint-based CBCs are the most effective method to determine an applicant's complete criminal history. Within the NLC, 19 or 79% of the 24 member states require a CBC from license applicants at the time of initial license by exam. Five or 21% of the NLC states do not require fingerprint-based CBCs although the boards of nursing (BON) in those states support attaining the legislative authority for fingerprint-based CBCs. Although these five states do not currently have a fingerprint-based CBC requirement, they have other public protection measures in place. The following facts should be considered by BON that may be dissuaded from joining the NLC due to lack of universal fingerprint-based CBC requirements:

- All BON's require initial applicants to self-disclose their criminal history on license applications. The National Council of State Boards of Nursing alerts BON's through Nursys when nurse arrests or convictions are reported in the media.
- Within a state, criminal history information is generally maintained in the state's criminal history repository. Many BON utilize this repository to determine an applicant's criminal history in that state.
- Most employers screen for criminal backgrounds.
- NCSBN is committed to assisting all states in their efforts to enact fingerprint based CBCs.
- The goal is to have all states performing fingerprint based CBCs by 2015.

Fingerprint-based CBCs are the best way to obtain all relevant information necessary to protect the public. Since fingerprints cannot be altered or forged and are linked to databases at the federal and state level, fingerprint-based CBCs provide the most comprehensive and accurate results. We encourage all states to work toward the enactment of fingerprint CBCs and we join NCSBN in their efforts working with states.

4. Enforcement of complaints and violations is variable among states. Some states don't discipline the same things as other states, such as the licensing state would. A Board of Nursing can only discipline the license, not the person.

**Response:** The NLC actually enhances and provides positive public protection. States utilize a comprehensive national data base to facilitate the sharing of licensure, investigative and disciplinary action information. This data base, called NURSISYS®, is housed at the National Council of State Boards of Nursing. There are currently 1.3 million nurses in 24 Compact states. All Compact states must by statute/law provide their nurse licensure and discipline information to the data base. The Compact also provides that when a home state suspends or revokes a

license, all other privileges to practice are similarly revoked. Action on the Privilege to Practice benefits public safety through 'economies of scale' in that once action is taken in the home state it automatically eliminates the need to take disciplinary action in the 23 other member states. For example, Texas alone has taken over 8,000 actions in 4 years. Each such action resulted in the automatic effect of eliminating the nurse's privilege to work in the other 23 Compact states.

As required by statute, all of the states within the NLC utilize the Nursys® data base and the "Nurse Alert" that flags Boards of Nursing when there is current significant investigative information. The investigation is usually conducted by the state in which the violation occurred. However, the home state and the remote state may decide on an individual basis which state will conduct the investigation and potentially discipline the licensee. An individual nurse who has been disciplined may lose multistate privileges under the NLC. The home state, may decide to restrict practice to the home state.

The NLC requires states to give the same priority and effect to reported conduct received from a remote state as it would if such conduct occurred within the home state. NLC states have the authority to take any action on the privilege to practice (PTP) that is allowed for action on a home state license. This ensures that licensees cannot circumvent the laws in the state of practice.

While a home state may not have an identical regulation to the remote state, there are other regulations which may apply appropriately such as "unprofessional conduct."

5. Concerned about the revenue loss. Indicated that with 407,000 licenses that California licenses more nurses than any other state. Although, Nancy indicated that other states have not found this to be a factor and asked Louise if she thought that by being the largest that it might make a difference. She indicated that she did not know.

**Response:** For comparison, Texas, a NLC state, has 350,000 licensees, which is not significantly different than California. Texas has not experienced ongoing financial hardship due to joining the NLC.

The NLC Administrators have reported that they have not experienced a significant enduring negative impact on the BON budget due to joining the NLC. In a January 2013 survey with 19 states responding, 17 states answered "True" to the statement: "In the years that have passed since implementation, however, I feel that being a member of the NLC has not had a significant enduring negative impact on the BON budget." The other two states responded "I don't know" and were newly appointed to their role.

Other fees include \$3,000 annual NLC dues and any costs associated with communicating with licensees and employers (a one-time initial expense). Therefore, after the initial year, NLC states have not experienced revenue hardship due to entering the NLC. According to the Executive Directors in the 24 states, no NLC state has needed to increase licensure fees to make up for any loss. There has not been any additional staff added due to joining the NLC. Rather, it will allow for the redistribution of labor and will provide board staff more time to dedicate to other aspects of the board's work.

Revenue loss and gain to the board can be calculated based on the following methodology.

Revenue lost

Calculate the number of your licensees residing in other Compact states. Multiply by your application fee. (In future the BON in the licensees' state of residency will issue their compact license. )

\$ \_\_\_\_\_

Revenue gained

Calculate the number of licensees residing in your State with a license issued by a compact state. Multiply by your application fee. (In future, your State, as their state of residency, will issue their compact license.)

\$ \_\_\_\_\_

Annual NLC fee: \$3,000

\$ \_\_\_\_\_

Additionally, we have attached a Fact Sheet regarding this revenue loss myth.



## GET THE FACTS ABOUT THE NURSE LICENSURE COMPACT (NLC)

### Myth:

Joining the NLC causes a significant financial burden on a state board of nursing (BON).

### Fact:

There are expenses associated with joining the NLC, but these expenses are primarily preimplementation and concurrent with implementation.

**Communication:** States joining the NLC must notify all licensees of their status as a compact state. Nurses licensed in more than one compact state must declare their primary state of residence. Postage costs associated with notifying licensees varies from state to state.

**Education:** Many executive directors have made state-wide trips to educate various groups (e.g., nursing programs, hospital associations and nurse executives) about the NLC. Costs associated with this in-state travel vary. The Nurse Licensure Compact Administrators (NLCA) is producing an educational video that will help BONs educate their constituencies about the NLC.

**Training:** The executive director of the BON will spend several hours training BON staff about their role and function as it relates to the compact. The NLCA also offer BONs an onsite one-day NLC orientation free of charge. Additionally, the NLCA is coordinating the production of a series of webinars to be utilized for staff training.

**Information Technology:** The BON licensure system must now be able to accommodate a new field in their database to indicate whether a license is single state or multistate. There is generally little or no expense associated with this modification.

**Nursys:** States joining the NLC are required to participate in the Nursys database if they are not doing so already. There are currently 44 jurisdictions participating in [nursys.com](http://nursys.com). There are no costs associated with this. However, prior to joining Nursys, a state may need to perform necessary data preparation. States are able to apply for funds to cover any data-related expenses not budgeted for through NCSBN's Direct Assistance Policy. NCSBN Nursys staff can also conduct an onsite orientation to explain Nursys functionality and reporting capabilities at no cost to the BON and provide ongoing support as required.

**NLCA Fees:** There is a membership fee of \$3,000 per year, which must be paid to the NLCA commencing the year following implementation.

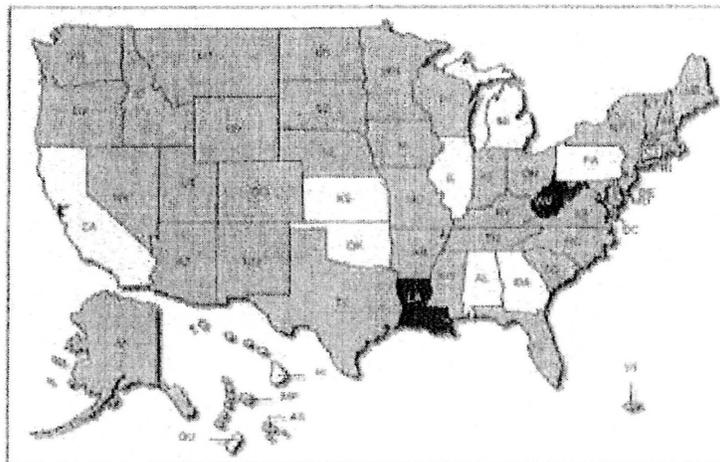
**Rule-making:** Member states are required to promulgate the NLC Model Rules. There are potential costs associated with this promulgation.

**Personnel:** Although some states may choose to hire additional staff to serve as an NLC Administrator, it is logical for the executive director to wear an additional "hat" as the state's NLC Administrator.

**Budget Impact Related to Licensure Revenue:** When a state joins the NLC, nurses licensed in that state that reside in and hold a multistate license in any other NLC state will no longer need to hold a license in the newly joined state. Conversely, nurses residing in the newly joined state who hold licenses in other NLC states will now need to be licensed in the newly joined state (their state of residency). NLC Administrators, looking back on their experience in the NLC over the past 10 years, have described this balance of licensees gained and licensees lost as a "wash."

**Overall:** NLC Administrators have described joining the NLC as "budget-neutral." No state has repealed the NLC due to financial issues nor has any member state reported an ongoing financial burden. Furthermore, no state has needed to increase licensure fees due to joining the NLC.

For more information about the NLC, contact Jim Puente, NLC associate, NCSBN, at 312.525.3601 or [jpuente@ncsbn.org](mailto:jpuente@ncsbn.org).



Participating Non-Participating States with Interstate Nursing Boards  
 IL, AZ is participating; LA, HI is not; WA, TN is participating; WV, RI is not

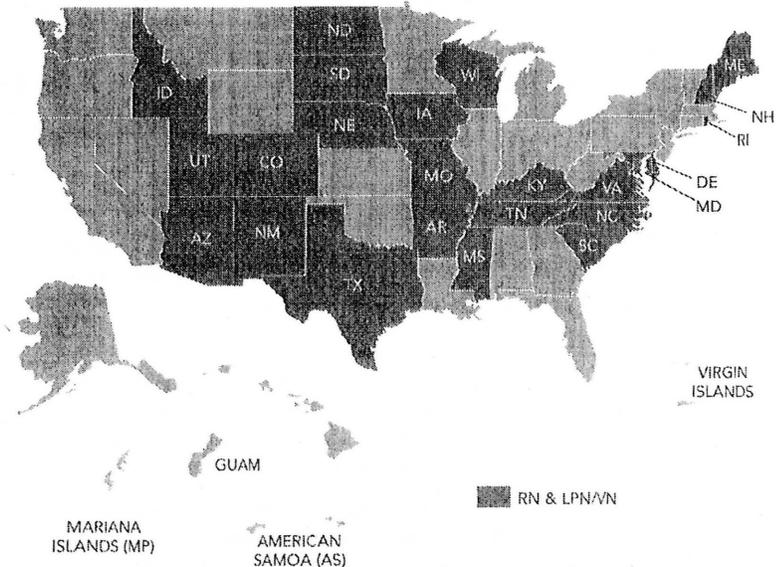


### Background

- The Nurse Licensure Compact (NLC) allows a registered nurse (RN) and licensed practical/vocational nurse (LPN/VN) to have one multi-state license in a primary state of residency (the home state) and to practice in other compact states (remote states), while subject to each state's practice laws and discipline.
- The NLC allows a nurse to practice both physically and electronically across state lines unless the nurse is under discipline or restriction.
- Advanced practice registered nurses (APRNs) are not included in this compact. APRNs must apply in each state in which they practice, unless exempted when employed in a federal facility.

### Multistate and Single-state Licenses

- A nurse must legally reside in an NLC state to be eligible for issuance of a multistate license. In order to obtain a compact license, one must declare a compact state as the primary state of residency and hold a nursing license in good standing. There is not a separate application for obtaining a multistate license.
- A nurse whose primary state of residence is a non-compact state is not eligible for a compact license.
- Upon being issued a compact (multistate) license, any additional active compact state licenses held are inactivated because a nurse can only hold one multistate license.
- A nurse licensed in a compact state must meet the licensure requirements in the home state. When practicing on a multistate privilege in a remote state, the nurse is accountable for complying with the Nurse Practice Act of that state.
- A nurse with an active compact (multistate) license wanting to practice in another compact state does not need to complete any applications nor pay any fees as the home state license is accepted as a privilege to practice in other compact states.
- A nurse who declares a noncompact state as the primary state of residence will be issued a single-state license.



- A nurse must hold a separate license in each noncompact state where practice privileges are desired.
- While under disciplinary action, multistate privileges may be removed and the nurse's practice may be restricted to the home state.
- The NCLEX® can be taken in any jurisdiction. However, graduates applying for a license, who legally reside in a compact state (the home state) can only apply to their home state board of nursing. This means that the applicant cannot apply for a compact license in a compact state other than the one in which he/she legally resides.



## Requirements when Moving

- When a nurse moves from a compact state to a noncompact state to practice nursing, the compact license is changed to a single-state license and the nurse must apply for licensure by endorsement in the new state of residency.
- When a nurse declares a compact state as the primary state of residency, the nurse must apply for licensure by endorsement in the new state of residency.
- When a nurse changes primary state of residency by moving from one compact state to another compact state, the nurse can practice on the former residency license for up to 30 days. The nurse is required to apply for licensure by endorsement, pay any applicable fees and complete a declaration of primary state of residency in the new home state, whereby a new multistate license is issued and the former license is inactivated. Proof of residency may be required.
- Licensure renewal cycles vary state to state. Nurses are required to promptly declare a new state of residency when they obtain a new driver's license, change where federal taxes are paid or register to vote and not wait for their license to lapse or expire in the prior home state.
- A nurse on a visa from another country applying for licensure in a party state may declare either the country of origin or the party state as the primary state of residency. If the foreign country is declared the primary state of residency, a single-state license will be issued by the party state.

