2019 NCSBN Annual Meeting - Committee Forum: APRN Compact Video Transcript

Event
2019 NCSBN Annual Meeting

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Presenter
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- [Katherine] Well, good afternoon, everyone. Last but not least, we're going to talk about the APRN Compact today. As David said, I served as the chair of this task force this year, and I'm going to present the report beginning on page 31.

You'll find the documents in the business book. As President Julie George said this morning, the recommendations in the report have been approved by the board of directors and forwarded to the delegate assembly for a vote at this meeting. Let me see if I can...These are the members of the task force, and I would ask them to stand as I call their names.

Jennifer Burns, Wyoming Board of Nursing. It's so bright I can't see. Shirley Brekken, Executive Officer of Minnesota Board of Nursing, Stacey Pfenning, Executive Officer, North Dakota Board of Nursing. And then we had three attorneys on this board, Rick Masters, who's counsel to the Nurse Licensure Compact, Tom Wilde, who's general counsel to NCSBN, and Stephen Feldman, who is an attorney from North Carolina, appointed by the board.

He has experience in antitrust law and has represented different licensing boards in North Carolina. I am very grateful to the hard work of this committee, and to the staff who supported the work. I will assure you that the barriers to adoption were thoroughly explored and no stones were left unturned.

Our goal was to create a statutory framework that will support wider adoption of the APRN Compact in order to achieve the purposes of the compact, which are to increase access to care and to improve mobility for APRNs. So, how did we get here? In 2015, the delegate assembly adopted an APRN Compact that's currently in effect, and three states, since that time, have adopted it.

Idaho, North Dakota, and Wyoming. There have been recent trends in the APRN statutes and legislation that have really hindered further adoption of the Compact. They are primarily, transitions to practice,

and those are requirements some states, 17 to count, have in their statute, that require a period of transition whether it's supervised, formal or not.

And that these continue to be introduced in states, and the hours vary. They range from 400 to 10,000 hours. So, states have recently adopted these provisions, and they've recently discussed them and been told they're valuable and they believe that, so you can see how that might be a barrier to adoption.

There are also ancillary supervision provisions. Sometimes these are in Nurse Practice Acts, and sometimes they're in other law, but they require supervision under certain circumstances. Maybe in the operating room, maybe when CRNAs do pain management, they vary quite a bit. But what happens is these provisions deter the adoption because legislators are not willing to support the Compact.

They're afraid they would create problems in their state. So, you know, convincing them is really a very difficult challenge right now. The board of directors in June of 2018 convened a World Café to talk about this issue.

Subsequently, they directed a task force be formed to look at these transitions to practice and ancillary provisions and to make some recommendations. The task force presented recommendations at the mid-year meeting in San Antonio, and then we created an online member feedback submission period that was completed, I think we received nine comments, and these were all sent to the board of directors for review in addition to the recommendations.

The board of directors then moved to send the APRN Compact amendments to the delegate assembly. They didn't change anything. They supported the recommendations, and here we are to consider them. So, I'm going to go through the recommendations that the committee or the task force makes and discuss them a little bit further.

We found in looking at transitions to practice that there is no evidence to support the transitions to practice are necessary for the public to be protected, but we do know there are 17 states that have some kind of program as I said, and the most common length of these programs is 2,080 hours.

That is equivalent to one year of full-time practice. The requirement to have APRNs complete 2,080 hours of experience before becoming eligible for a multi-state license is recommended by the task force.

This was a very pragmatic decision, knowing all the barriers to expand adoption. We made this recommendation to address the concerns of individual states, but kept it at a minimum number of hours equivalent to a year as I said, and only requiring experience, no supervision, no formal program, nothing of that kind.

Experience has to be in the role and population and congruent with the educational preparation. And the vast majority of APRNs would meet the requirements on implementation. Most of the APRNs are already licensed, already have a year or more of experience, so they would meet it, and it would affect only those with less than a year of experience.

And then although a single-state license would be issued for the first year of practice, ultimately, a multi-state license would be issued if the individual who was eligible meets the ULRs. And the goal is to

practice without supervision or collaboration. It would be realized in a relatively short period of time. Our second proposed amendment is not really to make any changes to address the ancillary supervision requirements.

They do differ a lot as I said earlier. They are role-specific, setting-specific areas of practice, geographic location, all over the place, and we determined that uniformity is very important to safe and operational success of the Compact or any compact. So, the proposed amendment is the APRN Compact should continue to supersede these provisions, and if there are any ancillary provisions in place when the compact is adopted, they would be superseded by the compact.

Our third recommendation is to amend article 10 to require 7 states enacting the APRN Compact. So, that would be the trigger instead of the current 10 states. The language is there in the box that exists currently.

