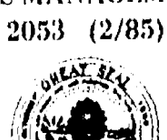
# MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M



ROLL NUMBER

1150

DESCRIPTION

2001 HOUSE JUDICIARY

HB 1150

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1150

House Judiciary Committee

☐ Conference Committee

Hearing Date 02-07-01

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| TAPE II | | x | 2798 to 6242 |
| TAPE III | | | 01 to 726 |
| | | | |
| Committee Clerk Signature | Joan Dura | | |

Minutes:Chairman DeKrey opened the hearing on HB 1150. An act to allow certain administrative agencies to enter into licensing compacts with other states.

Constance Kalanek: Executive Director of the North Dakota Board of Nursing (see attached testimony)

Chairman DeKrey: can you tell me how Nor Dakota compares with the nurses in Minnesota, South Dakota and Montana.

Constance Kalanek: Nurses do not have to write the test, their license is by endorsement.

Chairman DeKrey: So a nurse would only have to write the test in one state?

Constance Kalanek: Every state recognizes the license of North Dakota.

Chairman DeKrey: How will the compact help, would it speed up in any way, nurse licensing?

Constance Kalanek: A multistate licensure would allow the nurses to move across borders when their jobs take them there, such as clinics etc.

Rep Klemin: Would they be licensed just in North Dakota.

Constance Kalanek: They would be licensed in both states.

Rep Klemin: Even if they started in North Dakota?

Constance Kalanek: They would pay for a license in both states.

Rep Klemin: Is this an issue of licensing fee?

Constance Kalanek: This is an issue of licensing, it would be one license issued.

Rep Klemin: One fee and they could practice in all 13 states of the compact.

Constance Kalanek: Correct.

Rep Klemin: Then to me it is a fee issue.

Constance Kalanek: It allows the nurses the flexibility.

Rep Klemin: In a compact, how do you monitor nurses?

Constance Kalanek: A nurse is accountable to the Care Act in the state where the patient is.

Rep Klemin: In the new system, how will you keep track of the disciplinary action.

Constance Kalanek: There is a national data bank that does that.

Rep Klemin: Does a nurse have to obtain a multi state license.

Constance Kalanek: This hasn't been an option before.

Rep Grande: What is the fee for North Dakota?

Constance Kalanek: $50.00 for an LPN a renewal and $60.00 for an RN.

Rep Grande: what is the South Dakota fee?

Kalanek: It is similar to ours.

Rep Grande: I would like to see that information.

Constance Kalanek: You would pay a license o what is required in only one state.

Rep Grande: Do you have to have the same qualifications?

Constance Kalanek: When the compact is made, it has to be as least as the state you have your license in.

Rep Grande: Are there other states higher than North Dakota, do we have to change.

Constance Kalanek: At this point, there is not state higher then North Dakota.

Rep Grande What is the difference then.

Constance Kalanek: the fee.

Rep Grande: Will we have some in North Dakota with the compact license and some without.

Constance Kalanek: Not clear on your question, but anyone who meets the standards gets a multistate license.

Rep Klemin: At present North Dakota requires a bachelor degree.

Constance Kalanek: True.

Rep Klemin: Will all the states have to obtain a bachelor degree?

Constance Kalanek: If they do not have a bachelor degree they will be issued a transite license.

Rep Klemin: They can still come into North Dakota.

Constance Kalanek: If they do not met the full requirements, they can do continuing education to met the standards.

Rep Klemin: It will be easier to leave North Dakota, but harder for nurses to come in.

Constance Kalanek: We have higher standards, but this would allow clinics to have nurses move between states.

Rep Brekke: Does this apply to RN and LPN?

Constance Kalanek: Yes.

Chairman DeKrey: If no further questions, thank you for appearing.

Deborah K Johnson: President of the North Dakota Board of Nursing (see attached testimony)

TAPE III SIDE A

Deborah Johnson continues her testimony. Questions were asked of Ms Johnson.

Chairman DeKrey: If there are no further questions, thank you for appearing.

Jim Flemming: Attorney General Office, we are neutral on the bill. A senate bill has somewhat of the same approach to this issue.

Chairman DeKrey: If there are no further questions, we will close the hearing on HB 1150.

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1150a

House Judiciary Committee

☐ Conference Committee

Hearing Date 02-12-01

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| TAPE 1 | | x | 2280 to 2515 |
| | | | |
| | | | |
| Committee Clerk Signature | J. Rae Dietz | | |

Minutes: Chairman DeKrey: we are going to take a look at HB 1150. That was the bill from the State Board of Nursing, they have told us to do a DO NOT PASS motion, because their bill SBA 2115, passed in the Senate and they no longer need this bill.

COMMITTEE ACTION

Rep Maragos moves a DO NOT PASS motion, Rep Mahoney seconded the motion. The clerk will call the roll on a DO NOT PASS motion on HB 1150. The motion passes with 14 YES, 0 NO AND 1 ABSENT. Carrier is Rep Brekke.

Prepared by the North Dakota
Department of Human Services
1/31/01

**PROPOSED AMENDMENTS TO HOUSE BILL NO. 1150**

Page 1, line 10, after "." insert "This section does not apply to programs or treatment centers licensed pursuant to North Dakota Century Code chapters 25-03, 25-16, or 50-06."