## Definitions

- **Compact:** An interstate agreement between two or more states established for the purpose of remedying a particular problem of multistate concern. (Black's Law Dictionary)
- **Party or Compact State:** Any state that has adopted the NLC.
- **Home State:** The party state that serves as the nurse's primary state of residence.
- **Remote State:** A party state other than the home state where the patient is located at the time nursing care is provided or in the case of the practice of nursing not involving a patient, a party state where the recipient of nursing practice is located.
- **Primary State of Residence:** The state in which a nurse declares a principal residence for legal purposes.
- **Nursys®:** A database that contains the licensure and disciplinary information of all RNs and LPN/VNs as contributed by party states.



**NCSBN**

National Council of State Boards of Nursing

For more information about NLC, visit  
[www.ncsbn.org/nlc](http://www.ncsbn.org/nlc) or e-mail [nursecompact@ncsbn.org](mailto:nursecompact@ncsbn.org).



#### Definitions

- **Compact:** An interstate agreement between two or more states established for the purpose of remedying a particular problem of multistate concern (*Black's Law Dictionary*).
- **Party or Compact State:** Any state that has adopted the NLC.
- **Home State:** The party state that serves as the nurse's primary state of residence.
- **Primary State of Residence:** The state in which a nurse declares a principal residence for legal purposes. Sources used to verify a nurse's primary residence may include driver's license, federal income tax return, Military Form #2058 or voter registration.
- **Remote State:** A party state other than the home state where the patient is located at the time nursing care is provided or in the case of nursing practice not involving a patient, a party state where the recipient of nursing practice is located.
- **Nursys®:** A database with a free public access website ([www.nursys.com](http://www.nursys.com)) that contains the licensure and disciplinary information of all licensed RNs and LPN/VNs, as contributed by party states.

#### Background

- The NLC allows a nurse (registered nurse [RN] and licensed practical/vocational nurse [LPN/VN]) to have one multistate license in the nurse's primary state of residency (the home state) and practice in other compact states (remote states), while subject to each state's practice laws and discipline.
- Lawful practice requires that a nurse be licensed or have the privilege to practice in the state where the patient is located at the time care is directed or service is rendered. This pertains to practice by physical or electronic means.
- Nurses holding a multistate license are allowed to practice across state lines, except when practice is limited to the home state due to a restriction on the license or some level of disciplinary action.
- Advanced practice registered nurses (APRNs) are not included in this compact. APRNs must apply for licensure in each state in which they practice unless exempted when employed in a federal facility.
- To view a map of compact states, visit [www.ncsbn.org/nlc](http://www.ncsbn.org/nlc).

#### Employer Verification of a Nurse's Licensure Status

- Employers need to verify the licensure status of all nurses seeking employment. Many state boards of nursing (BONs) are paperless and no longer issue a wallet-size license card. NCSBN's online verification system, Nursys, provides licensure data obtained directly from the licensure systems of BONs through frequent database updates.
- It is important to verify licenses online with Nursys or with the state BON where the nurse is licensed.
- All NLC states provide licensure data to Nursys. Many, but not all non-NLC states provide licensure data to Nursys. To view a map of Nursys licensure-participating BONs, visit <https://www.nursys.com/NLV/LicenseVerificationJurisdictions.aspx>.
- For those states that submit licensure data to Nursys, employers can verify a nurse's license and receive a Licensure Quick Confirm report at no cost by visiting [www.nursys.com](http://www.nursys.com). The report will contain the nurse's name, jurisdiction, license type, license number, compact status (multistate/single state), license status, expiration date, discipline against license and discipline against privilege to practice.
- For those states that do not submit licensure data to Nursys, employers can verify a nurse's license via a BON's website, however, they will not have access to the licensee's licensure, discipline or privilege to practice status in other states.
- To verify temporary licenses, employers must contact the BON that issued the temporary license.



## Licensure and Privileges

- A nurse licensed in a compact state must meet the licensure requirements in the primary state of residence (home state). When practicing on a privilege in a remote state, the nurse is accountable for complying with the nurse practice act of that state.
- Compact states may issue a multistate or a single state license. Employers should verify licensure status online.
- A nurse with an active multistate license in good standing has the privilege to practice in any of the remote states.
- The NLC laws allow for the nurse to hold only one active multistate license in his or her primary state of residence. Employers should not require the nurse who holds an active multistate license to apply for licensure in a remote state when the nurse has lawfully declared a primary state of residence based on where he or she pays federal income tax, votes and holds a drivers license.
- A nurse who holds a license issued by a state that is not a member of the NLC has a single-state license that is only valid in that state.
- While under some levels of disciplinary action, multistate privileges may be removed and the nurse's practice may be restricted to the home state.

## Requirements When A Nurse Moves

- When a nurse declares a different compact state as his or her primary state of residence, the nurse must apply for licensure by endorsement in the new state of residency.
- When a nurse changes primary state of residency by moving from one compact state to another, the nurse can practice on the former license for up to 30 days. The 30-day period begins on the nurse's first day of employment. If the licensee begins employment before changing the primary state of residency, the 30 days begins upon the date that the licensee establishes a new primary state of residency. Obtaining a drivers license in the new state, for example, would signify the establishment of a new primary state of residency. The nurse is required to apply for licensure by endorsement and complete a declaration of primary state of residency in the new home state, whereby a new multistate license is issued and the former license is made inactive.
- Licensure renewal cycles vary state to state. Nurses are required to promptly declare a new state of residency when they obtain a new drivers license, change where federal taxes are paid or register to vote and must not wait for their license to lapse or expire in the prior home state.

## Complaints

To report a nurse practice violation, contact the BON where the nurse is practicing or report the information to the BON in the home state of licensure.



For more information about the NLC, visit [www.ncsbn.org/nlc](http://www.ncsbn.org/nlc) or e-mail [nursecompact@ncsbn.org](mailto:nursecompact@ncsbn.org).





### Findings of 2006 National Gallup Research on Nurse Licensure Compact

- Of 800 nurses surveyed, 88 percent supported the NLC.
- Nurses responded to having greater flexibility and reduced licensure fees practicing across state lines.
- BONs responded that there is improved communication and collaboration between states regarding disciplinary matters and there are streamlined licensing procedures and decreased regulatory barriers.
- Employers responded that the NLC has facilitated the nurse hiring process.

### Major Barrier Identified

A fear of union strike-breaking is a known barrier to adoption of the NLC. To this end, optional enabling language offers a provision which stipulates that NLC statutes do not supersede existing labor laws. In the history of the NLC, there has not been a reported situation where NLC nurses used their privilege to practice to go into another NLC state where there was a strike.

### Some NLC Supporters

- American Academy of Ambulatory Care Nursing
- American Organization of Nurse Executives
- American Association of Occupational Health Nurses
- American Nephrology Nurses Association
- American Telemedicine Association
- Case Management Society of America
- Center for Tele-health & e-Health Law
- Disease Management Association of America
- Emergency Nurses Association
- State Alliance for e-Health of the National Governors Association Center for Best Practices
- U.S. Department of Commerce

### From the First Annual Report and Recommendations from the State Alliance for e-Health:

*The State Alliance thoroughly examined the opportunities and challenges in pursuing options for multistate practice and e-health expansion. Among these were licensure structures to support cross-state e-health consultations, and remote delivery of health care services; the need to enable mail-order pharmacies, telehealth, and telemedicine; and the potential of the current Nurse Licensure Compact as a model for other health professions. Given the level of activity across the country of state nursing boards supporting the NLC and the NLC's benefits to enabling e-health, the State Alliance encourages the remaining state nursing boards to join the compact as well.*

*Governors and state legislatures should direct the state's nursing board to participate in the NLC, given the importance of the NLC for e-health purposes. Governors and state legislatures should provide financial support to the nursing boards for the initial implementation of the NLC and ensure that the boards are funded at levels needed to assure public protection operations.*

## ASSOCIATION SUPPORT

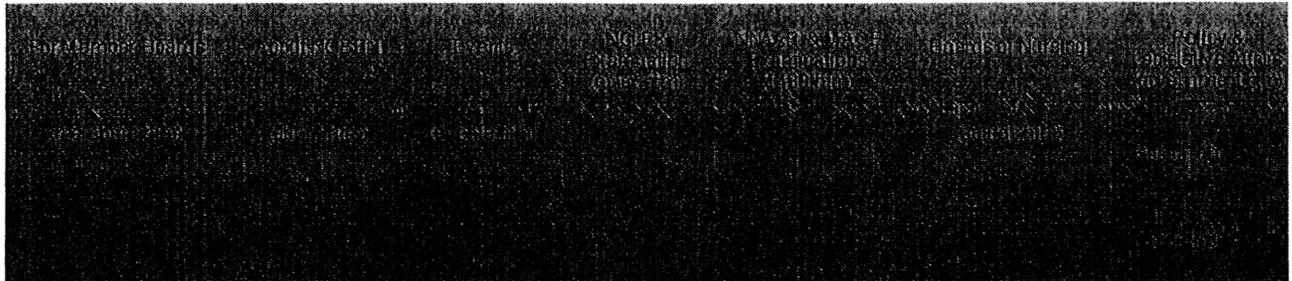
Oct 2010

The Compact is currently supported and regulated by NCSBN and the Nurse Licensure Compact Administrators. For further information, go to <https://www.ncsbn.org>.

NCL supporting organizations include:

- Association of Camp Nurses (ACN)
- American Nephrology Nurses Association (ANNA)
- American Telemedicine Association's nursing special interest group
- American Telemedicine Association (ATA)
- The American Association of Occupational Health Nurses (AAOHN)
- The American Organization of Nurse Executives (AONE)
- Case Management Leadership Coalition (CMLC)
- Case Management Society of America (CMSA) \_
  - Case Management Society of New England \_
  - Case Management Society of Atlanta \_
  - Case Management Society of St. Louis \_
  - Case Management Society of Chicago
- Disease Management Association of America
- Emergency Nurses Association (ENA)
- Many state nursing associations have expressed support for the NLC, and have worked to help adopt it
  - (i.e., Arkansas Nurses Association, Idaho Nurses Association, Texas Nurses Association).
- Several state hospital associations have supported the NLC and also have worked to adopt it in their states
- U.S. Department of Commerce, which supported the NLC in speech to the American Telemedicine Association in 2003 and formally recognized NLC in its report to Congress titled "Innovation, Demand and Investment in Telehealth" (February 2004)
- The Center for Telehealth and E-Health Law
- The Telehealth Leadership Council • Citizens Advocacy Center (CAC)

Excerpts from CMSA's POSITION STATEMENT: MULTISTATE NURSING LICENSURE IN CASE MANAGEMENT Revised: 11/04/2005 | Updated: 07/21/2009 | Revised October 2010



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## Model Legislation & Rules

NCSBN has developed models for states to enact the Nurse Licensure Compact (NLC). Below find [model legislation](#), [optional enabling language](#) and [model rules](#).

### Model Legislation for States to Enact the Nurse Licensure Compact (NLC)

Model NLC Legislation serves as the basis for what states need to enact to join the NLC. In order to be eligible to join the NLC, states must pass the model legislation without any material differences. See also [Optional Enabling Language](#) and [Model Rules](#) below.

Adopted as model law on November 6, 1998

#### ARTICLE I

##### Findings and Declaration of Purpose

- a. The party states find that:
  1. the health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws;
  2. violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;
  3. the expanded mobility of nurses and the use of advanced communication technologies as part of our nation's healthcare delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation;
  4. new practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;
  5. the current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant to both nurses and states.
- b. The general purposes of this Compact are to:
  1. facilitate the states' responsibility to protect the public's health and safety;
  2. ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation;
  3. facilitate the exchange of information between party states in the areas of nurse regulation, investigation and adverse actions;
  4. promote compliance with the laws governing the practice of nursing in each jurisdiction;
  5. invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses.

#### ARTICLE II

##### Definitions

As used in this Compact:

- a. "Adverse Action" means a home or remote state action.
- b. "Alternative program" means a voluntary, non-disciplinary monitoring program approved by a nurse licensing board.
- c. "Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws, which is administered by a non-profit organization composed of and controlled by state nurse licensing boards.
- d. "Current significant investigative information" means:
 

investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.
- e. "Home state" means the party state which is the nurse's primary state of residence.
- f. "Home state action" means any administrative, civil, equitable or criminal action permitted by the home state's laws which are imposed on a nurse by the home state's licensing board or other authority including actions against an individual's license such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.
- g. "Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.
- h. "Multistate licensure privilege" means current, official authority from a remote state permitting the practice of nursing as either a registered nurse or a licensed practical/vocational nurse in such party state. All party states have the authority, in accordance with existing state due process law, to take actions against the nurse's privilege such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.
- i. "Nurse" means a registered nurse or licensed practical/vocational nurse, as those terms are defined by each party's state practice laws.
- j. "Party state" means any state that has adopted this Compact.

