REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

MULTI-STATE NURSE LICENSURE COMPACT STUDY

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Authority for Study/Organization of Report

This Study Is Being Conducted As A Follow-Up To A Study Conducted In 2000 Regarding Actions The Commonwealth Could Take To Recruit, Train, And Educate Qualified Nurses In Virginia

During the 2000 interim, the Joint Commission on Health Care (JCHC) conducted a study of actions that the Commonwealth could take to recruit, train and educate qualified nurses in Virginia. Last year's study was conducted in response to issues raised in House Joint Resolution (HJR) 288 and Senate Joint Resolution (SJR) 228 of the 2000 Session of the General Assembly.

Following last year's study, the JCHC had legislation drafted to authorize Virginia's participation in a multi-state nurse licensure compact. (A copy of the draft legislation is provided at Appendix A.) Under such an arrangement, nurses who live in a "compact state" maintain one license which authorizes practice in all other participating compact states. One of the advantages of the compact is that nurses do not have to maintain duplicate licenses. However, when the draft legislation was circulated for public comment, the Department of Health Professions (DHP) raised concerns that participation in the multi-state nurse licensure compact may reduce nurse licensure fee revenues by approximately $500,000 per biennium. This potential revenue loss would result from nurses living in other compact states who no longer would have to pay a Virginia license fee to practice in Virginia. DHP further commented that, as a consequence, license renewal fees would have to be increased to offset the loss of revenue.

In response to the concerns raised by DHP, the JCHC decided not to introduce the legislation, and, instead, conduct further study of the issue during the 2001 interim.

This Report Is Presented In Five Major Sections

This first section discusses the authority for the study and organization of the report. Section II provides background information on the licensure and regulation of nurses in Virginia. Section III discusses the multi-state nurse licensure compact, and reviews the experiences of other states which have joined the compact. Section IV presents an analysis of the potential impact of Virginia's participation in the compact. Lastly, Section V presents a series of policy options

the Joint Commission may wish to consider in addressing the issue of whether Virginia should participate in the compact.

II.
Current Licensure and Regulation of Nurses in Virginia

The Virginia Board Of Nursing Regulates Virginia Nurses

Section 54.1-3002 of the *Code of Virginia* establishes the Board of Nursing which regulates the various nursing professionals, and approves the educational programs in the Commonwealth for training nurses. The Board consists of 13 members, including seven registered nurses, three licensed practical nurses, and three citizen members.

Section 54.1-3005 of the *Code of Virginia* identifies a number of specific powers and duties of the Board, which include: (i) prescribing minimum standards and approving curricula for nursing educational programs preparing persons for licensure or certification; (ii) approving nursing educational programs; (iii) certifying and maintaining a registry of all certified nurse aides; (iv) investigating illegal nursing practices; (v) promulgating regulations for the delegation of certain nursing tasks; and (vi) collecting, storing and making available nursing workforce information.

For the purposes of this study, the most critical function of the Board is the licensure and regulation of the various types of nursing professionals. Moreover, because the multi-state nurse licensure compact applies only to registered nurses (RNs) and licensed practical nurses (LPNs), this report addresses only those licensure and regulatory issues that pertain to RNs and LPNs.

The *Code Of Virginia* And The Board Of Nursing Regulations Specify Certain Qualifications And Practice Parameters For RNs And LPNs

The *Code of Virginia* and the Board's regulations include certain qualifications and practice parameters/restrictions. Figure 1 summarizes the qualifications for licensure for both RNs and LPNs. For both RNs and LPNs, the *Code of Virginia* states that these terms mean: "the performance for compensation of selected nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health processes; in the maintenance of health; in the prevention of illness or disease...".