Renumber accordingly

Date: 02-12-01
Roll Call Vote #: 1

## 2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
## BILL/RESOLUTION NO. HB-1150

House JUDICIARY Committee

☐ Subcommittee on

or

☐ Conference Committee

Legislative Council Amendment Number

Action Taken Do Not Pass

Motion Made By Rep Maragos Seconded By Rep Mahoney

| Representatives | Yes | No | Representatives | Yes | No |
|---|---|---|---|---|---|
| CHR - Duane DeKrey | ✓ | | | | |
| VICE_CHR --Wm E Kretschmar | ✓ | | | | |
| Rep Curtis E Brekke | ✓ | | | | |
| Rep Lois Delmore | ✓ | | | | |
| Rep Rachael Disrud | | | | | |
| Rep Bruce Eckre | ✓ | | | | |
| Rep April Fairfield | ✓ | | | | |
| Rep Bette Grande | ✓ | | | | |
| Rep G. Jane Gunter | ✓ | | | | |
| Rep Joyce Kingsbury | ✓ | | | | |
| Rep Lawrence R. Klemin | ✓ | | | | |
| Rep John Mahoney | ✓ | | | | |
| Rep Andrew G Maragos | ✓ | | | | |
| Rep Kenton Onstad | ✓ | | | | |
| Rep Dwight Wrangham | ✓ | | | | |

Total (Yes) 14 No 0

Absent 1

Floor Assignment Rep Brekke

If the vote is on an amendment, briefly indicate intent:

**REPORT OF STANDING COMMITTEE (410)**
**February 12, 2001 12:09 p.m.**

**Module No: HR-26-3037**
**Carrier: Brekke**
**Insert LC: . Title: .**

## REPORT OF STANDING COMMITTEE

**HB 1150: Judiciary Committee (Rep. DeKrey, Chairman)** recommends **DO NOT PASS** (14 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1150 was placed on the Eleventh order on the calendar.

2001 TESTIMONY

HB 1150

# NORTH DAKOTA BOARD OF NURSING

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Judiciary
~~HUMAN SERVICES~~ COMMITTEE

## TESTIMONY RELATED TO HB 1150

DeKrey Judiciary
Chairperson ~~Lee~~ and members of the ~~Human Services~~ Committee, my name is Constance Kalanek, Executive Director of the North Dakota Board of Nursing.

**On behalf of the board, I wish to offer testimony in support of HB 1150 relating to the Administrative Agency Compacts. The focus of my testimony is on multistate licensure compacts. The Attorney General's Office has also introduced legislation in SB 2115 relating to the practice of a regulated occupation or profession that substantively contains the intent of HB 1150.**

As multistate health care delivery systems and telecommunications technology has emerged, attention has been drawn to the perceived barriers created by a state-based licensure system. The primary issue faced by the nursing regulatory community has been the increasing practice of nursing across state lines. The geographic borders that separate states and their traditional practice area jurisdictions have been removed by technology. Unless a model of nursing licensure accommodates the nurse and the patient being in different locations, nurses may be practicing without appropriate legal authority if the nursing care processes cross-state lines. I have attached for your review an opinion provided by the Board's attorney Mr. Cal Rolfson entitled "Opinion Regarding Practicing Nursing by Telecommunication Across State Lines".

In an effort to proactively respond to this issue, the North Dakota Board of Nursing has been studying the current model of nursing licensure and has conducted a comprehensive review of the interstate compact and its implications. The Board of Nursing established a Multistate Licensure Advisory Task Force in 1998 composed of representatives from nursing and medical organizations, health care organizations, state government, legislators, and consumers. The committee has met several times over the last two and one-half years. In September 2000, the Task Force recommended to the Board of Nursing to draft legislation on licensure compacts that would

include all professional and occupational boards. The minutes are attached for your review.

**In September 2000, the MULTISTATE LICENSURE ADVISORY TASK FORCE** requested dialogue with boards and associations in North Dakota on license compact legislation. Since many regulatory boards could potentially be impacted by multistate licensure, the Task Force asked for input on this proposed legislation. The board surveyed 32 boards, associations, and individuals for input/reaction to the licensure issue. The board received fourteen responses, seven were not opposed, one very interested and took no position, one did not support, four supported, and one indicated they were neutral.

One of the key elements of this model (multistate licensure) of licensure is the interstate compact. An interstate compact is an agreement between two or more states established for the purpose of remedying a particular problem of multistate concern. The model provides that the practitioner is held accountable for the practice act and other regulations in the state where the professional provides nursing services to the citizens of that state. This accountability is similar to the motor vehicle driver who must obey the driving laws in the state where driving occurs.

Implementation of the multistate licensure model will proceed as individual state legislatures adopt the interstate compact and become a party to the compact. It is anticipated that it will take some time for a large number of states to become a party to the compact. To date thirteen states, including South Dakota, Iowa and Nebraska have passed legislation to enact the compact for nursing regulation. The board of nursing is aware of ten states that intend to address multistate licensure through rules or legislation in the next three years.

I have attached for your review a handout from the National Council of State Boards of Nursing entitled, Frequently Asked Questions. I have also attached a list of the states that have either implemented the compact or soon will be doing so. Hopefully, this information may be useful in your deliberation of this proposed legislation.

CONCLUSION

The Board of Nursing believes this legislation is a viable option which would increase access to care while maintaining public protection, allows for expedient access to qualified practitioners as expected by the consumer

without regard for state lines, and allows for practice across state lines either physically or electronically.