- k. "Remote state" means a party state, other than the home state, where the patient is located at the time nursing care is provided, or, in the case of the practice of nursing not involving a patient, in such party state where the recipient of nursing practice is located.
- l. "Remote state action" means any administrative, civil, equitable or criminal action permitted by a remote state's laws which are imposed on a nurse by the remote state's licensing board or other authority including actions against an individual's multistate licensure privilege to practice in the remote state, and cease and desist and other injunctive or equitable orders issued by remote states or the licensing boards thereof.
- m. "State" means a state, territory, or possession of the United States, the District of Columbia.
- n. "State practice laws" means those individual party's state laws and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline.
- o. "State practice laws" does not include the initial qualifications for licensure or requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

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### ARTICLE III

#### General Provisions and Jurisdiction

- a. A license to practice registered nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a registered nurse in such party state. A license to practice licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a licensed practical/vocational nurse in such party state. In order to obtain or retain a license, an applicant must meet the home state's qualifications for licensure and license renewal as well as all other applicable state laws.
- b. Party states may, in accordance with state due process laws, limit or revoke the multistate licensure privilege of any nurse to practice in their state and may take any other actions under their applicable state laws necessary to protect the health and safety of their citizens. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.
- c. Every nurse practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time care is rendered. In addition, the practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of a party state. The practice of nursing will subject a nurse to the jurisdiction of the nurse licensing board and the courts, as well as the laws, in that party state.
- d. This Compact does not affect additional requirements imposed by states for advanced practice registered nursing. However, a multistate licensure privilege to practice registered nursing granted by a party state shall be recognized by other party states as a license to practice registered nursing if one is required by state law as a precondition for qualifying for advanced practice registered nurse authorization.
- e. Individuals not residing in a party state shall continue to be able to apply for nurse licensure as provided for under the laws of each party state. However, the license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state unless explicitly agreed to by that party state.

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### ARTICLE IV

#### Applications for Licensure in a Party State

- a. Upon application for a license, the licensing board in a party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any restrictions on the multistate licensure privilege, and whether any other adverse action by any state has been taken against the license.
- b. A nurse in a party state shall hold licensure in only one party state at a time, issued by the home state.
- c. A nurse who intends to change primary state of residence may apply for licensure in the new home state in advance of such change. However, new licenses will not be issued by a party state until after a nurse provides evidence of change in primary state of residence satisfactory to the new home state's licensing board.
- d. When a nurse changes primary state of residence by:
  1. moving between two party states, and obtains a license from the new home state, the license from the former home state is no longer valid;
  2. moving from a non-party state to a party state, and obtains a license from the new home state, the individual state license issued by the non-party state is not affected and will remain in full force if so provided by the laws of the non-party state;
  3. moving from a party state to a non-party state, the license issued by the prior home state converts to an individual state license, valid only in the former home state, without the multistate licensure privilege to practice in other party states.

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### ARTICLE V

#### Adverse Actions

In addition to the General Provisions described in Article III, the following provisions apply:

- a. The licensing board of a remote state shall promptly report to the administrator of the coordinated licensure information system any remote state actions including the factual and legal basis for such action, if known. The licensing board of a remote state shall also promptly report any significant current investigative information yet to result in a remote state action. The administrator of the coordinated licensure information system shall promptly notify the home state of any such reports.
- b. The licensing board of a party state shall have the authority to complete any pending investigations for a nurse who changes primary state of residence during the course of such investigations. It shall also have the authority to take appropriate action(s), and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.
- c. A remote state may take adverse action affecting the multistate licensure privilege to practice within that party state. However, only the home state shall have the power to impose adverse action against the license issued by the home state.
- d. For purposes of imposing adverse action, the licensing board of the home state shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct had occurred within the home state. In so doing, it shall apply its own state laws to determine appropriate action.

- e. The home state may take adverse action based on the factual findings of the remote state, so long as each state follows its own procedures for imposing such adverse action.
- f. Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of licensure action and that such participation shall remain non-public if required by the party state's laws. Party states must require nurses who enter any alternative programs to agree not to practice in any other party state during the term of the alternative program without prior authorization from such other party state.

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#### **ARTICLE VI Additional Authorities Invested in Party State Nurse Licensing Boards**

Notwithstanding any other powers, party state nurse licensing boards shall have the authority to:

- a. if otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse;
- b. issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a nurse licensing board in a party state for the attendance and testimony of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located.
- c. issue cease and desist orders to limit or revoke a nurse's authority to practice in their state;
- d. promulgate uniform rules and regulations as provided for in Article VIII(c).

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#### **ARTICLE VII Coordinated Licensure Information System**

- a. All party states shall participate in a cooperative effort to create a coordinated data base of all licensed registered nurses and licensed practical/vocational nurses. This system will include information on the licensure and disciplinary history of each nurse, as contributed by party states, to assist in the coordination of nurse licensure and enforcement efforts.
- b. Notwithstanding any other provision of law, all party states' licensing boards shall promptly report adverse actions, actions against multistate licensure privileges, any current significant investigative information yet to result in adverse action, denials of applications, and the reasons for such denials, to the coordinated licensure information system.
- c. Current significant investigative information shall be transmitted through the coordinated licensure information system only to party state licensing boards.
- d. Notwithstanding any other provision of law, all party states' licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.
- e. Any personally identifiable information obtained by a party states' licensing board from the coordinated licensure information system may not be shared with non-party states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.
- f. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information, shall also be expunged from the coordinated licensure information system.
- g. The Compact administrators, acting jointly with each other and in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this Compact.

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#### **ARTICLE VIII Compact Administration and Interchange of Information**

- a. The head of the nurse licensing board, or his/her designee, of each party state shall be the administrator of this Compact for his/her state.
- b. The Compact administrator of each party state shall furnish to the Compact administrator of each other party state any information and documents including, but not limited to, a uniform data set of investigations, identifying information, licensure data, and disclosable alternative program participation information to facilitate the administration of this Compact.
- c. Compact administrators shall have the authority to develop uniform rules to facilitate and coordinate implementation of this Compact. These uniform rules shall be adopted by party states, under the authority invested under Article VI (d).

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#### **ARTICLE IX Immunity**

No party state or the officers or employees or agents of a party state's nurse licensing board who acts in accordance with the provisions of this Compact shall be liable on account of any act or omission in good faith while engaged in the performance of their duties under this Compact. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness.

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**ARTICLE X****Entry Into Force, Withdrawal and Amendment**

- a. This Compact shall enter into force and become effective as to any state when it has been enacted into the laws of that state. Any party state may withdraw from this Compact by enacting a statute repealing the same, but no such withdrawal shall take effect until six months after the withdrawing state has given notice of the withdrawal to the executive heads of all other party states.
- b. No withdrawal shall affect the validity or applicability by the licensing boards of states remaining party to the Compact of any report of adverse action occurring prior to the withdrawal.
- c. Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.
- d. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

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**ARTICLE XI****Construction and Severability**

- a. This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any state party thereto, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.
- b. In the event party states find a need for settling disputes arising under this Compact:
  1. The party states may submit the issues in dispute to an arbitration panel which will be comprised of an individual appointed by the Compact administrator in the home state; an individual appointed by the Compact administrator in the remote state(s) involved; and an individual mutually agreed upon by the Compact administrators of all the party states involved in the dispute.
  2. The decision of a majority of the arbitrators shall be final and binding.

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**Optional Enabling Language**

Optional enabling act provisions may be appropriate for states to utilize when looking to enact the NLC into law depending on the needs of the state.

1. The Nurse Licensure Compact is hereby enacted and entered into with all other jurisdictions that legally join in the compact, which is, in form, substantially as follows:
2. "The head of the nurse licensing board" as used to define the compact administrator in Article VIII(a) shall mean xxxxxxx.
3. To facilitate cross-state enforcement efforts, the legislature finds that it is necessary for [this state] to have the power to recover from the affected nurse the costs of investigations and disposition of cases resulting from adverse actions taken by this state against that nurse. Coordinating language shall be inserted in the appropriate location in the Nurse Practice Act.
4. This Compact is designed to facilitate the regulation of nurses, and does not relieve employers from complying with statutorily imposed obligations.
5. This Compact does not supersede existing state labor laws.
6. To facilitate workforce planning, the legislature finds it necessary for [this state] to grant the board of nursing the authority to collect employment data on nurses practicing on the multi-privilege in the NLC, on a provided form, provided that the submission of this data is not a requirement for practice under the multi-state privilege.

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**Nurse Licensure Compact (NLC) Model Rules and Regulations for RNs and LPN/VNs**

Article 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.

**As Amended November 13, 2012****1. Definition of terms in the Compact.**

For the Purpose of the Compact:

- a. "Board" means party state's regulatory body responsible for issuing nurse licenses.
- b. "Information system" means the coordinated licensure information system.
- c. "Primary state of residence" means the state of a person's declared fixed permanent and principal home for legal purposes; domicile.
- d. "Public" means any individual or entity other than designated staff or representatives of party state Boards or the National Council of State Boards of Nursing, Inc.

Other terms used in these rules are to be defined as in the Interstate Compact.

**2. Issuance of a license by a Compact party state.**

For the purpose of this Compact:

- a. As of July 1, 2005, no applicant for initial licensure will be issued a compact license granting a multi-state privilege to practice unless the applicant first obtains a passing score on the applicable NCLEX examination or its predecessor examination used for licensure.
- b. A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. Such evidence shall include a declaration signed by the licensee. Further evidence that may be requested may include but is not limited to:
  - i. Driver's license with a home address;
  - ii. Voter registration card displaying a home address; or
  - iii. Federal income tax return declaring the primary state of residence.
  - iv. Military Form no. 2058 - state of legal residence certificate; or
  - v. W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence. (Statutory basis: Articles 2E, 4C, and 4D)
- c. A nurse on a visa from another country applying for licensure in a party state may declare either the country of origin or the party state as the primary state of residence. If the foreign country is declared the primary state of residence, a single state license will be issued by the party state. (Statutory basis: Article 3E)
- d. A licensee issued by a party state is valid for practice in all other party states unless clearly designated as valid only in the state which issued the license. (Statutory basis: Article 3A and 3B)
- e. When a party state issued a license authorizing practice only in that state and not authorizing practice in other party states (i.e. a single state license), the license shall be clearly marked with words indicating that it is valid only in the state of issuance. (Statutory basis: Article 3A, 3B, and 3E)
- f. A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multi-state licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed ninety (90) days. (Statutory basis: Articles 4B, 4C, and 4D[1])
- g. The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance and the ninety-(90) day period in section 2f shall be stayed until resolution of the pending investigation. (Statutory basis: Article 5[B])
- h. The former home state license shall no longer be valid upon the issuance of a new home state license. (Statutory basis: Article 4D[1])
  - i. If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten (10) business days and the former home state may take action in accordance with that state's laws and rules.

### 3. Limitations on multi-state licensure privilege - Discipline.

- a. Home state Boards shall include in all licensure disciplinary orders and/or agreements that limit practice and/or require monitoring the requirement that the licensee subject to said order and/or agreement will agree to limit the licensee's practice to the home state during the pendency of the disciplinary order and/or agreement. This requirement may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and such other party state Boards. (Statutory basis: State statute)
- b. An individual who had a license which was surrendered, revoked, suspended, or an application denied for cause in a prior state of primary residence, may be issued a single state license in a new primary state of residence until such time as the individual would be eligible for an unrestricted license by the prior state(s) of adverse action. Once eligible for licensure in the prior state(s), a multistate license may be issued.

### 4. Information System.

- a. Levels of access
  - i. The Public shall have access to nurse licensure information limited to:
    - a. the nurse's name,
    - b. jurisdiction(s) of licensure,
    - c. license expiration date(s),
    - d. licensure classification(s) and status(es),
    - e. public emergency and final disciplinary actions, as defined by contributing state authority, and
    - f. the status of multi-state licensure privileges.
  - ii. Non-party state Boards shall have access to all Information System data except current significant investigative information and other information as limited by contributing party state authority.
  - iii. Party state Boards shall have access to all Information System data contributed by the party states and other information as limited by contributing non-party state authority. (Statutory basis: 7G)
- b. The licensee may request in writing to the home state Board to review the data relating to the licensee in the Information System. In the event a licensee asserts that any data relating to him or her is inaccurate, the burden of proof shall be upon the licensee to provide evidence that substantiates such claim. The Board shall verify and within ten (10) business days correct inaccurate data to the Information System. (Statutory basis: 7G)
- c. The Board shall report to the Information System within ten (10) business days
  - i. disciplinary action, agreement or order requiring participation in alternative programs or which limit practice or require monitoring (except agreements and orders relating to participation in alternative programs required to remain nonpublic by contributing state authority),
  - ii. dismissal of complaint, and
  - iii. changes in status of disciplinary action, or licensure encumbrance. (Statutory basis: 7B)
- d. Current significant investigative information shall be deleted from the Information System within ten (10) business days upon report of disciplinary action, agreement or order requiring participation in alternative programs or agreements which limit practice or require monitoring or dismissal of a complaint. (Statutory basis: 7B, 7F)
- e. Changes to licensure information in the Information System shall be completed within ten (10) business days upon notification by a Board. (Statutory basis: 7B, 7F)

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# Nurse Licensure Compact (NLC)



## Talking Points – Related Background

- **The state of practice rather than the state of residence holds greater logic for licensure.**

The National Council of State Boards of Nursing (NCSBN) states that the state of residency was selected rather than the state of practice, given there is greater authority over a resident versus non-resident; paralleling the driver's license compact.

ANA's long standing position identifies the state of practice as where the nurse is located (1999) since the intent behind licensure is 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.

- **There are inconsistencies between states' licensure / re-registration requirements.**

The NCSBN reports more than decade of experience without identified problems. The NLC, a mutual recognition model for licensure, accepts the variations between states, trusting the home state has performed due diligence.