Figure 1

Licensure Qualifications For RNs And LPNs

Type of Nurse	Qualifications
Registered Nurse	▪ completed four-year high school course of study or the equivalent; ▪ received a diploma or degree from an approved professional nursing education program ▪ passed a written examination as required by the Board; and ▪ committed no acts which are grounds for disciplinary action
Licensed Practical Nurse	▪ completed two years of high school or its equivalent; ▪ received a diploma from an approved practical nursing program ▪ passed a written examination as required by the Board; and ▪ committed no acts which are grounds for disciplinary action

Source: JCHC Staff Analysis of the *Code of Virginia* and the Board of Nursing's Regulations

RNs And LPNs Pay An Initial License Application Fee; Licenses Must Be Renewed Biennially At Which Time A Renewal Fee Must Be Paid

RNs and LPNs pay an initial application fee ($105) when securing a license to practice nursing in Virginia. RN and LPN licenses must be renewed every two years; a fee of $70.00 must be paid at each renewal. As illustrated in Figure 2, this amount reflects a substantial increase over the fees that were charged prior to April, 2000. The increase in fees was needed to pay for the increased costs of regulating the profession. The last fee increase occurred in 1995.

Registered Nurses and Licensed Practical Nurses Also Pay A $1.00 Fee To Support A Nursing Scholarship Fund

Section 54.1-3011.1 of the *Code of Virginia* requires the Board of Nursing to charge a $1.00 fee for the licensure of every practical nurse and registered nurse to support the Nursing Scholarship Fund. The Fund is used to provide scholarships for students enrolled in nursing programs that prepare students for licensure as LPNs and RNs.

There Are Approximately 82,300 RNs and 26,200 LPNs Licensed In Virginia

Data maintained by the Board of Nursing indicate that, as of May 3, 2001, there are 82,302 RNs and 26,226 LPNs licensed in Virginia. Included in these amounts are nurses who live outside of Virginia, but hold a Virginia license to practice in the Commonwealth. Currently, all nurses, including those who live out-of-state, must pay the appropriate licensure fees (see Figure 2) to practice in Virginia. Figure 3 illustrates the number of RN and LPN licenses issued to in-state residents and out-of-state nurses. Approximately 19% of RNs licensed in Virginia live in another state; whereas, only about 12% of LPNs licensed in Virginia live outside of the Commonwealth.

Figure 2

RN And LPN Application And Renewal Fees

Type of Fee	Amount of Fee	
	Amount Prior to April, 2000	Current Amount
Application for Licensure[1]		
- by examination	$25.00	$105.00
- by endorsement	$50.00	$105.00
Biennial Licensure Renewal	$40.00	$70.00

Notes:

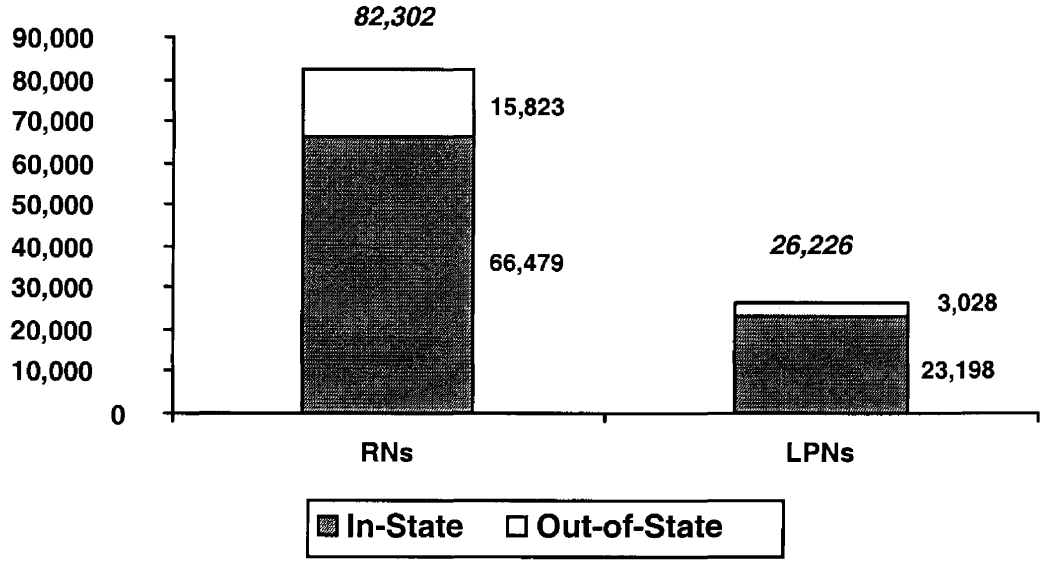
[1] The Board may issue a license by endorsement if the applicant has been licensed as a professional or registered nurse in another state.