Individual licensed nurses are always held accountable for their actions. The nurse who practices under a multistate licensure privilege is held accountable to the state's practice act where nursing services are provided. As expected, the board will continue to carry out its mission as to the safety of the specific nursing practices, protection of the public and the provision of competent practitioners. Thank you for giving me the opportunity to provide testimony on behalf of the North Dakota Board of Nursing. The Board appreciates your willingness to consider a proactive approach to licensing practitioners in North Dakota and your support for HB 1150.

I am now open for questions.

# MULTISTATE LICENSURE ADVISORY COMMITTEE
## September 13, 2000
## 10:00 – 11:00 AM
## IVAN TELECONFERENCE

## MINUTES

Present: Board Members None; Participants present were: Elizabeth Nichols RN, CUNEA, Grand Forks; Deb Haagenson RN, Fargo; Arnold Thomas, ND Health Care Association; David Peske, North Dakota Medical Association; Melana Howe, RN, Hettinger; Sharon Moos, RN, Executive Director of North Dakota Nurses Association; Elaine Taylor, LPN, NDLPNA; Staff: Karla Bitz RN; Linda Shanta RN; Julie Schwan, Cal Rolfson, Attorney at Law; and Constance Kalanek RN.

I. Rule-making. Cal Rolfson provided a summary of the legislative versus rule promulgation process. A videotape of Mr. Rolfson's summary is available upon request through the board office. A copy of the legislation currently in effect in Maine was reviewed and is attached. (See Sec. C-7.10 MRSA)

II. Fiscal Impact. Connie Kalanek reviewed the anticipated revenue loss for MSL participation. The potential estimated loss of revenue through renewal fee is approximately $42,050.00 and loss of endorsement fee is $8,400. This is a loss of 11% of the total budgeted income each fiscal year. The board has not projected the cost of implementation of a multistate licensure system.

III. Organizational Perspective. Melana Howe reported on the impact of MSL on the West River Health Services. The organization spends approximately $1100 each year on licensure fees for nurses. The organization pays for the second license when the nurse is employed to practice in more than one state. WRHS has a low turn over rate and have not had recruitment problems of qualified personnel.

IV. Discussion.

- The committee discussed the rule making process as it relates to multistate licensure compacts.
- A number of participants discussed the operational issues and tracking responsibilities of employers.
- Revenue loss was discussed. The board has not projected the cost of implementation of a multistate licensure system.
- Discussed drafting legislation that would be similar to the Maine document, which includes professional groups without specifying any one group.
- Discussed support from North Dakota Nurses Association and North Dakota Health Care Association for using a legislative process similar to Maine.
- Discussed the political ramifications and process related to proposing this type of legislation.

V. Recommendations

1. Present this discussion at the next board meeting on September 21-22, 2000.

VI. Adjournment. Meeting adjourned at approximately 9:50 AM.

**Next Meeting: NONE SCHEDULED.**

ROLFSON SCHULZ LERVICK
LAW OFFICES
A PROFESSIONAL CORPORATION

August 25, 1995

Karen Macdonald, R.N.
Executive Director
N.D. Board of Nursing
919 S. 7th St., Ste. 504
Bismarck, ND 58504

**Re: Opinion Regarding Practicing Nursing by Telecommunication Across State Lines**

Dear Ms. Macdonald:

This is in response to your request for my opinion concerning the legal impact of telecommunication of nursing data across state lines and its effect upon the Board's responsibility to regulate nurses and nursing practice within North Dakota. In particular, you ask whether nurses not licensed to practice nursing in North Dakota who provide nursing care through telecommunication to North Dakota residents are required to hold a North Dakota nursing license. Your letter cites several examples of how recent communications technology and increased offerings of managed care allows nurses to utilize that technology without a physical presence in North Dakota.

Some initial observations come to mind. It is clear that the North Dakota Board of Nursing (the "Board") cannot prevent North Dakota citizens from unilaterally seeking and contacting out-of-state health care providers, including nursing and medical providers for their health care needs. There is (or ought to be) a sort of "caveat emptor" (buyer beware) principle that applies when a North Dakota consumer personally seeks out-of-state health care services from professionals that are beyond the borders of our state and thus outside the gamut of North Dakota health care regulators. That caveat applies (or ought to), for example, whether the North Dakota resident drives to Minnesota to receive direct medical care there or whether it is received while within the borders of North Dakota via telecommunications from out-of-state health care givers.

The problem arises when errors in professional nursing practice occur and the patient's health and safety is jeopardized as a result. If those errors occur in Minnesota while the patient is present there, for example, the patient potentially has both civil (malpractice) and administrative (licensure) recourse in Minnesota, and questions of jurisdiction and residency or citizenship do not

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ROBERT H. LUNDBERG, OF COUNSEL

generally surface. However, when care is rendered by way of an interstate telephone line, the regulatory focus becomes cloudy.

The four examples you cite pose real regulatory dilemmas for the Board. Since the Board's authority to regulate at all comes from state law and supporting rules, it is necessary to briefly examine those underpinnings of authority.

## APPLICABLE STATE LAW AND RULES

Chapter 43-12.1 establishes legislative authority in the Board to regulate the "practice of nursing." N.D.C.C. § 43-12.1-02 defines the practice of nursing for both registered nurses and licensed practical nurses. N.D.C.C. § 43-12.1-03 specifically requires that "[a]ny person" providing such nursing care to a resident "of this state" must hold a current valid license to do so from the Board.