Regardless, licensure standards and qualifications vary between states, including: frequency & requirements for re-licensure and re-registration; continuing education; criminal background checks (CBC)\*; recognition of non-traditional education programs particularly with regard to number of clinical hour requirements for entry into practice; how nurse diversions & addictions are addressed; and what constitutes an infraction and resultant actions.

\*Type and depth to which the CBC is performed varies. As of April 2013, 19 of the 24 NLC states require a CBC.

Additionally, Boards of Nursing resources differ from state to state, all of which can result in delayed processing for licensure; investigation of complaints and subsequent disciplinary actions.

ANA believes:

**The state of practice rather than the state of residence holds greater logic for licensure.**

**There are inconsistencies between states' licensure / re-registration requirements.**

Continued

## Background

The NLC allows a nurse to have one license (in his / her state of residency) and to practice in other states (both physically and electronically) of which participate in the Compact. Should the state of residence change, a new license must be obtained. The universal acceptance of drivers' licenses granting the privilege to drive in any state is a familiar example of the use of mutual recognition agreements.

Regardless of the origin of the license, nurses are held accountable to the laws, rules and regulations associated with their practice in every state in which they practice.

The NLC includes registered nurses (RNs) and licensed practical or vocational nurses (LPN/LVNs). Advanced practice registered nurses (APRNs) are not included in the NLC. A separate APRN Compact offers states the mechanism for mutually recognizing APRN licenses and authority to practice.

The NLC has systems in place to identify nurses who are subject to discipline or monitoring agreements. Nursys® is the national nurse licensure database, which alerts other NLC states when a licensee is under investigation. Non NLC states have the ability to subscribe to Nursys® for licensure verification and disciplinary tracking as well. All but four Boards of Nursing participate (Alabama, Hawaii, Louisiana Practical Nurse Board, and Oklahoma. (NCSBN 2013) As of 2013, an expanded e-alert feature to Nursys® is available to deliver directly to interested subscribers, any real-time changes, regarding license status, renewals, expirations; as well as disciplinary action and resolve.

24 states have joined the NLC. A map of current NLC states can be viewed by visiting [www.ncsbn.org/nlc](http://www.ncsbn.org/nlc) (NCSBN April 2013)

At least three state Attorneys General have rendered opinions that the NLC interferes with state sovereignty (Florida, Indiana, & Oklahoma).

Reviewed / Updated  
ANA Board of Directors  
April 2013

# Nurse Licensure Compact (NLC)



## Talking Points – Related Background

- **The state of practice rather than the state of residence holds greater logic for licensure.**

The National Council of State Boards of Nursing (NCSBN) states that the state of residency was selected rather than the state of practice, given there is greater authority over a resident versus non-resident; paralleling the driver's license compact.

ANA's long standing position identifies the state of practice as where the nurse is located (1999) since the intent behind licensure is 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.

- **There are inconsistencies between states' licensure / re-registration requirements.**

The NCSBN reports more than decade of experience without identified problems. The NLC, a mutual recognition model for licensure, accepts the variations between states, trusting the home state has performed due diligence.

Regardless, licensure standards and qualifications vary between states, including: frequency & requirements for re-licensure and re-registration; continuing education; criminal background checks (CBC)\*; recognition of non-traditional education programs particularly with regard to number of clinical hour requirements for entry into practice; how nurse diversions & addictions are addressed; and what constitutes an infraction and resultant actions.

\*Type and depth to which the CBC is performed varies. As of April 2013, 19 of the 24 NLC states require a CBC.

Additionally, Boards of Nursing resources differ from state to state, all of which can result in delayed processing for licensure; investigation of complaints and subsequent disciplinary actions.

ANA believes:

**The state of practice rather than the state of residence holds greater logic for licensure.**

**There are inconsistencies between states' licensure / re-registration requirements.**

Continued

## Background

The NLC allows a nurse to have one license (in his / her state of residency) and to practice in other states (both physically and electronically) of which participate in the Compact. Should the state of residence change, a new license must be obtained. The universal acceptance of drivers' licenses granting the privilege to drive in any state is a familiar example of the use of mutual recognition agreements.

Regardless of the origin of the license, nurses are held accountable to the laws, rules and regulations associated with their practice in every state in which they practice.

The NLC includes registered nurses (RNs) and licensed practical or vocational nurses (LPN/LVNs). Advanced practice registered nurses (APRNs) are not included in the NLC. A separate APRN Compact offers states the mechanism for mutually recognizing APRN licenses and authority to practice.

The NLC has systems in place to identify nurses who are subject to discipline or monitoring agreements. Nursys® is the national nurse licensure database, which alerts other NLC states when a licensee is under investigation. Non NLC states have the ability to subscribe to Nursys® for licensure verification and disciplinary tracking as well. All but four Boards of Nursing participate (Alabama, Hawaii, Louisiana Practical Nurse Board, and Oklahoma. (NCSBN 2013) As of 2013, an expanded e-alert feature to Nursys® is available to deliver directly to interested subscribers, any real-time changes, regarding license status, renewals, expirations; as well as disciplinary action and resolve.

24 states have joined the NLC. A map of current NLC states can be viewed by visiting [www.ncsbn.org/nlc](http://www.ncsbn.org/nlc) (NCSBN April 2013)

At least three state Attorneys General have rendered opinions that the NLC interferes with state sovereignty (Florida, Indiana, & Oklahoma).

Reviewed / Updated  
ANA Board of Directors  
April 2013

## TELEHEALTH ARTICLES

October 11, 2011

## **California Signs Telehealth Advancement Act**

California Gov. Jerry Brown signed Assembly Bill 415, the Telehealth Advancement Act of 2011, and opened the door for far-reaching expansion of telehealth services in California.

The bill was authored by Assembly Member Dan Logue (R-Chico), recognizing telehealth's future role in providing access to health care. It was supported by the state's telehealth stakeholders and leaders and passed with no opposing votes in the legislature.

The telehealth bill advances and updates California's 1996 Telemedicine Development Act. It enables health care providers to better provide care for Californians especially in rural and underserved areas of the state. The act allows for the provision of a broader range of telehealth services, expansion of telehealth providers to include all licensed healthcare professionals, the expansion of telehealth care settings and the ability for California hospitals to establish medical credentials for telehealth providers more easily.

The California State Rural Health Association (CSRHA), sponsor of the bill, worked in collaboration with the Center for Connected Health Policy (CCHP), the California Telemedicine and eHealth Center (CTEC), the California Telehealth Network (CTN) and many other health care organizations in the state, including the CCHP Telehealth Model Statute Work Group, to make crucial recommendations for the new bill.

# **FIRST REPORT FROM THE HEALTH CARE PRACTICE TASKFORCE TO THE STATE ALLIANCE FOR E-HEALTH August 15, 2007**

This report was financed by funds provided by the US Department of Health and Human Services, Office of the National Coordinator for Health IT (ONCHIT) under a contract with the National Governors Association for the State Alliance for e-Health. The report contents do not necessarily represent the official views of ONCHIT.

## **LETTER FROM CO-CHAIRS OF THE HEALTH CARE PRACTICE TASKFORCE**

Dear Members of the State Alliance,

In response to our charge to identify and address issues pertaining to the regulatory, legal, and professional standards that have an impact on the practice of medicine, the Health Care Practice Taskforce has spent the last several months deliberating licensure and liability issues that create barriers to an interoperable electronic health information exchange (eHIE). From testimony and discussions at the Taskforce meetings, licensure quickly became the top priority issue for this Taskforce.

Recognizing the barriers created by the lack of uniformity in the licensure process for nurses, physicians and pharmacists, the Taskforce puts forth the following recommendations for your consideration:

**Recommendation 1.1:** The State Alliance for e-Health should recommend that state medical, nursing, and pharmacy boards work to implement online licensure applications.

**Recommendation 1.2:** The State Alliance for e-Health should recommend that all state nursing and pharmacy boards develop common core licensure application forms, and state medical boards adopt the FSMB's Common Licensure Application Form (CLAF). Individual states may include state specific requirements.

We present the following report for your consideration and look forward to speaking with you at the meeting of the State Alliance on e-Health.

Sincerely, Dr. Darleen Bartz

and Thelma McClosky Armstrong Health Care Practice Taskforce Co-Chairs

**MEMBERS OF THE HEALTH CARE PRACTICE TASKFORCE OF THE  
STATE ALLIANCE FOR E-HEALTH (2007-2008)**

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**Dr. Rowen Zetterman, MACP, MACG** Chief of Staff, VA Nebraska - Western Iowa Health Care System and President, Nebraska Medical Association

August 15, 2007

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## **REPORT FROM THE HEALTH CARE PRACTICE TASKFORCE TO THE STATE ALLIANCE FOR E-HEALTH**

### **I. Introduction**

The Health Care Practice Taskforce is charged by the State Alliance for e-Health with identifying and addressing issues pertaining to “the regulatory, legal, and professional standards that have an impact on the practice of medicine and create barriers to interoperable, electronic health information exchange (eHIE).”<sup>1</sup> In addition to supporting the State Alliance on these issues, the charge specifically requires that the Practice Taskforce:

“Develop and advance actionable policy statements, resolutions, and recommendations for referral to the State Alliance to inform their decision-making process in addressing state-level issues related to best practices and the harmonization of regulatory, legal, technical, and professional standards that have an impact on the practice of medicine in interoperable, eHIE.”<sup>2</sup>

In response to the charge, the Health Care Practice Taskforce held their first meeting in February 2007 to examine licensure and liability issues in relation to eHIE. By March, the Taskforce developed a list of priority issues and corresponding questions to address in the coming months. These include:

- **Licensure:** What are the benefits and challenges surrounding various compact models and licensure schemes and how can they be applied to e-health activities? What are states’ credential requirements for physicians, pharmacists, and nursing professionals, and should there be a nationwide set of core credentials for these professions?
- **CLIA:** How do the Clinical Laboratory Improvement Amendments (CLIA) hinder eHIE and what are some possible solutions?
- **Liability:** What do we know regarding physician's liability in eHIE, and how should that information be relayed to health care providers?

From testimony and discussions at the Taskforce meetings, licensure quickly became the top priority issue for the Taskforce. A problem that resonated throughout each meeting was how the licensure process is often a barrier to health care professionals who want to practice e-health across state lines in ways that would be classified as remote delivery of healthcare services, such as those defined as telehealth.<sup>3</sup> As such, the primary focus of this report is state licensure requirements.

## **II. Current State of Licensure for Medical Boards, Boards of Pharmacy and State Nursing Boards**

The way medicine is practiced is constantly evolving. Currently, a collaboration of state and local health departments are moving toward integration of health information and an interconnected electronic system.<sup>4</sup> There is a great desire to improve quality of care while protecting patient safety, all of which can be facilitated by the use of health information technology.

Patients are now receiving more cross-state consultation with healthcare providers. As technology and procedures advance, consumers are pursuing specialty experts who reside in other states to provide direct consultation for a patient residing in another state. A more technology savvy healthcare consumer market is increasing the demand for internet and e-mail consultative services. In addition, disastrous events, such as Hurricane Katrina, focused attention on the Nation's need to permit healthcare providers to practice medicine in different states or across bordering state lines at a moment's notice.

In order to maintain consumer protections in this evolving e-health environment, it is necessary to promote a system that ensures qualified, licensed providers are able to satisfy the demand for cross-state consultation. As the healthcare industry moves toward a more interconnected environment, with provider to provider exchanges of information across state lines, the necessity of streamlining the licensure process for physicians, nurses, and pharmacists will become increasingly vital to both licensed professionals and consumers.

### **Role of State Boards**

"Historically, states have had the authority to regulate activities affecting the health, safety and welfare of their citizens. The state defines the process and procedures for granting a health professional license, renewing a license, and regulating medical practice within the state."<sup>5</sup> The structure and authority of healthcare licensing boards varies from state to state. Some boards are independent and maintain all licensing and disciplinary powers, while others are part of a larger umbrella agency, such as a state department of health, and share legal and investigative resources with other regulatory boards.<sup>6</sup>

State boards serve as the front line of protection for the millions of people who receive medical care by determining whether or not a physician, nurse or pharmacist meets the minimum necessary qualifications to practice in the given profession. The boards enforce practice acts and regulations in order to identify and take action against those who are responsible for poor quality care, unprofessional behavior, and other violations of these acts. The boards' capacity to be effective is often hampered by lack of resources and state funding. Many raise money through licensure and registration fees. In many states large proportions of these funds go into general revenues rather than the boards' own budgets.

The Taskforce has chosen to focus its initial recommendations on physician, nursing and pharmacy boards, recognizing the vital role that these professions play in the frontlines of the provision of health services for most Americans.

### **A. Physician Licensure**

There are currently 70 boards of medicine in the United States and its territories that license and regulate allopathic and osteopathic physicians.<sup>7</sup> Some jurisdictions have separate allopathic and osteopathic boards, while other jurisdictions have composite boards, which license and regulate both allopathic and osteopathic physicians. The various boards can also be distinguished by their regulatory processes, funding and resources, but all 70 boards share the common charge of the protection of the public. In accordance with this charge, the licensure process ensures that only qualified, competent physicians are granted a license to practice in the jurisdiction. Over time, the various licensing boards have developed their own distinctive laws and regulations to accomplish their purposes. In short, there

is a lack of uniformity in how boards achieve their

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common goal, for example, the licensure of qualified, competent practitioners. As the boards differ in processes and resources, there also exist differences in the length of time from the submission of an application to the issuance of a license. Should a physician wish to obtain licenses in more than one jurisdiction, the physician must abide by the processes of the respective boards, which may require efforts that are viewed as duplicative and time-consuming.