- Other fees are charged by the Board for duplicate licenses, reinstatement of licenses, verification of license, etc.

Source: Virginia Board of Nursing

Figure 3

Number Of RNs And LPNs Licensed In Virginia
May, 2001



Source: Virginia Board of Nursing

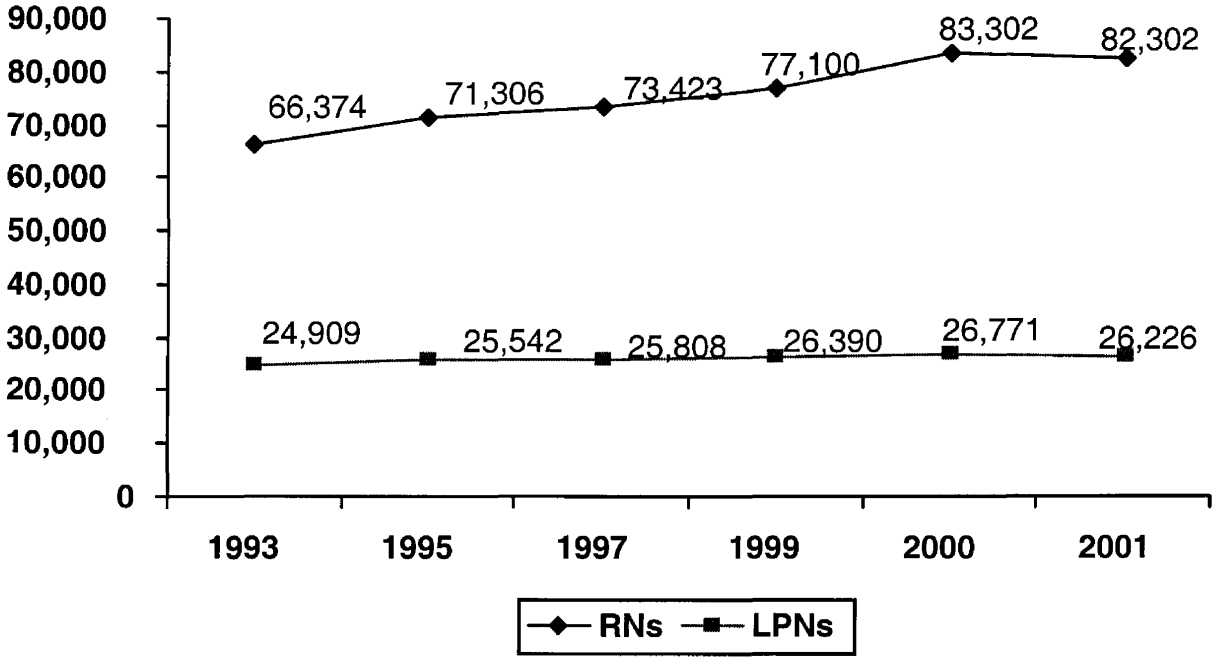
The Number Of RNs And LPNs Licensed In Virginia Had Been Increasing During The Past Several Years; However, The Number Of RNs And LPNs Declined Slightly In 2001

According to records maintained by the Board of Nursing, the number of RNs and LPNs licensed in Virginia had been increasing in the past several years. As seen in Figure 4, the total number of licensed RNs increased from 66,374 in 1993 to 83,302 in 2000, but declined to 82,302 in May, 2001. Similarly, the number of LPNs licensed in the Commonwealth increased from 24,909 in 1993 to 26,771 in 2000, but declined slightly in 2001 to 26,226.