We looked at other health care licensing compacts to see what their threshold was for enactment, and the lowest number of states was in the PSYPACT Compact, which is for psychology or psychologists, and that was seven states. So, the amendment proposes to reduce the number of states required for enactment or implementation to seven, and the goal or the rationale is to make sure that licensure mobility will be a reality sooner, and increasing needs for access to care will be addressed.

We did look at the number of states with transition programs and number of hours that these programs required, the number of states with no supervisory or collaborative agreements are better situated to go forward, and we believe the goal of seven states in the next three years is achievable, and we believe that three is too small a number to meet the intended purposes of the Compact and to draw more states in.

Recommendation number four is to amend the Compact to include uniform license requirements. It was thought at the time the last model was adopted, that there might be changes to the consensus model that we were unsure of that and we didn't want to tie the hands of the states in moving forward.

We left that ULR to rulemaking authority of the commission. However, the lack of the ULRs in the Compact has created questions and concerns among state lawmakers and other stakeholders in states. So, the task force recommends they be included, including the Nurse Licensure Compact ULRs because a state might adopt the APRN Compact but not adopt the NLC.

We do have one exception there. So, in terms of what the consensus model ULRs to be included are, they would include roles, population foci, certification, licensure, and education. And then in the NLC, they would include the criminal background checks, misdemeanors related to nursing, participation in alternative to discipline programs, and foreign education provisions.

But for the felony prohibition, there was a recommendation that felonies be related to patient safety, and for felonies and misdemeanors, rules would be adopted by the commission. Now, why is that?

There is shifting public policy in this area as many of you know in your states. We found that criminal justice reform is being promoted by many government agencies at the federal level as well as public non-partisan or bi-partisan organizations, particularly the Institute of Justice and the White House in the Obama administration and by the Department of Labor in the Trump administration.

So, since 2015, 27 states have reformed occupational licensure laws to make it easier for ex-offenders to go to work, and, of course, through licensure. Specifically, 16 states bar licensing boards from denying ex-offenders licenses unless the tie can be made to the license that's being sought.

So, these are the kinds of things that we thought would be proactive and forward-thinking to amend in the Compact and allow that to be determined by the commission in terms of rulemaking. Our fifth recommendation is to amend the Compact to explicitly allow the applicant to select a single-state license, so not be required to have a multi-state license if they don't want one.

That was the original intent of the APRN Compact, and we considered whether the APRN Compact even has jurisdiction over single-state licensure. So, the proposed amendment adds language to affirmatively state that the Compact has no jurisdiction over single-state license, that's up to the state, and to affirmatively state an applicant can elect to apply for a single-state license, even if they're eligible for a multi-state license.

This is an issue that's been discussed by the Nurse Licensure Compact commissioners, and they've issued an advisory opinion that states that states may issue a single-state license if the applicant applies for it or if they don't qualify for a multi-state license. Our sixth recommendation is to amend the Compact to allow non-controlled prescribing for multi-state licenses.

The APRN Compact allows a multi-state licensee to prescribe non-controlled substances only if they held the authority prior to enactment. The proposed amendment says if the applicant meets the ULRs, then they will have authority to prescribed non-controlled substances in their home state or in a party state.

Prescribing is part of APRN education and certification, and we believe if the APRN meets the uniform license requirements, they should qualify to prescribe non-controlled substances. We left controlled substances the way they are in the current compact, which is they are controlled at the state and DEA or federal level. That remains unchanged in these revisions.

The discussions around opioids right now might make this particularly a sensitive issue, and, of course, the DEA has regulations about where a person must hold that authority to prescribe in a jurisdiction. We made a few other more minor recommendations.

One is to clarify some of the definitions that we thought were conflicting. Those included ULRs, roles, and party state law to amend the findings and declaration statement, which really talks about what the reasons are the Compact is established at the beginning of the Compact.

And that includes the rationale of the current system of duplicative APRN licensure requirements for practicing in many states is cumbersome, not only for APRNs but for healthcare delivery systems, and payers, and licensing boards, and regulators, and we believe it's unnecessary.

It creates the express authority, finally, for issuing advisory opinions. This is very common in other compacts. And the commission, the Nurse Licensure Compact commission, has issued an opinion

that...or an advisory on what particular issue already, even though this isn't explicitly mentioned in the NLC, but we believe it's probably a good practice to include it in this Compact.

So, joining me at the table are our staff attorneys who all will be able to answer questions along with me, and we're ready to take any questions you might have. Microphone number one. -

[Caroline] Kathy, Caroline, Louisiana. I want to go back, I think it was your amendment 3 where you weren't going to recommend any change to the collaborative practice agreements over certain situations that already exist in a state, but that the Compact would supersede those if it was adopted.