According to the presenters at the February and April meetings of the Health Care Practice Taskforce, even though many state medical boards have similar basic licensure requirements, such as information on medical training and certification, a closer examination of individual state licensure rules reveals wide variation across the states with respect to the requirements for obtaining a license. For example, in the area of continuing medical education (CME), "fifty-one boards require anywhere from 12 hours (Alabama) to 50 hours (several states) of continuing medical education (CME) per year for license registration. Some states also mandate CME content, such as HIV/AIDS, risk management, or medical ethics. In addition, many states also require that a certain percentage of CME be category 1, as measured, for example, through the American Medical Association Physician's Recognition Award."

8  
Medical licensing authorities in the United States require each applicant for licensure to pass an examination to ensure the physician is competent to practice medicine safely. The Federation of State Medical Board (FSMB) and the National Board of Medical Examiners administer the United States Medical Licensing Examination (USMLE), a three-step examination designed to be taken at different points during medical education and training. 9

Another obstacle for a physician wishing to obtain multiple licenses is the fact that many states require a current licensing exam to be taken by applicants if it has been more than 7 years since the physician passed the initial examination. After physicians are licensed, they must re-register periodically to continue their active status. During this re-registration process, physicians must demonstrate that they have maintained acceptable standards of professional conduct and medical practice. In a majority of states, physicians must also show that they have participated in a program of continuing medical education. 10

## **B. Nurse Licensure**

There are 59 nursing boards located in the 50 states, the District of Columbia, and four United States territories that license and regulate Advanced Practice Nurses, Registered Nurses (RNs), or as a Licensed Practical/Vocational Nurses (LPN/LVNs). Four states (California, Georgia, Louisiana and West Virginia) have two boards of nursing, one for registered nurses and one for licensed practical/vocational nurses.11 Individuals who serve on a board of nursing are appointed to their positions. State law dictates the membership of the board of nursing, which usually includes a mix of registered nurses, licensed practical/vocational nurses, advanced practice registered nurses, and consumers.

Once a nurse completes education and training, a nurse must apply for a license in the state where he or she intends to work. As with physicians and pharmacists the requirements to obtain and keep a nursing license vary from state to state. However, all states use the licensure examination of the National Council of State Boards of Nursing, known as the NCLEX-RN or NCLEX-PN license examination for RNs and LPN/LVNs respectively which nurses must take in order to obtain a license. Applicants are eligible for examination for licensure as a RN if they hold a

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degree, diploma, or certificate from an accredited nursing program that is approved by the State Board.

There are also variations in state law with respect to nurse licensure requirements for both RNs and LPN/LVNs. For example, continuing education is not mandated in some states, such as Connecticut, however all nurses are expected to keep current with nursing practice and advance as health professionals after graduation.

For the 22 states participating in the National Council of State Boards of Nursing (NCSBN) Nurse Licensure Compact (see discussion below for details), each state still sets its own licensure requirements, which may be similar but contain some variation in the details. This Compact is not

applicable to advanced practice nurses such as nurse-practitioners. Nurses regulated under the Compact, must be licensed in their state of residence, while accepting the authority of each remote state's practice and discipline laws in which the nurse practices. The Compact enables remote states to take disciplinary actions allowed by law, with the exception of licensure actions. Only the state of residence can revoke a nurse's license.<sup>12</sup>

### **C. Pharmacist Licensure**

State boards of pharmacy have many roles, some of which include: • licensing pharmacists by examination or by reciprocity • licensing pharmacies • renewing pharmacists' licenses annually • maintaining a register of pharmacists; • approving degree programs for colleges of pharmacy; and • investigating complaints of alleged violations of laws relating to the practice of pharmacy and disciplining pharmacists.

Pharmacist licensure requirements, like those of physicians and nurses, vary from state to state. Some states, such as Arkansas, require the successful completion of a criminal background check within the last four years, while others only require the applicant to be of "good moral character."<sup>13</sup> Some states also have minimum age requirements. To be licensed as a pharmacist in New York State, an applicant must be at least 21 years of age.<sup>14</sup> However, in many other states, the applicant need only be 18 years old.

There is some uniformity with regard to the testing mechanism used by states for applicants. Since 2004, when California was added, all 50 states utilize the National Association of Boards of Pharmacy (NABP) North American Pharmacist Licensure Examination (NAPLEX) as the professional practice examination required for initial licensure as a pharmacist. In addition, 44 of the 50 states use a state-specific version of the Multistate Pharmacy Jurisprudence Examination (MPJE), while the other states use a jurisprudence examination of their own. Both the NAPLEX and the MPJE examinations are computer-adaptive tests that are accessible from anywhere in the country to qualified candidates almost every day of the year.

## **III. Approaches that states are taking for streamlining licensure**

The lack of uniformity in the licensure process and the methods which state boards accept licensure applications pose significant challenges to e-HIE. At the February and April meetings of the Health Care Practice Taskforce, Taskforce members received presentations from a  
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representative of a telehealth network and representatives from state medical boards each indicating the need for more streamlined licensure processes to support e-health activities across state lines.

States have identified some approaches for streamlining the licensure process including: a) common licensure; b) online licensure applications; c) licensure compacts; and d) reciprocity.

### **A. Common Licensure**

The objectives of a uniform application are to: • facilitate health care practice across state lines, • reduce burden faced by applicants in seeking licensure in multiple states, • reduce administrative redundancies and encourage uniformity, • facilitate the mobilization of physicians to disaster-affected areas, • maintain the same level of public protection as the current regulatory system, and • assure state medical board revenues are sufficient to fulfill regulatory responsibility to protect the public.<sup>15</sup>

One well recognized example of a common licensure application form is the Common License Application Form (CLAF) developed by the Federation of State Medical Board (FSMB). The CLAF is designed to streamline the process for applying for licensure in multiple states with the technical platform (trusted agent platform) that allows for the common information to be immediately primary source verified and provided to the receiving medical board.<sup>16</sup> The States may add their individual requirements by allowing for the attachment of application addendums; thus achieving the objectives of the common licensure form while maintaining the integrity of the individualized state requirements. In an effort to help streamline the licensure process for physicians in Ohio, the State Medical Board of Ohio is part of a nationwide pilot program testing a common licensure application for physicians. Through a pilot program of the FSMB, the State Medical Board of Ohio supports an online Common Licensure Application Form (CLAF). The CLAF is a uniform licensure application form developed by

the FSMB in an attempt to:

- 
- 

Reduce the number of incomplete applications received by state medical boards, Allow for the collection of uniform information, and Add convenience for physicians applying for licensure in multiple states.

The CLAF includes a common set of components that are found on most licensure applications, such as name, address, basic identification information, post graduate education, and examination history. The State medical boards can incorporate an addendum to the CLAF, which includes information that is specific to the Board's needs, such as information pertaining to preliminary education, proficiency in English, and board certifications.

Also utilizing the CLAF are Kentucky and New Hampshire. The State Medical Board of Ohio intends for the CLAF to be an added convenience for physicians that seek to practice in both Ohio and Kentucky. FSMB is currently working with additional medical boards to convert their applications to the CLAF.

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## **B. Online Licensure Applications**

The use of common tools, such as an online application, by multiple states is a crucial element in supporting the evolving practice of medicine in the electronic health exchange context. In some cases, the state-based application structure has failed to keep pace with advancements in technology.

At the February and April meetings Taskforce members learned that some medical boards are attempting to address these challenges by implementing online licensure applications *and* common licensure applications. For example, the North Carolina Medical Board recently implemented online licensure applications for Medical Doctors (MDs) and Doctors of Osteopathic Medicine (DOs). According to the North Carolina Medical Board, online licensure applications have not only reduced the timeframes for obtaining a license, but have also reduced administrative errors. Since the Board's implementation of online licensure applications, timeframes for obtaining a MD and DO license reduced approximately 25%, from four months to three months. Staff has also indicated that since information is entered electronically and drop down menus are incorporated for some fields, handwriting is no longer a factor for administrative errors.

As with the North Carolina Medical Board's online licensure applications, components of an online licensure application can include:

- a secure web portal to access the application, • 24-7 access to a licensure application, • drop down menus to select appropriate information for a field, • links to the websites of medical schools and health care entities to obtain contact information for validating credentials, • credit card payment capabilities, and • instant updates on status of licensure application.

The North Carolina experience is an example of how the online application process can break down key barrier for physicians, as well as nurses and pharmacist, in their pursuit of multiple licenses. Based upon the Health Care Practice Taskforce's request for more information regarding the number of state medical, nursing, and pharmacy boards that currently utilize online license applications, the National Governors Association Center for Best Practices conducted research to assess these figures. The websites of these boards were searched for online applications and members of the Federation of State Medical Board, the National Association of Boards of Pharmacy, and the National Council of State Boards of Nursing were contacted via e-mail requesting statistical information regarding this topic.

According to the e-mail reply of Kristin Hellquist, with the National Council of State Boards of Nursing, approximately 80% of nursing boards use online licensure applications.

Prior to conducting a search of the state boards of pharmacy websites, the NGA Center contacted Moira Gibbons, Legal Affairs Senior Manager for the National Association of Boards of Pharmacy (NAPB), requesting information regarding the number of states currently using an online application process. Although NAPB utilizes an online application to register licensure candidates for their examinations, it does not track the total number of states with online applications used to obtain a

pharmacist license. In her e-mail message to NGA, Ms. Gibbons

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stated that because "the boards already collect a number of paper documents related to licensure (diplomas and other proof of graduation, documentation of completing requisite undergraduate and internship hours, affidavits, et al), some states may not have an immediate need to make an online licensure application available to applicants."<sup>17</sup>

Lisa Robin, the Federation of State Medical Boards' Vice President of Government Relations, responded to this inquiry informing NGA that only North Carolina, Ohio, New Hampshire and Kentucky utilize online applications. She also confirmed that while many states have "electronic applications" these are in fact PDF downloads that must be printed and mailed in.

### **C. Licensure Compacts**

The major barriers presented by licensing, credentialing, and practice standards variations to the implementation of telehealth practice caused the Board of Nurse Examiners and the National Council of State Boards of Nursing (NCSBN) to work together to develop a Nurse Multi-state Licensure Mutual Recognition Model, herein the Nurse Licensure Compact (NLC). The compact allows practice, whether physical or electronic, across state lines when the nurse is licensed in a state that has adopted the interstate model.<sup>18</sup> Each nurse practicing in "remote" states and participating in the NLC has only one licensing record.

Since 1998, Nurse Licensure Compact has included registered nurses (RNs) and licensed practical or vocational nurses (LPN/VNs), ~~but does not include advanced practice nurses, such as nurse practitioners.~~ "An interstate compact is an agreement between two or more states established for the purpose of remedying a particular problem of multi-state concern."<sup>19</sup> The Compact cannot be changed or amended without the consent of all party states.

The Compact allows for "mutual recognition" of nursing licensure among party states that agree to the compact. The mutual recognition model of nurse licensure allows a nurse to possess one license in the state of residency and to practice in other states, subject to each state's practice law and regulation. Under mutual recognition, a nurse may practice across state lines, in a physical or electronic capacity, unless otherwise restricted.

The American Nurses Association (ANA) has expressed concerns that the Compact may limit a nurse's right to due process and raise significant liability questions.<sup>20</sup> Two keys to the success of the nursing community have been the ability to reach broad community consensus on the need for interstate licensure and the development of a widely accepted model based on mutual recognition. Since 1998 the nurses have successfully promoted the introduction of legislation and the adoption of state laws that may allow them to practice across the borders of those states that adopt the compact. However, currently only 22 states have implemented the NLC, with Rhode Island planning implementation in the upcoming year.<sup>21</sup>

### **D. Reciprocity**

Although there is no current mutual recognition model or uniform application for pharmacy boards, the National Association of Boards of Pharmacy's (NABP) Electronic License Transfer Program (ELTP) enables licensed pharmacists to reciprocate an existing pharmacist license from one state or jurisdiction to another utilizing the uniform licensure requirements recognized by all states, the District of Columbia, Puerto Rico, and the Virgin Islands.<sup>22</sup> The program serves as a clearinghouse that screens the applicant's licenses for current license status and disciplinary

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actions. It also verifies background information such as examination grades, internship hours, other state licenses, and legal issues.

The NABP utilizes a single on-line Preliminary Application in the ELTP as a means to obtain information about the various credentials that are needed to make a decision about a pharmacist's request for reciprocity. However, it is still up to each state board of pharmacy to determine eligibility for reciprocity in accordance with the laws of that state.<sup>23</sup> Many states and other jurisdictions also require applicants for reciprocity to successfully complete the Multistate Pharmacy Jurisprudence Examination (MPJE), since individual state laws and rules relating to drugs can vary significantly from state to state.<sup>24</sup>

## **IV. Recommendations**

Recognizing the efficiency provided by online licensure applications and the promise that it holds for common licensure applications, the Taskforce recommended that:

**Recommendation 1.1:** The State Alliance for e-Health should recommend that state medical, nursing, and pharmacy boards work to implement online licensure applications.

**Recommendation 1.2:** The State Alliance for e-Health should recommend that all state nursing and pharmacy boards develop common core licensure application forms, and state medical boards adopt the FSMB's Common Licensure Application Form (CLAF). Individual states may include state specific requirements.