Figure 4

Number of RNs And LPNs Licensed In Virginia:

1993 - 2001



Source: Virginia Board of Nursing

III.
Mutual Recognition Model Of Nurse Licensure: Multi-State Nurse Licensure Compact

In The "Mutual Recognition" Model Of Nurse Licensure, A Single License Allows A Nurse To Practice In Those States That Join A Multi-State Nurse Licensure Compact

As noted in the previous section, nurses who work in more than one state must maintain duplicate licenses (i.e., a separate license must be obtained from each state). Examples of this include nurses who live in border areas and work in two or more neighboring states; nurses whose employer operates health care facilities in various states at which she/he may be assigned temporarily; and nurses who work for contract agencies that require frequent travel to other states. There also are nurses who may work in only one state but who, nonetheless, wish to maintain a license in another state.

Like Virginia, all states require nurses to pay an initial application fee and a renewal fee to maintain an active license to practice nursing. Nurses who maintain duplicate licenses also must pay multiple licensing fees. Under a "mutual recognition" model, states pass legislation authorizing participation in a multi-state nurse licensure compact. In these "compact states," a nurse would obtain a single license from his/her state of residence which would allow the nurse to work in all other states participating in the compact. This would eliminate the need for the nurse to maintain duplicate licenses and to pay multiple licensing fees. (Duplicate licenses and the accompanying fees still would be necessary to practice in states which do not participate in the compact.)

The National Council Of State Boards Of Nursing Developed The "Mutual Recognition" Model, And Recommend That States Join The Multi-State Nurse Licensure Compact

The National Council of State Boards of Nursing (NCSBN) is an organization whose members are the executive directors of the state boards of nursing across the country. Through the NCSBN, boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety, and welfare, including the development of licensure examinations for nursing.

NCSBN developed the mutual recognition model of nurse licensure and the multi-state nurse licensure compact. In doing so, NCSBN announced that its policy goal was to "simplify governmental processes and remove regulatory barriers to increase access to safe nursing care." Since the development of the mutual recognition model and compact language in 1998, NCSBN has recommended that all states adopt this approach to regulating both RNs and LPNs. (The mutual recognition model and multi-state licensure compact does not apply to certified nurse aides or advanced practice nurses.)

The Multi-State Nurse Licensure Compact Specifically Addresses Four Areas: Jurisdiction, Discipline, Information Sharing, And Administration

As noted previously, to implement the mutual recognition model of nurse licensure and regulation, states must join the multi-state nurse licensure compact. To do so, each state must pass legislation authorizing its participation. The language of the compact legislation must be essentially the same in all participating states so that each jurisdiction abides by the same rules and provisions. The NCSBN developed "boilerplate" language for use by each of the participating states. This language formed the basis for the bill drafted by the JCHC last year prior to the 2001 Session of the General Assembly (see Appendix A). While states do have some limited flexibility in modifying the compact language, the provisions must remain essentially the same. Based on information provided by NCSBN, four specific areas are addressed in the compact: jurisdiction, discipline, information sharing, and administration.

Jurisdiction: In a state that adopts the compact, the nurse is *licensed* only in the state of residence or "home state." The nurse would need to meet that state's licensure requirements and abide by the nursing practice act and other applicable state laws, just as currently required. Other states participating in the compact in which the nurse practices, but does not live, are called "remote states." Under the compact, remote states grant a *privilege* to practice, but do <u>not</u> issue a license. To practice in a remote state, the nurse must have an unencumbered license in his/her home state. When practicing in the remote state, the nurse must do so within the scope of practice and in accordance with the standards of the remote state. The multi-state compact does not define nursing, nursing practice or scope of practice. These matters will continue to be addressed in the respective states' practice acts.