N.D.C.C. § 43-12.1-04 sets out those persons who are statutorily exempt from such licensure, which includes the following exemptions:

1. In cases of emergency or disaster.

2. Students practicing nursing as part of a Board approved nursing education program.

3. Duly licensed nurses from another state who are employed by the federal government.

4. Duly licensed nurses in another state or Canada whose employment requires them to accompany and care for a patient in transit.

5. Providing nursing for an immediate family member.

6. A person who is not licensed as a nurse by the Board who renders assistance under the provisions of N.D.C.C. Ch. 23-27 (Licensing of Ambulance Services).

7. Certain individual habilitation or case plan services.

The rules adopted by the Board relevant to this issue generally include the provisions of N.D.A.C. Chs. 54-02-07 (Disciplinary Action), N.D.A.C. 54-05-01 (Standards for Quality of Practice for Licensed Practical Nurses), N.D.A.C. 54-05-02 (Standards for Quality of Practice for Registered Nurses), and N.D.A.C. 54-05-03.1 (Advanced Registered Nurse Practice).

It is clear that the principal statutory direction and responsibility of the Board is to protect the health and safety of the public through the regulation of nursing practice occurring within the borders of this state. N.D.C.C. § 43-12.1-01. The statement of legislative intent found in this statute explicitly states that "...the practice of nursing is directly related to the public welfare of the citizens of the state of North Dakota..." and the public interest requires that the Board "...assure that qualified, competent practitioners and high quality standards..." are maintained. (Emphasis added). Id.

This introductory policy statement of legislative intent, as with all other laws affecting the Board, is liberally construed. N.D.C.C. Section 1-02-01. The North Dakota Supreme Court has also underscored the direct responsibility of the Board of Nursing to protect North Dakota citizens and through its regulatory process to assure responsible nursing practice within its borders. Trinity Medical Center et al. v. North Dakota Board of Nursing et al., 399 N.W.2d 835 (N.D. 1987).

In light of the "information superhighway" as that term has come to be commonly used of late, interstate telecommunications regarding health care (telephone, television, facsimile, and computer technology are examples) have not only impacted the general public with new challenges offering immediate access to interstate health care provision, but also have required boards of nursing (and other health care licensing boards) to face unique licensure issues. "Telemedicine" is rapidly becoming an expanded high-tech genre of health care that permits North Dakota health care licensees and their clients to participate in live interactive video and computer linking with health care professionals and specialists in other states. This is particularly helpful with patients/clients in North Dakota who live in communities that may be isolated from technical and sophisticated advances in health care that are more common in larger urban areas out of state. However, the statutory responsibility of the North Dakota Board of Nursing to protect the citizens of this state remains unchanged in spite of such advancements in telecommunications.

Again, it is axiomatic that the North Dakota Board of Nursing has jurisdiction only to regulate its nursing licensees, and the practice of nursing that occur within the borders of North Dakota. Those nurses duly licensed by the Board, whether practicing nursing within or without North Dakota, who receive interstate telecommunications regarding the health care of North Dakota patients/clients are, of course, subject to the Board's regulatory jurisdiction. However, the difficulty the Board faces with health care telecommunications, for example, is manifested when the North Dakota licensed nurse interacts with a physician or other health care professional out-of-state not licensed in North Dakota

and from whom the North Dakota nurse may be receiving direction.

The exemplary issues and collateral questions you present may be summarized as follows:

1. Satellite hospitals have patients being monitored by the "parent" hospital. Nurses in North Dakota receive an electrocardiogram response via telemetry from out-of-state and may make and communicate decisions regarding patient care to the nurses in the out-of-state satellite hospital who are doing the actual physical care.

2. Managed care corporations from other states enroll North Dakota residents, and provide consultation to them over the telephone regarding the management of their medical problems. Often this is a role for the out-of-state licensed nurse in the corporation.

3. North Dakota residents are able to access mail-order pharmaceutical businesses and by submitting their prescriptions, receive medications directly from the out-of-state pharmacies.

4. Border health care agencies outside of North Dakota (home health, hospice) may have North Dakota clients who either are cared for by physicians in adjoining states or the agency cachement area might include border communities.

5. Nurses duly licensed in North Dakota may respond to an order for the health care of a person residing in North Dakota from a physician via telecommunications when the physician is in another state and unlicensed in North Dakota?

6. You question whether the North Dakota licensed nurse receiving such telecommunications must verify the credentials of the physician providing the consultation and medical orders if the physician is from another state?

7. You question whether the North Dakota nurse must verify the physician-client relationship through some means and criteria?

8. You ask what licensure liability is imposed on the nurse in North Dakota for an error in the implementation of a telecommunicated order?

9. You ask how standards for client confidentiality are maintained and assured under these scenarios?

Since these issues are newly emerging issues nationally as a result of the "information superhighway", few if any boards of nursing through the United States have resolved these issues (though I suspect they are all currently wrestling with them). As a result there is a dearth of judicial precedent nationally by which to guide any research in this area.