In support of the above recommendations, the Taskforce obtained the following position statements on licensure issues from various national member organizations. Concerning the issues of online licensure applications and common licensure applications, position statements are as follows:

- Federation of State Medical Boards (FSMB): The FSMB supports the work of online licensure applications and common licensure applications through the facilitation of the CLAF pilot project.
- American Osteopathic Association (AOA): The AOA supports the development of online licensure applications.
- American Medical Association (AMA): The AMA supports the FSMB's CLAF.

In an ideal world, states should implement both recommendations in concert, moving toward both the uniformity of the application and establishing an online approach. This combined recommendation advances an interconnected electronic health information infrastructure by promoting the adoption of an application system that is both uniform in its content and form as well as available online. The Alliance may consider advancing these recommendations to the states as one. However, the Taskforce did not want to condition one recommendation upon the other at the risk of alienating states that are willing to adopt a common application form, but are not prepared to implement this application online. It should be noted that in addition to the economic benefits to the states in using a common application, the administrative burdens of processing paper applications and lengthy timeframes for obtaining a license would be greatly reduced by an online application process.

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For healthcare professionals, obtaining multiple licenses may facilitate the practice of telemedicine.

The Taskforce recognizes that the need for cross-state licensure for telemedicine practice has the potential to create a backlash by state governments that may view common applications as the first step towards preempting their jurisdiction over professional licensure. <sup>25</sup> The Taskforce also recognizes that cross-state licensure encompasses broader issues than those relating to telemedicine alone. The need for multi-state licensure to practice telemedicine has focused a spotlight on the larger and more difficult question of professional licensure on a state-by-state basis versus licensure on a multi-state, regional or national basis.<sup>26</sup>

## **V. Taskforce Next Steps**

In response to its charge by the State Alliance, the Taskforce plans to continue its examination of the regulatory, legal and professional standards impacting the practice of medicine. The Taskforce plans to further examine issues that create barriers to eHIE, and discuss possible solutions with respect to streamlining the licensure process.

### **A. The Licensure Process**

The Taskforce will continue an examination general licensure models which may aid in reducing the barriers to interstate practice. Such models may include but are not limited to:

- Endorsement: State boards can grant licenses to health professionals in other states that have equivalent standards. This model allows states to retain their traditional power to set and enforce standards. Since providers must apply for a license in each state that they wish to practice, complying with diverse state requirements can be time consuming.
- Reciprocity: "Many states allow out-of-state licensed [providers] to receive an in-state license through abbreviated licensing processes such as endorsement, registration, or reciprocity. This does

not necessarily eliminate the administrative and costly burden of obtaining licenses in multiple states, but it may reduce it. However, the physician would be subject to multiple state medical board's statutes and regulations upon abbreviated application approval."<sup>27</sup>

- **Mutual recognition:** A system in which the licensing authorities voluntarily enter into an agreement to legally accept the licensure policies and processes of the licensee's home state.
- **Registration:** A model that permits a health professional who wishes to practice part-time in another state to inform the board of the other state and agree to operate under the legal authority and jurisdiction of that state.
- **Limited licensure system:** A licensure model that limits the scope of practice by allowing for the delivery of specific health services under a defined set of circumstances.
- **Certain licensure exceptions** such as the consulting exception whereby a physician who is unlicensed in a particular state can practice medicine in that state at the request of, and in consultation with, a referring physician.

The Center for Telehealth & E-Health Law (CTeL) will examine federal and state licensure laws, rules and procedures in order to identify common requirements and major areas of difference. CTeL will describe how such laws, rules and procedures permit or hinder the exchange of electronic health information including telehealth and e-mail exchanges. As part of its analysis, CTeL will explore potential liability issues that may arise as a result of current licensure

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requirements and identify states' definition of practice of medicine. CTeL will suggest solutions to permit the interstate transaction of electronic health information to support the delivery of health care. The Taskforce is due to receive this work product at the end of August 2007.

### **B. Addressing Liability**

The Taskforce will examine liability issues that may arise in the eHIE context. One issue that maybe considered is the fact that several states have mandatory professional liability coverage minimums. The Taskforce may examine the extent to which multi-state licensure should include professional liability coverage.

As part of its support for the Health Care Practice Task Force, The National Association of Attorneys General (NAAG) is reviewing liability issues arising from the exchange of electronic health information. The review includes case law from the state and federal courts and information available about cases that did not proceed to trial but were reported in the media. The purpose of the review is to identify and analyze situations where electronic transfer of personal health information, faulty technology, or misuse and failure to use health information technology could change the dynamics of risk to individuals, health care providers, and other actors in the health care arena. The review will identify several areas that may deserve heightened attention because of the potential for liability. The Taskforce is due to receive this work product at the end of August 2007.

### **C. The Exchange of State Lab Results**

The Taskforce will identify and discuss issues with respect to the exchange of state laboratory results and develop recommendations. The Taskforce will examine: patient access to information, the variation in state laws pertaining to the statutory definition of an "authorized person" to receive lab results, state law conflicts in relation to the Clinical Laboratory Improvement Amendments (CLIA), as well as regional health information organizations (RHIOs) issues and other third party matters. The Taskforce anticipates developing additional recommendations and/or policy statements on the issues discussed above and intends to provide the State Alliance with a report on additional recommendations at the next scheduled meeting.

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ENDNOTES

<sup>1</sup> Health Care Practice Taskforce official charge. <sup>2</sup> Health Care Practice Taskforce official charge. <sup>3</sup> Remote delivery differs from remote consultation, which is generally supported by current licensure models. <sup>4</sup> U.S. Department of Health & Human Services, Office of the National Coordinator for Health Information

Technology, available at <http://www.hhs.gov/healthit/foundation.html>, accessed on August 9, 2007. <sup>5</sup> Joanne Kumekawa, "Center for Telemedicine Law, Quarterly Telemedicine Licensure Update" March 1999, available at <http://www.hrsa.gov/telehealth/pubs/licens.htm>, accessed on August 6, 2007. <sup>6</sup> Ibid. <sup>7</sup> Federation of State Medical Boards, "State of the States: Physician Regulation 2007," available at <http://www.fsmb.org/pdf/FSMB%202007%20State%20of%20States%20Report.pdf>, accessed on August 6, 2007. <sup>8</sup> For more information on individual state licensure requirements and variations for with respect to physician licensure please consult the American Medical Association's "State Medical Licensure Requirements and Statistics 2007." <sup>9</sup> United States Medical Licensing Examination, "2004 USMLE bulletin," available at <http://www.usmle.org/bulletin/2004/Overview.htm>, accessed on August 7, 2007. <sup>10</sup> A majority of state boards of medicine utilize online applications for the licensure renewal process. <sup>11</sup> National Council of State Boards of Nursing, available at <https://www.ncsbn.org/126.htm>, accessed on August 7, 2007. <sup>12</sup> Ibid. <sup>13</sup> Ark. Code Ann. § 17-95-409. <sup>14</sup> New York State Education Department, "License Requirements, Physician," available at <http://www.op.nysed.gov/medlic.htm>, accessed on August 3, 2007. <sup>15</sup> Federation of State Medical Boards' Common License Application Form, available at <https://s1.fsmb.org/claf/>. <sup>16</sup> Ibid. <sup>17</sup> Email correspondence with Moira Gibbons, Legal Affairs Senior Manager, National Association of Boards of Pharmacy, July 27, 2007. <sup>18</sup> Georgia A. Martin, "Telehealth: Are you at risk?" *Nursing Risk Management* 2002, available at: <http://www.afip.org/Departments/legalmed/jnrm2002/georgia.htm>, accessed on August 9, 2007. <sup>19</sup> For a legal definition of "mutual recognition" please consult: Bryan A. Garner, *Black's Law Dictionary* 8<sup>th</sup> ed. West Publications, 2005. <sup>20</sup> Rose Gonzalez Director and Janet Haebler Associate Director Government Affairs, American Nurses Association, Testimony before the Health Care Practice Taskforce, May 30, 2007. <sup>21</sup> National Council of State Boards of Nursing, available at <https://www.ncsbn.org/1058.htm>, accessed on August 7, 2007. <sup>22</sup> National Association of Boards of Pharmacy, available at <http://www.nabp.net/index.html?target=/lictransfer/intro.asp&>, accessed on August 9, 2007. <sup>23</sup> Ibid. <sup>24</sup> National Association of Boards of Pharmacy, available at <http://www.nabp.net/competency/intro.asp#m>, accessed on August 7, 2007. <sup>25</sup> Laura Keidan Martin, "Not so fast, it's regulated: Some warnings for the e-health biz," *Business Law Today*, September/October 2000, available at <http://www.abanet.org/buslaw/blt/blt9-martin.html>, accessed on August 6, 2007. <sup>26</sup> Joanne Kumekawa, "Center for Telemedicine Law, Quarterly Telemedicine Licensure Update" Vol.1 No.2, March 1999, available at <http://www.hrsa.gov/telehealth/pubs/licens.htm>, accessed on August 6, 2007. <sup>27</sup> Thomas Wm. Mayo and Tara E. Kepler, *Telemedicine: Survey and Analysis of Federal and State Laws*, American Health Lawyers Association 2007: 16.

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**I. Introduction****California Nurses Association Position Statement on TELENURSING**

Telenursing is an emerging field that could have a major, if not a revolutionary, impact on the delivery of nursing care at intrastate, interstate as well as global levels. Questions surrounding the implications of telenursing have increased in intensity, particularly in the clinical practice settings and legislative and regulatory arenas.

As the development of telecommunication technologies continues its rapid evolution, particularly in health care, it is important that it is harnessed to best serve the individual health care, privacy and confidentiality needs of patients in California. Toward that end, the California Nurses Association has developed this position statement to reiterate its commitment to ensure that telemedicine is utilized to increase accessibility, quality, and affordability, and that registered nurses play a major advocacy role in the delivery of safe, therapeutic, effective and efficient patient care where confidentiality and privacy are protected.

The intent of this position statement is to emphasize the registered nurse's unique role in the health care delivery system, including that of a patient advocate, and that telenursing only be used to enhance and augment this unique role. It will also explore the potential of technology replacing human interaction in the delivery of health care and supplanting critical thinking and independent clinical judgment with critical pathways and other forms of artificial intelligence.

**II. Statements of the Problem**

The threshold questions are whether registered nurses in the State of California are authorized to practice telenursing. If so, how should the practice of registered nurses in telenursing be defined. Finally, are registered nurses authorized to assist physicians and others with the delivery of telemedicine and telehealth in intrastate, interstate, and global settings.

The practice of nursing over distance using telecommunication technology requires legal authorization within the state and across state lines. Multi-state regulations are currently being explored by the National Council of State Boards of Nursing, Inc., which would allow registered nurses to practice telenursing across state lines.

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Under existing California law, in order to legally practice in this cross-state manner, registered nurses are required to be licensed in every state in which they are practicing telenursing regardless of where they are physically located. Clear authority is essential since registered

nurses are directly responsible and accountable to the patients for the quality of nursing care rendered. Moreover, state government through regulatory authority has a vested interest in protecting the welfare and safety of the public.

Issues with critical implications involve accepting orders from physicians licensed in other states. In California a registered nurse is permitted to accept orders from California licensed physicians, dentists, podiatrists, or specified clinical psychologists, therefore precluding the taking of orders from the same providers licensed in another state.

**A. Authority Under the Nursing Practice Act**

The use of telenursing in providing nursing care is not specifically mentioned in the California Nursing Practice Act. Therefore, an understanding of the California Nursing Practice Act is essential in developing a response to these critical questions and in addressing the issues surrounding telenursing. Within the State of California, the statute provides clear

recognition that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. The Act further provides clear legal authority for functions and procedures which have common acceptance and usage. It recognizes the existence of overlapping functions between physicians and registered nurses, and permits additional sharing of collaborative functions within organized health care systems.

The Act defines the practice of nursing as those functions, including basic health care, which help people cope with difficulties in daily living that are associated with their actual or potential health or illness or problem or the treatment thereof including basic health care.

A more specific interpretation of the statutory definition is as follows:

Nursing is the assessing, managing and caring of human responses to health and illness which require a substantial amount of scientific knowledge or technical skills (core).

Nursing practice includes, but is not limited to, data collection; assessment; nursing diagnosis; planning, developing, implementing and evaluating programs, protocols and care plans; intervention and evaluation in the promotion and maintenance of health and  
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wellness; triage; the case-finding and management of illness, injury, or infirmity; the restoration of optimum functioning; or the achievement of a dignified death (patient).

Nursing functions include provision of health assessment; direct care and treatment services; patient advocacy; teaching; counseling; advice; applied psychotherapeutic techniques; psychosocial, psychological or mental health assessment; administration; supervision; delegation; assignment; evaluation of practice; and consultation services (RN).

In general, telenursing activities, particularly telephone advice/consultation, triage and patient education, involve basic health care and relate to activities described in the definition of nursing.

#### **B. Telenursing and the Nursing Process**

Under the Standards of Competent Performance (California Code of Regulation Subsection 1443.5 (1), Title 16), the formulation of a nursing diagnosis is a two-step approach; (1) by observing the patient's physical condition and (2) by interpreting information obtained from the patient and others including the health team.

Furthermore, Subsection 1443.5 (5) mandates that RNs evaluate the effectiveness of the care plan through observation of the patient's physical condition and behaviors, signs and symptoms of illness, and reactions to treatment and through communication with the patient and health team members, and modifies the plan as needed.