Discipline: NCSBN notes that it is important for both the state of residence and remote state to be able to take appropriate disciplinary action to protect the health and safety of their respective citizens. As such, under the

compact, both the state of residence and remote state may take disciplinary action against a nurse who is practicing in an incompetent or unethical manner. The distinction between the actions taken by the respective states is that the home state takes action against the *license* (e.g., probation, suspension or revocation), while the remote state takes action against the practice *privilege* granted by the compact (e.g., issue a cease-and-desist order). The compact allows for both states to conduct disciplinary investigations concurrently rather than having to wait for one state to take formal action against the nurse as is currently the process. Both disciplinary procedures include due process provisions for the nurse.

Information Sharing: The compact provides for reporting and maintenance of licensure and discipline information on each nurse through a "coordinated licensure information system." The compact provides that the coordinated licensure information system will be administered by a non-profit organization composed of and controlled by state nurse licensing boards (ostensibly, the NCSBN or a subsidiary). There are confidentiality protections in the compact provisions. One such provision allows states to "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." Further, "[A]ny personally identifiable information obtained by a party state's 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."

Administration: The compact provides that the executive of the nurse licensing authority in each party state is among a group designated as "compact administrators." This group of compact administrators jointly has the authority to write the rules and regulations to implement and administer the compact. The rules and regulations developed by the compact administrators include issues related to jurisdiction, discipline, information sharing, and other pertinent matters.

Figure 5 summarizes these and other key aspects of the multi-state nurse licensure compact as described by NCSBN.

Figure 5

Key Provisions of the Multi-State Nurse Licensure Compact

Issue	Key Provision
Nurses Covered by Compact	RNs and LPNs only
Jurisdiction	Nurses are licensed only in state of residence; duplicate licenses in other compact states are not permitted; to practice in other "non-compact" states, a nurse must obtain a duplicate license 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
Discipline	"Home" state (state of residence/licensure) can take action against the *license*; "remote" states (other compact state in which nurse practices) can take action against practice *privilege* provided by the compact
Information Sharing	All participating states provide licensure and disciplinary information to a "coordinated licensure information system"
Administration	Compact is administered according to rules and regulations adopted by the "compact administrators" who are the nurse executives of the participating states
Impact on State Licensure Requirements	States will continue to have complete authority in determining licensure requirements and disciplinary actions according to their respective Nurse Practice Act.
Implementation of Compact	States must enact legislation to authorize participation in the compact; legislation must be essentially the same in each state to ensure consistency of administration
Withdrawal From Compact	States can withdraw from the compact by repealing the enabling legislation; six months notice must be given to the executive heads of all other party states prior to the effective date of the withdrawal; there is no minimum length of participation

Source: JCHC staff analysis of information provided by the National Council of State Boards of Nursing

The National Council of State Boards of Nursing And States Participating In The Compact Identify Several Advantages Of The Mutual Recognition Model And The Multi-State Nurse Licensure Compact; However, There Is General Consensus That This Approach Does Not Help To Address The Current Nursing Shortage

According to the National Council of State Boards of Nursing (NCSBN) and the states which have joined the compact, there are several advantages to adopting the mutual recognition model of licensure and joining the compact. Chief among these advantages are that the compact: (i) addresses the licensure issues related to "telehealth" or "telenursing;" (ii) addresses the issue of nurses practicing in multiple states or living in one state and working in another; (iii) eliminates the need for nurses to maintain duplicate licenses and pay multiple licensure fees; and (iv) improves the timeliness of licensure and discipline information-sharing. However, there is general agreement that mutual recognition does not help to address the nursing shortage. It is important to note that while this model of regulation and the compact provide a more streamlined licensing system with several noted advantages, it does not increase the actual number of available nurses.