Since these issues are often issues of residency, some general guidance currently exists on this subject. The U.S. Supreme Court laid to rest the issue of residency as a prerequisite to professional licensure. In 1983, the Supreme Court of New Hampshire refused to issue a license to practice law in that state though the applicant had taken and passed the New Hampshire exam. The rationale of the New Hampshire Bar Board in denying the license was because the applicant resided in Vermont. The applicant sued the New Hampshire Bar for alleged violation of her rights under the "privileges and immunities" clause of Article IV, Section 2 of the United States Constitution (stating, in part, that "citizens of each State shall be entitled to all Privileges and Immunities of citizens of the several States.") On appeal, the U.S. Supreme Court ruled in the applicant's favor holding that the residency rule denied the applicant her constitutional rights under the privileges and immunities clause. Supreme Court of New Hampshire v. Piper, 470 U.S. 274 (1985).

Other than qualified by the narrow issue of residency discussed above, the North Dakota Board of Nursing, in my opinion, remains responsible to regulate the practice of nursing within North Dakota and where nursing care is provided to North Dakota residents. Where interstate telemedicine and telecommunications are involved in nursing practice, I advise the Board to consider the adoption of rules that will specifically speak to these unique and emerging issues. The reason for the adoption of rules, of course, is to develop standards of practice that have not previously existed in this telecommunication area. Rules also give guidance to the Board in any disciplinary process and help insure due process for any nursing practice that may come under regulatory scrutiny. Until such rules are considered, deliberated upon by the Board, and ultimately adopted, each case involving questions regarding telecommunications of health care information in the nursing setting is better considered by the Board, and its disciplinary process on a case by case basis.

In short, subject to the clear authority of the Board to regulate nursing practice as broadly discussed above, the complexity of this issue and the multitude of unique facts that can vary the host of questions presented, make a clear legal response to those questions impractical.

I will be pleased to work with you and the Board in this challenging but vital effort.

Sincerely,

Calvin N. Rolfson
Special Assistant Attorney General

00-BON.LTR

# State Compact Bill Status

*Page Last Updated 01/26/2001. Most Recent Change(s) to This Page Marked in Blue.*

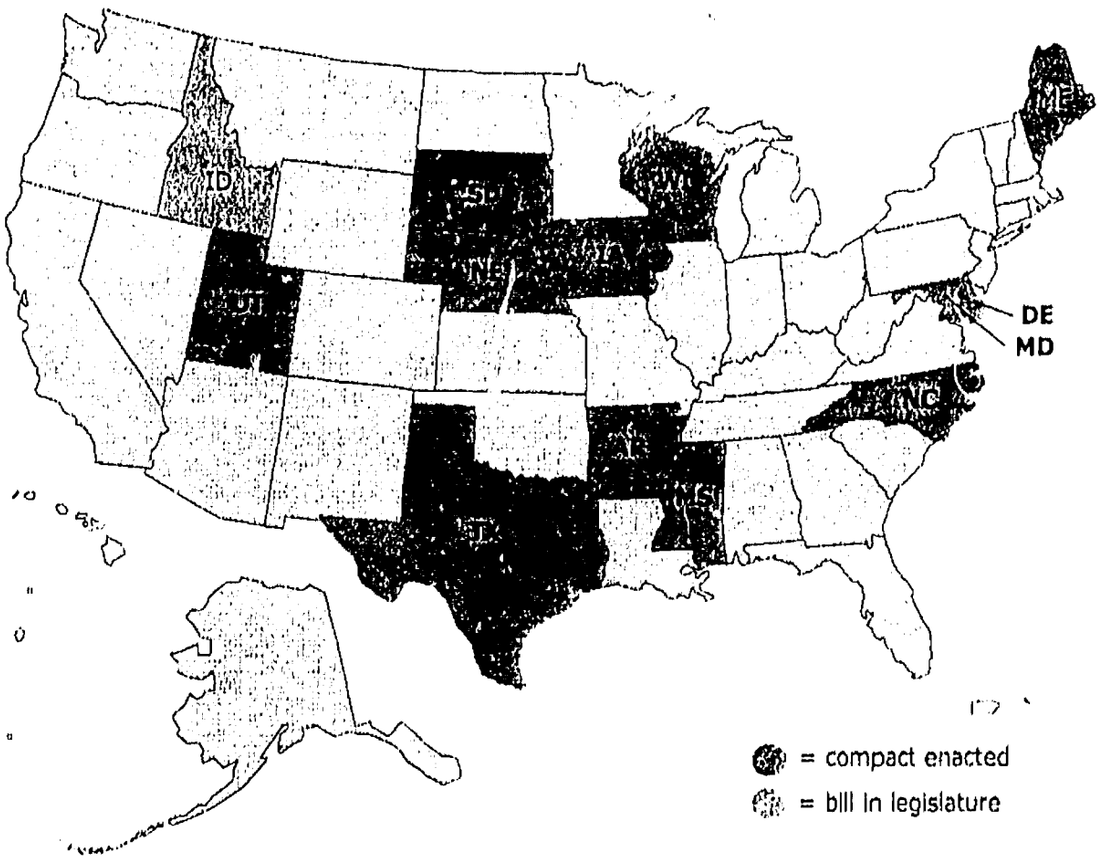
The following table and map indicate the status of bills introduced in different states in order to enact the interstate nurse licensure compact. States shaded in green have enacted such legislation; states shaded in orange have introduced legislation regarding the compact. Bill text, if available, may be accessed by clicking the link in the far-right column of the table; bill text is provided by state legislative Web sites. Note that some of the bills are offered as Adobe® Acrobat® PDF files and require that Adobe Acrobat Reader be installed on your computer in order to access the files. The National Council takes no responsibility for the accuracy, accessibility or availability of bill text linked to this page.