What is problematic, however, is the delivery of clinical nursing care via cyberspace without the benefit of a face-to-face, direct observation, using all senses assessment. The nursing process is severely compromised when an essential assessment component such as data collection is limited to subjective data obtained from the patient/family/others and objective data obtained from one not trained in the arts and sciences of nursing/medicine, or based on an electronic facsimile of the patient images. Moreover, even if digitized images of the patient were to be transmitted to the RN for a nursing diagnosis, is electronic observation really an observation as intended by the Nursing Practice Act. It clearly is not, for the applicable provision of the Nursing Practice Act - Business and Professions Code Section 2725 (b) (4) - requires that direct patient care includes the following:

“Observation of signs and symptoms of illness, reaction to treatment, general behavior, or general physical condition, and (A) determination

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whether the signs and symptoms, reactions, behavior, or general appearances exhibit abnormal characteristics; and (B) implementation, based on observed abnormalities, of

appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.”

Of greater concern is the delivery of critical care in the community or home care settings without the physical presence of a qualified registered nurse or physician. For example, diagnosis and management of cardiac dysrhythmia. At minimum, the physician ( authorized and qualified to practice telemedicine in the State of California) should be assisted by a registered nurse with critical care background who has demonstrated competency in obtaining and transmitting digitized images of the patient.

Finally, cyberspace diagnosis complicates and obfuscates the nursing process. Therefore, formulation of a nursing diagnosis and evaluation of a care plan can only be accomplished through direct face-to-face observation by the direct care RN.

### **C. Telenursing and Patient Advocacy**

The RN advocacy role delineated in Subsection 1443.5(6) of the California Code of Regulations (Title 16) clearly require that all RNs regardless of education preparation or credentialing including providers of direct and indirect care must act as patient advocates by initiating actions to improve health or to change decisions or activities which are against the wishes or interest of the patient. Telenursing driven care depersonalizes the relationship with patients. Unfettered telenursing will have a chilling effect on the RN’s ability to act as advocate for her/his patient.

Advocacy takes a variety of form in telenursing. First, there are concerns surrounding qualifications and authorization of consulting and/or treating physicians. Then there are serious concerns about informed consent when the patient is informed by the physician about care via telemedicine, it must include information about the nature, extent and consequences of such care, the right to refuse, and the alternatives available.

The confidentiality of the patient’s electronic medical records and the security of the patient’s identify and image during the transmission must be preserved at all cost.

Finally there are concerns about the ethicality of tediagnosis and too heavy reliance on telemedicine since there is no substitute for face-to-face interactions with the patients. Undue reliance on remote diagnosis can jeopardize the accuracy of the diagnosis and may result in harm to the patient. Such reliance will also create erosion of skill for the next

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generation of registered nurses who (unless stopped) will be trained in tasks instead of educated in skills.

As patient advocate the profession must avoid at all cost the repeat and/or perpetuation of the health care environment which existed after World War I, where working conditions were not conducive to safe and therapeutic nursing care nor for the professional development of registered nurses. Nursing became focused on tasks in order to take care of large numbers of patients. As a result, the patient’s “humanism was mechanized; his organic whole was fractured into parts, his basic physiological and technical needs were reduced to a checklist on paper. Thus, he became an automated patient.”

### **D. Conclusion**

1. Registered nurses are authorized to practice intrastate telephone advice/consultation and triage under common nursing practice and the definition of nursing provisions of the Nursing Practice Act (Business and Professions Code Section 2725).
2. The use of electronic communication technologies to provide patient-specific clinical nursing care in community-based settings without an assessment based on direct observation contravenes the principles of the Nursing Practice Act.
3. Patients requiring acute and/or critical nursing care services are not qualified recipients of

community-based telenursing. Such care must be provided in organized health care systems such as acute care settings.

### **III. Position Statements by Nursing and Health Care Organizations**

In preparation for this project, CNA wrote to all nursing organizations (specialty and nursing societies) as well as other health care associations in California. Of the many responses received, only a few have dealt with the issue and therefore have not adopted an official position with the following exceptions:

#### **A. Emergency Nurses Association (ENA) Position**

ENA has a position statement regarding telephone advice in an emergency room setting (adopted in 1991). The ENA statement indicates that "nurses should not render opinions regarding diagnosis or treatment by telephone. Rather ER nurses should inform the caller that conditions cannot be diagnosed by telephone and the caller should either go to the emergency room or see a private physician."

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The position statement does recognize that "telephone triage programs exist. ENA believes that these programs should be based on clearly defined protocols with medical direction by experienced, professional emergency staff members. A quality assurance program should be utilized to ensure quality control of the telephone triage program."

#### **B. National Rural Health Association**

The Association "recognizes that there is an ongoing process of experimentation, evaluation, and implementation of telemedicine applications in many urban and rural locations around the country, and the advocates for these technologies are numerous and enthusiastic. However, the efficacy of these methods has not been fully demonstrated. Likewise, the potential effects of their widespread implementation on the health care delivery system are unknown."

Looking at the current activities as a whole, the National Rural Health Association "believes that these technologies hold promise for improving access to health care services for rural patients."

Accordingly, the Association "favors initiatives designed to systematically evaluate these methods to encourage the development throughout the country of the communication infrastructure that supports them and to encourage implementation of telemedicine programs that enhances rural health care."

### **IV. Telehealth and Advance Practice Registered Nurses**

Proponents of telemedicine cite its potential to improve access to specialized health care in under served rural areas. Advocates of the development of extensive intrastate and interstate telemedicine systems argue that the technology offers the rural primary care provider with rapid access to speciality consultation and eliminates the need for patients to travel to distant tertiary centers. Telemedicine offers the potential for advanced practice nurses to fill the void in primary care practitioners in under served rural communities. However, caution is required where referral and/or supervision may occur over state lines.

#### **A. Authority to Practice Across State Lines**

The threshold issue is the same for all registered nurses. Licensure in California does not provide authority to practice in any other state. Other states may exercise regulatory authority over nurses who provide telenursing services to patients located in that state from an out of state location. Courts have historically given states broad authority to

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regulate out of state businesses and professionals engaging in conduct which affects residents of that state. Such authority is based on the premise that each state has an interest in protecting its residents from unqualified practitioners through its licensing system. Under

such circumstances, courts will most likely uphold a state's requirement that out of state practitioners comply with that state's licensing laws, so long as such requirements are not more stringent than imposed on in state residents and compliance is not impossible for out of state practitioners. This is essentially a question of Constitutional law and is unlikely to change absent federal legislation preempting state regulation of nursing licensure and imposing a national or regional system.

### **B. Collaborative Practice**

California has generally led the nation in expanding nursing practice to include essentially medical functions under standardized procedures jointly developed by nursing and medical staff in organized health care facilities. Nurses engaging in telenursing must exercise caution in performing those same functions in the context of telenursing across state lines. While the majority of states have enacted broadly worded nurse practice acts similar to that of California. Most do not codify the concept of standardized procedures. Therefore a nurse licensed in California, providing telephonic advice to a patient outside California pursuant to standardized procedures may be found to be practicing medicine without a license in another state. Notwithstanding that he or she is practicing appropriately within the bounds of the California Nurse Practice Act. Nurses engaging in telenursing activities must meet licensing requirements of states where patients to whom they offer advice are located. Moreover, their practice must conform with the parameters of RN practice in that state.

### **C. Professional Liability**

#### **1. Administrative Liability**

The states have the legal authority to regulate health care. The Supreme Court recognized that "the states have a compelling interest in the practice of professions within their boundaries, and that as a part of their power to protect the public health, safety and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions." (Goldfarb vs Virginia State Bar (1975) 421 U.S. 773, 792). All states require the registered nurse to be licensed in that state in order to practice in that state. Failure to comply constitutes practicing nursing without a license. While the precise consequences of practicing without a license vary from state to state, the offense is generally punishable by a fine and/or imprisonment. In California,

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practicing nursing without a license is a misdemeanor punishable by imprisonment for up to one year and a fine up to \$1000.00. (Business & Professions Code § 2799).

To date, few state boards of nursing have begun to address this issue directly. Medical Boards in several states have addressed the issue of out of state physicians practicing telemedicine in their state. For example, in 1995 Texas amended its' Medical Practice Act to require physicians practicing telemedicine in Texas from other states to be licensed in Texas. Texas exempts physicians from out of state whose contact within Texas occurs only episodically and at the request of a Texas physician. Some states have proposed completely eliminating statutory consultation exemptions for telepractitioners. Even states which permit consultation exemptions have tightened them by prohibiting out of state physicians from establishing telemedicine links within state hospitals and physicians. Given the current status of state regulation, change appears unlikely without federal action. For the present time, nurses practicing in a telenursing setting are well advised to be licensed in each state where they or their employer has regular contact with patients.

#### **2. Civil Liability**

Telenursing across state lines may expose the registered nurse to civil lawsuits by patients treated in other states. A lawsuit for professional negligence may be brought by an out of state patient in California. However, it is highly probable that the patient could bring the

California registered nurse before the courts in another state. A single telephonic contact may be sufficient grounds to do so. Courts have found that intentional and recurrent contact by an out of state business or professional will be sufficient for the State to exercise jurisdiction over the business or individual located out of state.

The issue of professional negligence in telemedicine per se has not yet been addressed in any reported cases. However, the issues are similar to a number of cases, in several states, where the question of professional negligence involved telephone contact between patient and nurse or physician, or between referring and consulting physicians. Courts which have addressed the issue have found that a medical consultant who offers only an informal opinion or recommendations has not established a duty of care. This may be analogous to telephone situations where the nurse offers general information only, but does not give individual advice.

In contrast, in a number of cases courts have found that a physician consulting with or about a patient by telephone establishes a physician-patient relationship and can be sued for professional negligence. Those situations may be sufficiently similar to the conduct of a registered nurse in the context of telenursing to adapt some of the same criteria. A

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nurse patient relationship, and thus liability for professional negligence, may be found where one or more of the following criteria exist: (1) the patient obtained or relied on advice from the nurse; (2) there was direct contact between the patient and the nurse; (3) the nurse performed an assessment, or had the opportunity to do so; (4) whether the patient was referred to the nurse for treatment or consultation; (5) whether the nurse reviewed (or had access to) the patient's medical record; (6) whether the patient was charged for the service; and (7) whether the nurse had any authority or control over the patient's care. Many of these criteria are applicable to telephone triage or advice line transactions, commonly occurring today. It is highly likely that a nurse and/or her employer would be held liable for negligent acts or omissions in telephone advice which cause a patient harm.

#### **D. Reimbursement**

The California Department of Health Services promulgated its initial Medi-Cal reimbursement policy for telemedicine consultations. Medi-Cal will only reimburse telemedicine providers if the DHS has verified that the services provided are equivalent to services which would be provided in a face-to-face setting. Telemedicine services Providers are required to use interactive audio-video systems. The health care provider must, at a minimum, be able to visually examine the patient's entire body, including ear canals, nose and throat, as well as the capability of hearing heart and lung sounds clearly using a stethoscope. In order to receive reimbursement, the DHS policy requires the provider to be licensed in California. If operating from outside California, the provider must also be licensed in the state from which they are operating. Providers with the ultimate responsibility for the patient's care must obtain verbal and written consent from the patient. Images or information cannot be disseminated without additional written consent of the patient. Telephone conversations, E-mail or facsimile transmissions between practitioner and patient are not deemed telemedicine and will not be reimbursed. DHS will review telemedicine programs individually, prior to authorizing reimbursement. The cost of telemedicine equipment and transmission is not reimbursable by Medi-Cal.

#### **E. Federal Reimbursement**

In October 1996 the Health Care Financing Administration (HCFA) started a three year, four state demonstrations project for Medicare telemedicine reimbursement. HCFA selected five networks as participants in the demonstration project, but only three are submitting claims. Medicare reimburses telemedicine consultants at the same rate as for an "in person"

encounter. However, the presenting provider is paid only half of the standard rate. Demonstration networks also complain about slow reimbursement and a requirement for interactive audio-video teleconferencing capability. Critics site low Position Statement on Telenursing page: 10 reimbursement and the expense associated with the necessary telemedicine equipment as reasons for limited participation in the pilot project.

#### **V. Definition and Types of Telehealth, Telemedicine, Telenursing and Other Transactions Via Electronic Telecommunications**

A working definition of telenursing is as follows: "Telenursing is the practice of nursing over distance using telecommunication techniques." (National Council of State Boards of Nursing, Inc.)

Telemedicine has been defined as: "The use of information technologies such as satellite transmission, video conferencing or electronic data transfer for health care education, consultation and delivery."

Examples of Common Electronic Transactions: Telephone triage, advice and consultation are becoming extremely common.

Videoconferencing for grand rounds and medical education between major teaching hospitals and satellite hospitals.

Electronic stethoscopes, microscopes and imaging equipment that transmit results to remote locations for reading, interpretation and analysis are used in many states and remote clinics. The use of new devices which monitors ECG and oxygen-saturation levels through a transmitter. This device also allows physicians to monitor a patient's status in real time through a remote PC.

The creation of a joint venture in Florida between prisons and nearby medical facilities. The aim of the project is to reduce the number of transfers of inmates and so save on costs. This is to be achieved through the use of electronic measurement and assessment then transmission of tests to a central hospital location where the results are assessed by a nurse.