Telehealth/Telenursing: Both the NCSBN and states which have joined the compact indicate that the practice of "telenursing" in which nursing services are provided to patients through telephone triage services or other similar arrangements has increased substantially in recent years. NCSBN cites statistics that indicate 24-hour nursing services were available to 2 million Americans in 1990, 35 million Americans in 1997, and a projected 100 million in 2001. Moreover, this practice increasingly is provided across state lines through regional and national call centers. Examples of this type of telenursing would be nurses who provide utilization review services for managed care insurance plans, and nurses who triage patients for inpatient or other levels of care. While this type of practice does not involve the traditional "hands-on" care, there is consensus among the state boards of nursing that this does constitute the practice of nursing. NCSBN has concluded that current licensure laws do not address adequately whether states have the authority to regulate the practice of a nurse who physically is located in another state. The mutual recognition model addresses this issue by enabling a nurse licensed in one compact state to also have licensure privileges in all other compact states without having to purchase a duplicate license.

Cross-State Practice/Practice in Multiple States: Currently, nurses who work in multiple states must maintain a separate license in each jurisdiction and

pay the accompanying licensure fees. Examples of this situation include nurses who work for employers with facilities in several states and whose job duties require them to travel to other states and provide nursing services. Another example would be "traveling nurses" who work for nursing agencies and are sent to different states for varying lengths of time to work on a contract basis. As with telenursing, mutual recognition enables these nurses to have one license that allows them to work in multiple compact states.

Information-Sharing: NCSBN notes that mutual recognition and the multi-state licensure compact enables individual boards of nursing in the compact states to have more timely access to licensing and disciplinary information on nurses. Also, NCSBN notes that such a system facilitates a more accurate count of licensed nurses. By maintaining a single license for each nurse, an accurate, non-duplicated count of nurses can be developed for workforce planning purposes.

Concerns About The Compact Have Been Raised By The American Nurses Association And Some State Attorneys General

While several advantages have been identified by proponents of the mutual recognition approach to nursing regulation and the multi-state licensure compact, concerns have been voiced by others. The American Nurses Association (ANA) issued a position statement in 1999 expressing "grave concerns" about the multi-state nurse licensure compact recommended by the NCSBN. NCSBN adopted several language changes to the model compact legislation which allayed some of ANA's concerns. However, in its February, 1999 position statement, the ANA Board of Directors stated that it continues to believe the following seven "guidelines" for nurse licensing and regulation have not been addressed adequately by the multi-state nurse licensure compact:

- "the state of predominant practice should be the state of licensure; if the nurse is not practicing, the nurse should be licensed in his/her state of residence;

- interstate practice must not be implemented in a way that allows persons to circumvent or contravene existing public policy as expressed by a state's laws or policies, including laws on the use of strikebreakers and striker replacement or initial and continuing licensure requirements;

- approaches to interstate advanced practice nursing should be addressed for consistency in connection with interstate practice for other RNs;

- mechanisms should be in place that ensure nurses have ready and ongoing access to practice-related information, including current board of nursing policies;

- mechanisms should be in place to ensure that a board of nursing knows who is practicing in its state under authority of a license granted by another state or through an interstate practice agreement;

- the right of individual nurses to a fair hearing of any disciplinary matter must be protected; and no unfair or undue burden, financial or otherwise, should be placed on a nurse's exercising his/her right to a fair hearing; and

- the rule-making process to implement any interstate practice legislation should be clearly spelled out in the legislation, and proposed implementation regulations of key provisions should be developed simultaneously with any legislation." (Source: ANA)

JCHC staff contacted the ANA to determine if this position has been modified since 1999. A representative of ANA stated that the position statement is still current.

As will be discussed later in this section, two states advised JCHC staff that their state nursing organizations share ANA's concerns and oppose the compact. However, the states which have joined the compact reported that their state-level nursing organizations fully supported their joining the compact.