| STATE | BILL # | STATUS | DATE OF LAST ACTION | EFFECT. DATE | BILL TEXT |
|---|---|---|---|---|---|
| Arkansas | S 28 | Signed by Governor | 2/24/1999 | 7/1/2000 | [click] |
| Delaware | HB439 | Signed by Governor | 6/23/2000 | 7/1/2000 | [click] |
| Idaho | 4 | To Health and Welfare Committee | 1/8/2001 | N/A | [click] |
| Iowa | HF 2105 | Signed by Governor | 3/16/2000 | 7/1/2000 | [click] |
| Maine | LD 2558 | Permission to implement Compact by rule | 8/11/2000 | N/A | [click] |
| Maryland | S 590 | Signed by Governor | 4/27/1999 | 7/1/1999 | [click] |
| Mississippi | H 535 | Signed by Governor | 4/22/2000 | 7/1/2001 | [click] |
| Nebraska | L 523 | Signed by Governor | 2/15/2000 | 1/1/2001 | [click] |
| North Carolina | S 194 | Signed by Governor | 7/2/1999 | 7/1/2000 | [click] |
| South Dakota | H 1045 | Signed by Governor | 2/16/2000 | 1/1/2001 | [click] |
| Texas | H 1342 | Signed by Governor | 6/19/1999 | 1/1/2000 | [click] |
| Utah | S 146 | Signed by Governor | 3/14/1998 | 1/1/2000 | [click] |
| Wisconsin | A 305 | Signed by Governor | 12/17/1999 | 1/1/2000 | [click] |

Other information about state legislation is available through the Other Web Resources section of this Web site.

## Map of State Compact Bill Status




Click one of the following links to access a map page formatted for print-outs or transparencies: color map | black-and-white map.

***QuickLink* Code: QL-mr100001**


*This file was last modified: 01/26/2001 7:35:18 AM*




# Frequently Asked Questions

## 1. What is the mutual recognition model?

The mutual recognition model of nurse licensure would allow a nurse to have one license (in his or her state of residency) and practice in other states, as long as that individual acknowledges that he or she is subject to each state's practice laws and discipline. Under mutual recognition, practice across state lines would be allowed, whether physical or electronic, unless the nurse is under discipline or a monitoring agreement that restricts practice across state lines. In order to achieve mutual recognition, each state would have to enter into an interstate compact that allows nurses to practice in more than one state.

## 2. What is an interstate compact?

"An interstate compact is an agreement between two or more states established for the purpose of remedying a particular problem of multistate concern." (*Black's Law Dictionary*)

An interstate compact:

- supersedes state laws
- may be amended by all party states agreeing and then changing individual state laws

## 3. How many jurisdictions must enact a compact before it becomes effective?

A compact could be effective after only two jurisdictions enact it into law; however, the motion passed by the Delegate Assembly proposed that a state enacting the compact include an effective date no sooner that January 1, 2000. The compact's applicability would obviously be limited without broader participation by the states.

## 4. How would primary residency for licensure purposes be determined?

The compact administrators defined primary residence in the compact rules and regulations. The sources used to verify primary residence may include, but are not limited to, driver's license, federal income tax return or voter registration.

## 5. Why was residency, not practice location, used for determining jurisdiction?

Mutual recognition is similar to many other familiar activities based on state or place of residence, including obtaining a driver's license, paying taxes and voting. Given the many employment configurations in which nurses work, there is likely to be less confusion about where a nurse resides than about the location of his or her primary state of

practice. Tracking down a nurse in the event of a complaint/investigation would be more readily accomplished with a residence link, or address, than an practice, or employment, link.

## 6. Why is an individual limited to one license at a time?

The one license concept has a number of advantages including:

- reduces the barriers to interstate practice
- improves tracking for disciplinary purposes
- promotes cost effectiveness and simplicity for the licensee
- acts as an unduplicated listing of licensed nurses
- facilitates interstate commerce

## 7. Can an individual hold both an RN and an LPN/VN license?

Yes, the mutual recognition model provides for this authorization (i.e. one license per each license type if permitted by a home state).

## 8. Can the interstate compact "mandate" that an individual hold only one license of each type (RN and LPN/VN)?

Yes, the "one license limit" is a term of the compact, and all party states would agree and be bound to impose such a limit. The basic reason for this limit is public protection, in that one license assures that all pertinent information about a nurse's licensure and discipline, past and present, is integrated and readily accessible to boards in one place. This mandate does not apply to non-party states.

## 9. Will the mutual recognition model reduce the level of a state's licensure requirements?

No. Under mutual recognition, states will continue to have complete authority in determining licensure requirements and disciplinary actions on a nurse's license per the state's Nursing Practice Act.

## 10. How does the mutual recognition model address the varying scopes of nursing practice as authorized by each party state?

The mutual recognition model provides that the nurse is held accountable for the nursing practice laws and other regulations in the state where the patient is located at the time care is rendered. This accountability is similar to the motor vehicle driver who must obey the driving laws in the state where he or she is driving. The accountability is no different from what is expected today.