- What is she talking about? I'm not following you. Where are you?

- Okay. It was 2, was it 2? Amendment 2.

- The ancillary supervision.

- Right. The ancillary supervision, but over certain things that already exist in a state. Right. Like that, that if they adopted the Compact, it would supersede those provisions. My question is, do you think that that will continue to cause states to throw up their legislators and legislatures to throw up resistance to adopting the Compact because this would supersede state requirements that they already have for these kinds of things?

- Sure. I'm going to ask Rebecca and Nicole to respond to this because they are the ones out there trying to get bills introduced and passed. - [Rebecca] Yeah, that's a good question. Yes, I do think it's going to make it not more difficult. It will continue to be difficult.

But we didn't find those to be as big of an issue as we did with the questions regarding transitions to practice. So, I think it will be tough, especially when it comes to laws and regulations involving opioids. I mean, because it's such a, you know, politically and emotionally charged topic.

But one of the main reasons the task force decided that they had to be superseded was that they are just so different in every state, and with a compact, you need that uniformity.

So, that was probably the biggest reason the task force decided that even though this may make it, you know, difficult to enact, it really is necessary to implement the Compact.

- Microphone seven. - [Janet] Hi, Kathy, Janet Hableré [SP]. And I thank you for the report. Two questions. The first one is in relation to the three states that have adopted the Compact, what will happen with them?

- Because the language is changing significantly, they would have to reintroduce legislation.

- Okay, great. Thank you. The second question has to do with the felony conviction tied to or associated with patient care. What will happen with the e-Compact? Anything? Any changes related to that compact to be consistent?

- With the NLC?

- Yeah.

- That will be up to the NLC commission if they want to recommend changes. And, of course, that would require some amendments at every state that's passed the NLC.

- Understood. I would expect some questions about that.

- Yeah, okay.

- Thank you.

- Thank you. Microphone seven. - [Diane] Hi, this is Diane Tomkins with ANCC. As I was reviewing the content within the...not necessarily the recommendations, but in the report, and I was looking at article 3, and they were looking at foreign-educated APRNs.

I was just wondering if you could elaborate more on the expectations of any of those clinicians coming to the United States and how we were going to be comparing their educational preparation and then how were they going to be meeting our requirements here in the States for all the alignment between education and certification, and accreditation.

- States are required to look at this now, and we are not recommending any changes to that portion of the ULRs. But, I think that there are very few jurisdictions outside the U.S. who prepare APRNs or who prepare them the way they do in the U.S., so it's really done on a case-by-case basis right now.

They may need additional education to qualify.

- The reason I bring it up is just that I've been noting, yes, a very small uptick, but just noticing more inquiries from individuals outside the U.S. inquiring about getting licensed here in the United States. So, when I saw this, it was just making a connection. This is something I just...I'm sure states are aware of it, but it's just an issue that is seemingly to be gradually increasing and wanting to make sure that we're all consistent in how we're looking at when these individuals are seeking to become licensed in the U.S.

- Absolutely. Thank you for your comments. Microphone one. - [Eirik] Kathy, hello, I'm Eirik [SP], Nebraska. I'm practice consultant.

I have some questions about the transition to practice, and we are one of those states that has a 2,080-hour requirement. And if I'm understanding the language, the individual would have to have acquired 2,080 hours in their role in population focus. And how would that be?

Would it be up to the licensure to enforce that? Would you have to review the practice agreement? And maybe this is obvious to everyone else, but it's not to me.

- Well, Eirik, that's a little bit more in the weeds than our recommendations go. States can have requirements because individuals will be issued a single-state license during that experience period. So,

the states may have particular requirements of them that really have nothing to do with the APRN Compact.

But it is an experience-only requirement. It is not a formal program requirement. It's not a supervised experience. It is simply experience before they would be eligible for a multi-state license.

- So, we would have to...I'm still lost in terms of how we would... how that would be enforced. Would you have to review the nature of the practice?

- I think states would handle that very differently.

- So, it would be up to us to determine how we would do that.

- That's correct.

- Okay. Thank you.

- You're welcome. Microphone two. - [Ron] Hi. Thank you for your work. My name is Ron Costello [SP].

I'm from Delaware. I had a question during the open comment period for the APRN Compact. Did the committee hear back from the national associations representing the four different APRN roles, and they did receive feedback. How was that feedback incorporated? Were any changes made?

Could you comment on that, please?

- Do you all want to respond to that?