Attorneys General Opinions: The Office of the Attorney General in Kansas, Nebraska, Wisconsin, and Maryland, and the California Department of Consumer Affairs Legal Office issued opinions/interpretive documents regarding the constitutionality of the compact. In a 1999 opinion, the Kansas Attorney General opined that the provisions of the compact which allow a nurse who is licensed in his/her home state to be granted licensure privilege in all other participating states (i.e., remote states) is unconstitutional. Specifically, the Kansas Attorney General stated that "[B]ecause the compact would, through absolute reciprocity, allow other states' legislatures the unqualified right to determine the qualifications for the practice of nursing in this state by nonresidents, we believe the compact would be an unconstitutional delegation of legislative authority." As a result of this legal opinion, Kansas decided not to join the compact.

A 1999 opinion issued by Nebraska Attorney General Don Stenberg agreed with the Kansas opinion that the compact would "constitute an impermissible delegation of the legislative power." However, subsequent to the 1999 opinion, the Attorney General suggested amendments to the compact language that resolved his constitutional concerns. As is reported later in this section, Nebraska is one of 15 states which have joined the compact.

Attorney General J. Joseph Curran, Jr. of Maryland disagreed with the Kansas opinion, and concluded that the compact does not "invalidly delegate legislative power." The Maryland opinion also stated that "[I]t is our view that this no more constitutes an invalid delegation of legislative power than do the provisions of law that permit a nonresident of this State to drive here based on an out-of-state driver's license."

Wisconsin's Attorney General, James E. Doyle, opined in September, 1999, that the compact "may (emphasis added) constitute an impermissible delegation of legislative power. In my opinion, that concern has a substantial basis, although I cannot conclude with certainty that our courts would find 1999 S.B. 129 (compact legislation) to violate the Wisconsin Constitution's prohibition against the delegation of legislative authority." However, like Nebraska, this concern ultimately did not prevent Wisconsin from joining the compact as the state legislature passed legislation in 1999 to join the compact.

In California, the Board of Vocational Nurse and Psychiatric Technician Examiners requested legal assistance from the California Department of Consumer Affairs Legal Office on the compact. The legal office did not opine on the ultimate constitutionality of the compact, but identified "issues which may be problematic for the board." In advising the Board, the legal office stated that "the constitutionality of the Compact as drafted is not a clear issue." The legal analysis identified the following as areas of concern: "(1) authority for states to enter into such a formal agreement absent Congressional approval; (2) possible violation of the Privileges and Immunities clause of the U.S. Constitution; (3) double jeopardy; and (4) difficulties in providing 'full faith and credit' to disciplinary actions occurring outside the state."

In summary, although some constitutional objections to the compact have been raised, the fact that 15 states have enacted legislation to authorize participation in the compact suggests that the Attorneys General in these states believe the compact to be constitutional. Staff with the Virginia Board of Nursing indicated that while no formal opinion was requested by the Virginia Office of