## 11. Does the interstate compact affect the authority of the home state to discipline?

As provided in the compact, both the state of licensure ("home state") and state where the patient is located at the time the incident occurred ("remote state") may take disciplinary action and thus directly address the behavior of the out-of-state nurse. The compact will not diminish current authority of the home state to discipline, but will actually enhance the home state's ability to discipline. The compact will enable ready exchange of

investigatory information, allowing the home state to have the most current and accurate information in order to better determine the appropriate course of action in disciplinary cases.

## 12. How would violations be reported and/or be processed in a mutual recognition model?

Complaints would be addressed by the home state (place of residence) and the remote (practice) state. Complaints to the home state concerning a violation in the home state would be processed in the current system. A complaint to the home state concerning a violation in a remote state would be processed cooperatively. For example, the remote state may issue a cease and desist order to the nurse, and the home state may take disciplinary action against the license of that nurse. A complaint to the remote state concerning a violation in the remote state would be processed by the remote state and also reported to the home state. A coordinated licensure information system will enable the sharing of information. All information involving any action would be accessible to all party states. The Disciplinary Data Bank, which is a subset of the Coordinated Licensure Information System containing only final actions, would continue to be accessible to non-party, as well as party states under the current system.

## 13. What is meant by multistate licensure privilege?

Multistate licensure privilege means the authority to practice nursing in a remote state pursuant to the interstate compact. It is not an additional license.

## 14. What is meant by home state action?

Home state action means any administrative, civil, or criminal action permitted by the home state's laws which is imposed on a nurse by the home state's board of nursing or other authority, including actions against an individual's license. Only the home state can take action against the license.

## 15. What is meant by remote state action?

Remote state action is a new authority provided by the proposed interstate compact. Remote state action is any administrative, criminal or civil penalty imposed on a nurse by a remote state's licensure board or other authority, including actions against an individual's multistate licensure privilege to practice in the remote state. For example, under the compact, authority is given to issue cease-and-desist orders by the remote state or the remote state licensing board.

## 16. What disciplinary actions must a home state take based on a remote state action?

The home state will evaluate the nurse's behavior which led to the remote action and will respond based on the laws of the home state. The home state is required by the compact to evaluate the nurse's behavior in the same manner (i.e., "with the same priority and effect") as it would had the incident occurred in the home state, but the home state is not required to take any particular actions nor to enforce the remote state's laws.

## 17. Would every complaint received by the remote state(s) and results of the complaint investigation need to be shared with the home state?

The remote state will report to the administrator of the information system any remote state actions as well as the factual and legal basis for such actions. The remote state will also report any significant current investigative information yet to result in a remote state action. The administrator of the information system will notify the home state. The compact administrators will develop policies and guidelines for defining significant complaints, as it is recognized that many complaints are not substantiated and reporting these would increase workloads and may be nonproductive.

### 18. Concerning complaints, what information would be reasonably necessary to share with a party state?

Each party state may share information or documents relevant to a current, significant investigation.

### 19. How would individuals participating in alternative programs be affected by the compact?

Nothing in the 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 the prior authorization from such other party state.

### 20. Will a state board have the authority to deny licensure by endorsement to an applicant who has had discipline action in another state?

Yes. The licensing authority in the state where an application is made may choose not to issue a license if the applicant does not meet the qualifications or standards for granting a license.

### 21. Why are advanced practice registered nurses (APRNs) not included in the mutual recognition model?

The Board of Directors endorsed mutual recognition for all nurses, with a different timeline for APRNs. The rationale for the different timeline of implementation for APRNs is that a base of comparable licensure requirements does not exist for APRNs.

### 22. Does the interstate compact affect states' collective bargaining rights?

The compact does not impact the statutory authority at the federal or state level for collective bargaining. This is not a regulatory issue. In terms of licensure process actually implemented by states when there were strikes in the recent past, there would be little or no practical difference in the ability of employers to bring in licensed nurses from other jurisdictions under mutual recognition.

### 23. When will the mutual recognition model be implemented?

State legislatures will first need to enact the interstate compact into state law. The motion

adopted by the Delegate Assembly says state legislatures are encouraged to agree that implementation will not take place before January 1, 2000. This would enable Member Boards and National Council to accomplish the activities outlined in *Strategies for Implementation of the Mutual Recognition Model of Nursing Regulation.*

### 24. How does enactment of the interstate compact affect a state's current Nurse Practice Act?

Enactment does not change a state's Nurse Practice Act in any way. The compact gives states additional authority in such areas as granting practice privileges, taking actions and sharing information with other party states.

### 25. How does enactment of the interstate compact affect the individual licensee?

The individual RN or LPN/VN residing in a party state will be able to practice in all the party states, unless there is some restriction placed on the multistate licensure privilege. The individual RN or LPN/VN residing in a non-party state will continue to be licensed in individual state(s), just as at present.

### 26. If a nurse lives in a party state and obtains a license in a non-party state, must she or he give up the license from the party state?

No. The license from the home state, which is a state that is a party to the compact, allows the nurse to practice in all the party states. The license obtained from the non-party state would allow practice in just that state.

### 27. Is there a time requirement for applying for a new license in a new home state when changing residence from one party state to another?

According to the interstate compact rules and regulations, 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 multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed thirty (30) days.

### 28. The compact enables the compact administrators to develop rules and regulations to administer the compact. How do these rules and regulations provide authority in the individual party states?