- So, we did receive one letter from the nurse practitioner organization, AANP, and we did respond to that letter. We took all comments into consideration, whether that was from an outside national organization, our own members, everyone. And those comments were compiled and given to the board. The board also reviewed the recommendations from AANP as well.

So, yes, we did receive feedback, and it was discussed, I think and there was a formal response as well, I should say, to the organization. - [Nicole] And if I could just add, from the state-level perspective, we also, the task force, of course, took into consideration what Rebecca and myself have been hearing at the state level as states are considering enacting or introducing the APRN Compact or states that have introduced it, and as they go through the process, we're getting feedback from the coalition groups, which include all four roles in most of the states.

- Microphone seven. - [Phyllis] Hi. Thank you, Kathy, and thank you for the task force that did all the work on this. I just have one question. So, Phyllis Mitchell from Vermont, I'm sorry.

Was that number...? How did the group come up with that number of 2,080 hours? Was that based in some sort of evidence? Thank you.

- No. The evidence, it was based on...

- But I figured...

- The evidence it was based on was more states than other requirements have a 2,080 requirement. So, it's also on the lower end, but not the very lowest. So, we felt like it was a fairly minimal requirement to have a year of experience practicing as an APRN under a single-state license and then being eligible for multi-state when they complete that and meet the other ULRs.

You're welcome.

- Can I say something?

- Yes, of course, Rebecca.

- The goal was to increase the group of states who could be primed and ready to join the Compact. So, the 2,080, that was the greatest number of states within states that have transitions to practice with that kind of threshold. So, we felt like that would grow our pool to the largest number of states who could file and be ready to implement it right away.

I think the task force thought was always, how can we move this ahead? How can we get this Compact going really, you know, as quickly as possible?

- Any other questions or comments? - [Male] [inaudible], Joey.

- Microphone three. - [Joey] Joey Ridenour [SP], Arizona. And I want to thank Kathy and David for meeting with me earlier this week to talk about some of the issues that came out from Arizona when we presented it to the board last month.

And I think a lot of the issues can be resolved, but I think there's one that I just need to see what your thoughts are, and that is with the harmonizing between the NLC and the advanced practice. It's about the felony. Is there a need in statute to say maybe there needs to be a number of years from the time that the felony had absolute discharge or can we do that in rule?

And I realize that the commission has to be established and all these decisions are made by the commission. But I think for us in Arizona, it's important to know that to receive a felony, not in every state, but most states, it's a pretty significant crime and recidivism is high until you reach that fifth year as a whole.

And again, it's just a general statement. It's not about any one crime. And so, I'm trying to get some of your thoughts about what you think the possibility would be to have it more aligned with the NLC.

- Joey, I would say that when we discuss this issue, we recognize that it's creating a difference between the two compacts and I appreciate your comments about qualifying it. Our thought was that the commission, through rulemaking, could decide how long for certain crimes or how to weigh those because, again, the factor would be, are they related to patient safety?

If you look at the public policy recommendations that are out there in government right now, they're talking about two main things, the relevancy to the license that would be held, and the recency of the crime because crimes are all over the place at the felony level across our states. There are certain ones that are more common like DUI, but even DUI doesn't reach a felony threshold at the same level in each state.

So, it's all over the place. So, you may have to get a single-state license under the NLC for a felony that you wouldn't be penalized for in another state if you had the same number. So, it's just a very confusing and big topic, and we thought that that really should rest with the commission to decide what those, you know, requirements would be under a rule.

- We do have further discussions after this meeting to really see, is there a way to work something out now? So, I know that when I go back and try to hopefully, implement it, that I will have more support than not. It's just a request.

- Thank you, Joey. Did you all have anything you wanted to add? - [David] So, I mean, I think there's a couple of things. One is, as Kathy said, you know, part of this we need to look at rulemaking. I think the other part is actually about as we move forward with implementation of these issues, how do we bring together the staff from the various boards to try and have that, kind of, normative influence.

I'm very conscious of the fact that we can't tell individual states what to do, but I think if we can collate the evidence that's there, place that out there, provide common training. I think that goes a long way in terms of moving this forward. And as I think Rebecca said, looking at this, we've probably got a three-year window as well until we get to that point.

And my recommendation on some of these issues would be the...and remembering that ultimately., there will be a commission that will decide these things as well, but my recommendation would be that as we identify some of these things, we work as the family of NCSBN to then prepare materials to hand to the commission, who would ultimately, when the Compact comes into being, we then have to ratify those processes as well.

So, I see an opportunity to move forward on some of these issues ahead of time.

- Yeah.

- There.

- Anything else? Well, thank you all very much. We appreciate your attention and look forward to continuing the discussion.