The use of an at-home monitoring device by many elderly people. This device gives voice commands to the person on how to use its vital sign monitoring equipment. It then transmits the information to a central nurse's station, either in a hospital or a home health agency. In addition, this telemedicine device asks or reminds patients at scheduled intervals to take their medication, eat properly, and

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change dressings on wounds. The device is programmed to contact the nurse when vital signs do not meet parameters or the patient does not respond. The nurse can see video of the patient, though the company admits that currently the standard of video is not high.

#### **A. Regulation of Telehealth/Telemedicine**

There is currently a limited body of law which regulates or governs transactions which occur solely in cyberspace. Before a state has regulatory jurisdiction over a telehealth/telemedicine provider, it is important to discern where the treatment, consultation, or any other transaction occurred.

Where the transmission occurs within the state of California involving providers or entities licensed by the State of California, the regulatory jurisdiction is clear. The question is whether California can find some means to legally justify imposing its regulatory jurisdiction on an out of state provider or entity. In 1994 California introduced the first ever legislation regulating telemedicine. Subsequently California enacted the Telemedicine Development Act of 1996 which, amongst others, requires the Department of Health Services to prepare a report for the Legislature by January 1, 1999 regarding the quality of health care provided by telemedicine. The proponents argued that the new law will greatly enhance the quality and

comprehensiveness of health care services to homebound patients.

Effective January 1, 1997, private health insurance and managed care plans are required to integrate telemedicine into their existing reimbursement policies and procedures. This is presumably a flexible approach which will allow private payers to phase in telemedicine reimbursement and treat telemedicine in a similar manner as traditional face-to-face care. California's Medi-Cal Program is also required to have a telemedicine reimbursement policy in place by July 1, 1997. Face-to-face contact between the health care provider and the patient is no longer a requirement.

Another chaptered piece of legislation introduced by the Medical Board of California (SB 2098-Kopp) addresses the issue of telemedical practitioners. The new law authorizes the Board to develop a registration program to permit out-of-state physicians to practice in California via telemedicine. The Board is charged with the development of a Registration Program to be approved by the Legislature.

The main concerns are patient protection and minimum qualifications requirements. A further concern is that telemedical practice can be conducted outside the scope of existing Position Statement on Telenursing page: 12

peer review mechanisms and the practice of medicine across state lines can create risks to efficient quality control and enforcement by the Board.

So far only a handful of states have taken a position on licensure requirements of Telehealth providers (Florida, Nevada, Texas to name a few). In contrast, there are no existing requirements on licensure of telehealth providers other than physicians.

#### **B. Conclusion**

Until further clarification and analysis of applications and implications of the Medical Board's of California physician registration program, registered nurses are precluded from accepting orders from physicians, dentists, podiatrists or clinical psychologists not licensed in the state of California.

#### **VI. Artificial Intelligence in Medicine and Nursing**

There are many presumed appropriate applications of artificial intelligence in medicine and nursing.

Artificial Intelligence has been defined as a multi-disciplinary field encompassing computer science, neuroscience, philosophy, psychology, robotics, and linguistics: devoted to the reproduction of the method or results of human reasoning and brain activity.

The application and form of electronically stored medical information have a direct impact on the design of any health care delivery system. The PC based multi-media biomedical library developed for NASA was originally intended for long term space missions where complete isolation support was a distinct possibility.

One fact is certain; machines are only good for storing information. Machines cannot think, analyze or reason as health care professionals do, nor are they educated or capable of critical thinking or capable of making split second judgments in crisis intervention situations. Machines are capable of quantifying data but it will take a qualified professional to interpret the data otherwise it is meaningless. At issue here is will the profession control technology or will technology control the profession.

Certain artificial intelligence software packages like "expert systems," represent an attempt to use a computer to store and apply the knowledge of an expert. They have been tried extensively in medicine, especially for diagnosis and prognosis.

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#### **A. Medical Expert Systems**

Expert systems can be divided into three groups: 1. Medical Diagnostic Programs

Diagnostic programs have been around since the 1950s. From hardware to software this artificial intelligence program is used by physicians to diagnose diseases. The physician enters the symptoms, test results, and medical history into the program, which then suggests a list of possible diagnoses.

These “knowledge-based” computer software programs are known as medical expert systems (MESs) and are becoming more widely available to the public. While MESs allow medical diagnosis with the touch of a finger, the widespread use of MESs carries the risk of product caused injuries to users particularly when used without physician supervision. The most obvious danger of unsupervised patient at-home use is incorrect diagnosis by MESs, resulting in patients improperly treating their ailments.

## 2. Protocol Programs

Standardized care using patient protocols or routines have been around since the mid-1970s. Clinical pathways are also called critical paths, care maps, collaborative plans of care, multi disciplinary action plans (MAPS), and anticipated recovery paths are interdisciplinary patient care plans that delineate assessments, interventions, treatments and outcomes for specific health-related conditions across a designated time line. As a case management tool, they can be developed for surgical procedures, medical diagnosis, and health related interventions.

## 3. Prognostic Programs

These programs are used to calculate the chances of a critically ill patient survival for a given disorder or predicting patient outcomes based upon patient physiology. The program recommends withholding of any treatment if the chances of survival fall below the percentage calculated by the program. Thus, in accordance with the current economic politics of corporate health care, it is generally used as a means to deny care thereby generating revenues. Furthermore, the large scale exclusion of negative

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events from the data systematically corrupts quality data, ultimately resulting in artificial inflation of quality outcomes (also known as elegant mathematics).

## **B. Medical Informatics**

Medical informatics are not simply medical computing, telecommunications, or information engineering, but presumably a dialogue among physicians, patients, and medical informaticians --specialists in medical information. Medical informatics claims to be a science that seeks and develops new knowledge, which purportedly builds new theories, and organizes principles and solutions based on results of previous experiments. Because informatics are so essential to the practice of medicine and develop tools to solve real problems in every day clinical practice, investigators in cognitive sciences and artificial intelligence have often sought this arena for exploring their hypothesis.

Although there is not a widespread use of nursing informatics, the challenge for the nursing profession is to define the appropriate means by which the potential uses of such informatics is realized.

## **C. Demand Management and Information Therapy Also-Known as the “No Care Zone”**

Proponents of demand management are celebrating the demise of managed care and are welcoming the long awaited demand management health care delivery system where a self diagnosis and self triage is accomplished through the use of hardcopy and/or software medical information systems. Demand management uses decisions and self- management support systems to mobilize consumers and help them decide how, where, when, and why to use health care services by incorporating teleservice technologies, triage, algorithm-driven care guidelines, and provider data bases.

In the future demand management may very well link up with “Information Therapy” a term first utilized in 1992. Information therapy is described as the use of medical information as a

form of therapy similar to drug therapy, physical therapy or any other form of medical therapy. Studies indicate that information and the process of seeking medical information can empower patients as well as improve medical outcomes while lowering medical costs. This is an area which demands further investigation and it is anticipated that information therapy will become an important therapeutic concept in the near future.

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#### **VII. Telepresence Surgery**

There have been other applications for medical technology:

This type of surgery is a novel technology that will allow procedures to be performed on a patient at locations that are physically remote from the operating surgeon. This new method provides the sensory illusion that the surgeon's hands are in direct contact with the patient. In its experimental stage, vascular surgeons studied the feasibility of the use of telepresence surgery to perform basic operations in vascular surgery, including tissue dissection, vessel manipulation and suturing.

#### **VIII. Privacy and Protection of Individually Identifiable Health Information**

Private health information is being shared, collected, stored and transmitted across state lines without state and/or federal safeguards. Currently only credit, video, and motor vehicle records are protected from unauthorized disclosure by federal privacy safeguards ( Federal Privacy Act).

Revolutions in both health care communications ( computerized medical records) and biology (genetic information/research to help prevent disease) caused the federal government to strongly urge Congress to develop and adopt a comprehensive measure to protect the privacy of medical records, to guarantee to consumers the right to inspect their records and to punish unauthorized disclosures of personal health data by hospitals, insurers, health plans, drug companies and others.

#### **Problem Statement**

There have been many instances where the patient's or consumers' privacy were violated: Electronic records make it easier to snoop or engage in chart browsing which creates some concerns since hospital mergers have made it more likely that employees will receive medical care from their own institution. The most likely targets are certain patients, hospital employees, celebrities, and patients with sensitive diagnoses.

Electronic medical records are pooled for nonmedical reasons such as cost containment studies; financial viability (a banker on the board of a state health commission retrieves the names of cancer patients with loans at his bank and calls in the loan).

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Drug companies are using electronic medical records to market new remedies to people suffering from a specific condition and health plans and life insurance companies looking for new costumers.

Most disturbing is the potential for misuse (genetic discrimination) of information gleaned from genetic testing since scientists are now able to predict, with increasing regularity, the genetic abnormalities that may affect a person's health. For example, genetic information used to identify a person's remains may be disclosed to another source and then used to deny insurance for that person's relatives. Such information being released without their knowledge and consent. As more genetic links to disease and behaviors are discovered, this information becomes more precious to insurers and others.

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#### **RECOMMENDATIONS**

1. Oppose any and all technologies which are developed to maintain a health care system driven by private interest rather than the individual health care needs of an entire population;

information systems which do not provide for competent human intervention;  
computers/software or medical equipment which is used to supplant instead of supplement health care providers/givers skilled judgment.

2. Oppose any or all forms of automation which replace health care professionals with technology or force them to keep pace with machines or interfere with the face-to face, hands on "therapeutic touch" by health care professionals.

3. No disclosures of health information or genetic information without informed consent of patient and affected parties. Health care and genetic information about consumers should be disclosed for health purposes and/or research only. Under no circumstances can health information be used for hiring, firing, promotion or to deny affordable health insurance or in any other way infringe on one's civil rights.

4. Individuals or entities who legally receive health information must be required to safeguard the information or be subjected to legal or disciplinary sanctions when trading such information for economic gains or undue advantage.

5. There will be no sanctions against registered nurses or other health care workers for disclosing health information or records to authorized public officials for the purpose of patient advocacy and protecting the public interest

6. Encourage the use of technical security safeguards like audit trails, security codes, scrambling devices, passwords or electronic blocks. Encryption of confidential information transmitted via Internet or other on line means. Support legislation to classify Medical Expert Systems (MESs) as products, not services, giving injured patients the right to litigate any injuries resulting from the use of such systems in the courts, pursuant to product liability principles.

7. Sponsor or support regulations or legislation to assure the strictest regulation of Medical Expert Systems (Class III) medical devices, where such systems are to be marketed to the consumer for use without the supervision and intervention of a registered nurse or physician.

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Approved by the CNA Board of Directors, May 1998.

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#### **SELECTED DEFINITIONS**

**Administrative Agency** - a governmental body charged with administering and implementing particular legislation. Examples include the California Board of Registered Nursing and the California Medical Board.

**Administrative Liability** - liability which may be incurred by the individual who holds a license to practice as a registered nurse, physician, or any other profession licensed and regulated by a given State. Administrative liability involves a violation of laws, regulations, rules, orders or decisions promulgated by an administrative agency charged with the authority to regulate the practice of the licensee's profession. Administrative action is taken by the State against the licensee as a form of consumer protection.

**Artificial Intelligence** - a multi-disciplinary field encompassing computer science,

neuroscience, philosophy, psychology, robotics, and linguistics: devoted to the reproduction of the method or results of human reasoning and brain activity.

Civil Liability - liability which may be incurred by one individual for damages or injury he or she has caused to another person. In the health care context civil liability commonly involves an allegation of professional negligence against a nurse, physician or health care facility.

Civil liability may also include allegation of intentional bad acts, not limited to assault, battery, and infliction of emotional distress.

Demand Management - uses decisions and self-management support systems to mobilize consumers and help them decide how, where, when, and why to use health care services by incorporating teleservice technologies, triage, algorithm-driven care guidelines, and provider data bases.

Information Therapy - the use of medical information as a form of therapy similar to drug therapy, physical therapy or any other form of medical therapy.

Nursing Practice - those functions, including basic health care, which help people cope with difficulties in daily living that are associated with their actual or potential health or illness or problem or the treatment thereof including basic health care.

Telehealth - the use of electronic communications networks for the transmission of health information and data.

Telenursing - the practice of nursing over distance using telecommunication techniques.

Telemedicine - the use of electronic communication networks for the transmission of information and data related to the diagnosis and treatment of medical conditions.

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## Attachment B

### NURSE LICENSURE COMPACT STATES

State	Date of Implementation
1. Arizona	July 1, 2002
2. Arkansas	July 1, 2000
3. Colorado*	October 1, 2007
4. Delaware	July 1, 2000
5. Idaho	July 1, 2001
6. Iowa	July 1, 2000
7. Kentucky	June 1, 2007
8. Maine*	July 1, 2001
9. Maryland	July 1, 1999
10. Mississippi	July 1, 2001
11. Missouri	June 1, 2010
12. Nebraska*	January 1, 2001
13. New Hampshire	January 1, 2006
14. New Mexico	January 1, 2004
15. North Carolina	July 1, 2000
16. North Dakota	January 1, 2004
17. Rhode Island	July 1, 2008
18. South Carolina	February 1, 2006
19. South Dakota	January 1, 2001
20. Tennessee	July 1, 2003
21. Texas	January 1, 2000
22. Utah	January 1, 2000
23. Virginia*	January 1, 2005
24. Wisconsin*	January 1, 2000

\*Fingerprinting Not Required