The interstate compact is a legal contract between states that enables nursing practice across state lines. In each state that adopts the compact, the compact is an additional statutory layer above the individual state's Nurse Practice Act, which remains in place. The compact administrators develop the rules and regulations to administer the compact, and then individual state boards of nursing adopt the rules. If an individual state refuses to adopt the rules the compact administrators develop, that state would be in violation of the contract established by the interstate compact and thus could lose the status of party state to the compact.

### 29. How will an employer know that a nurse's license is no longer valid?

The burden will be on the employer, as it is now, to verify licensure at all significant times of change in the status of nurses who they employ. Under the interstate compact, these

significant times will include any time a nurse changes state of residence.

To: Judiciary Committee
Chairman Dekrey

From: Melana Howe, RN
Director of Patient Care Services
West River Regional Medical Services
Hettinger, ND

I am a nursing executive and work in healthcare administration at West River Regional Medical Center. Our organization provides healthcare for approximately 24,000 people in a 24,000 square mile area, covering two states. I am writing in support of House Bill 1150.

As a member of the Nursing Practice Committee of the ND Board of Nursing, I have followed the work of the National Council of the State Boards of Nursing; specifically in their work with the Multistate Licensure Compact.

Our organization employees various professionals whose practice takes them into both North Dakota and South Dakota. The mutual recognition model of nurse licensure would allow a nurse to have one license (in his or her state of residency) and practice in other states, as long as that individual acknowledges that he or she is subject to each state's practice laws and discipline.

Today, in the business of providing healthcare, numerous licensed practitioners in border communities frequently find themselves crossing state lines. In our organization, we have physicians, physician assistants, nurse practitioners, nurses, lab, radiology and respiratory care technicians with dual licensure. West River Regional Medical Center pays for the second license for our employees. Therefore, current practice does have a financial impact to healthcare organizations.

As I look to the future, I expect more 'crossing the state lines' because of telemedicine, telehealth, and fewer organizations covering larger geographic areas. Agencies that utilize temporary or locums staffing will increase and multistate licensure would remove time barriers that currently exist in cases of short notice.

I urge you to support this bill as presented as I find it proactive and practical to today's and the future healthcare environment.

Thank you

Dear Committee Members,

As you know, Altru Health System is a border facility in our state that provides care to both North Dakota and Minnesota patients. Our geographic location creates unique challenges related to Minnesota and North Dakota professional licensure regulations as they currently exist.
Passage of HB 1150 would enhance our ability to provide care to our patients, particularly in the area of intrastate telephonic care.
Altru Health System strongly supports passage of HB 1150.

Sincerely,
Rick Gessler, R.N.
Employment/Employee Relations Manager
Altru Health System
Grand Forks, ND

February 7, 2001

Chairperson Dahl and members of the ~~Human Services~~ Judiciary Committee, my name is Deborah K. Johnson, President of the North Dakota Board of Nursing.

On behalf of the board, I would like to offer testimony in support of HB 1150. As you know, this bill relates to Administrative Agency compacts. I will address aspects of miltistate licensure compacts and why the passage of HB 1150 would be beneficial to North Dakota.

The mission of the North Dakota Board of Nursing is protection of the public safety through the provision of sound nursing care. The board accomplishes this mission through the regulation of nursing licensure, education and practice. As our state and our nation move into the 21st Century one of the challenges we face is the increasing practice of health care across state boundaries. Where does the jurisdiction reside if a nurse lives in one state and practices in another one or two? In order to effectively regulate safe nursing practice under circumstances such as these, it becomes necessary to develop a model of nursing practice which make it possible for safe regulation of practice to occur.

I have been a board member since 1996. The issue of multistate regulation and licensure has been an issue we have studied since I first came to the board. In 1997, our state voted to support the idea of MSL at a special convening of the National Council of State Boards of Nursing. Since that time, we have studied the issue through our Multistate Licensure Task Force of which I have been a member. The board based group of educators, consumers, health care organizations, legislators and medical organizations met and recommended, after dialogue and consensus building that the North Dakota Board of Nursing draft legislation on administrative agency compacts which would include all professional and organizational boards. The result, after much discussion is HB 1150. The following are points for your consideration:

- HB 1150 suggests a model of collaboration between two states for the purpose of addressing a potential problem. Current health care technology has blurred the boundaries of practice arenas. The health and expansion of hospitals to clinics in other states are examples of this. In order to provide for safe practice and protection of the public, both the practitioner and the sate licensing board need a mechanism for accountability. HB1150 allows such accountability. The practitioner is held responsible for following the practice requirements in the state where she or he is providing care.

- HB 1150 will allow the development of administrative agency compacts through the process of rule promulgation rather than the more costly change in the nurse practices act. In this way, North Dakota can proceed with the development of

interstate agreements for it's professional boards in ways that are safe, in our own time frames and as our professional boards and state feel ready to do.

- HB 1150 will support options that increase access of care, especially in our border cities and towns. It will accomplish this by allowing qualified practitioners to provide health care across state lines. It will permit practice by identifying HOW we practice, not so much as where we practice.

In conclusion HB 1150 is a result of much board based collaboration effort. It is an effort on all members parts to address health care planning futuristically and responsibly. We feel it's passage will enable the practitioner to provide safe health care and remain responsible and accountable for individual practice no matter where it takes place. This will continue to support the mission of the board to protect the public with the regulation, education and licensure of nurses. The board and I appreciate your willingness to consider a positive approach to the licensing of practitioners and your support of HB 1150.

I am now open to any questions you may have.