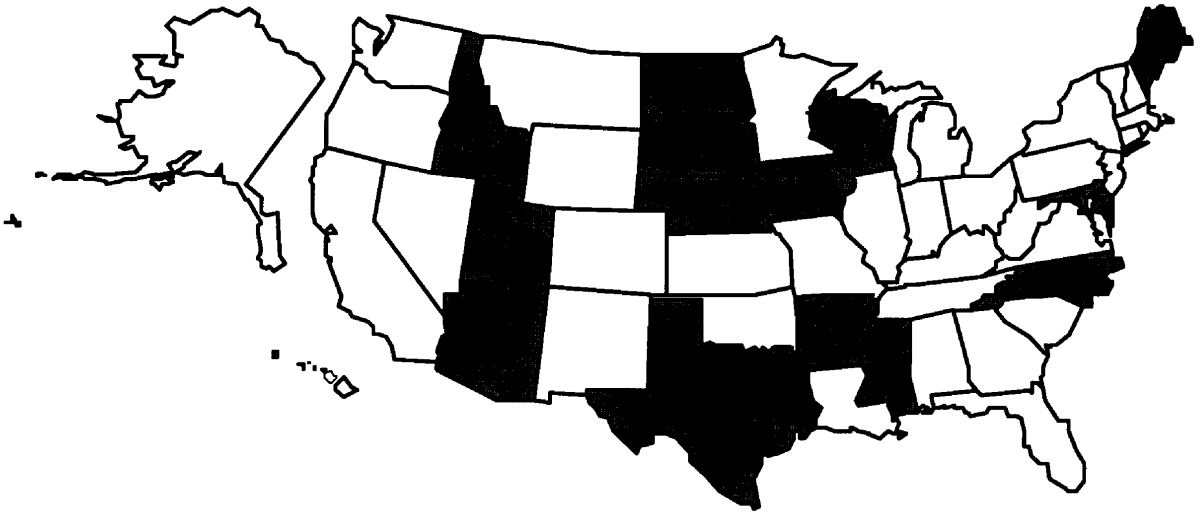
the Attorney General, the Board's Assistant Attorney General reviewed the compact language and did not raise any objections.

Fifteen States Have Enacted Legislation To Join The Multi-State Nurse Licensure Compact

As illustrated in Figure 6, 15 states have enacted legislation to join the multi-state nurse licensure compact. The states that have passed legislation to join the compact have done so since 1998 (Figure 7). Utah was the first to pass legislation to join (1998); however, Maryland was the first state to implement the compact (1999). Five states (Arizona, Idaho, Maine, Mississippi, and North Dakota) have passed the enabling legislation, but have not yet implemented the compact.

Figure 6

States Which Have Enacted Legislation To Join The Multi-State Nurse Licensure Compact



Source: National Council of State Boards of Nursing

Figure 7

Implementation Date of Those States Which Have Joined The Multi-State Nurse Licensure Compact

State	Implementation Date
Arizona	July 1, 2002
Arkansas	July 1, 2000
Delaware	July 1, 2000
Idaho	July 1, 2001
Iowa	July 1, 2000
Maine	July 1, 2001
Maryland	July 1, 1999
Mississippi	July 1, 2001
Nebraska	January 1, 2001
North Carolina	July 1, 2000
North Dakota	2003
South Dakota	January 1, 2001
Texas	January 1, 2000
Utah	January 1, 2000
Wisconsin	January 1, 2000

Source: National Council of State Boards of Nursing

States Indicate The Main Reasons For Joining The Compact Are To Address The Issue Of Cross-State Practice Of Nursing And To Eliminate The Need For Nurses To Maintain Duplicate Licenses; States' Limited Experience With The Compact Has Been Positive

Joint Commission staff conducted a telephone survey of the Executive Directors of the Boards of Nursing in all 15 states which have passed legislation to join the compact. Interviews were conducted with the nursing executive in 13 of the participating states. Based on these interviews, the reasons for joining the compact most often cited by nursing executives were: (i) the ability to regulate better various forms of the cross-state practice of nursing (e.g., telenursing, and living in one state and working in another state), and (ii) eliminating the need for nurses to maintain duplicate licenses. Other reasons for joining that were cited less often were: (i) obtaining more timely nurse licensure and discipline information; and (ii) improving continuity of care for patients. While the compact has been in effect for a little less than one year, all of the nursing executives indicated that, thus far, their experience with the administration and operation of the compact has been positive.

Among Those States That Currently Do Not Participate In The Compact; Ten States Indicate They Will Seek Legislation To Join; Nine States Have Decided Not To Join At This Time

JCHC staff conducted a mail survey of the 35 states (including the District of Columbia) which currently do not participate in the multi-state nurse licensure compact. (A copy of the survey is attached at Appendix B.) The survey was sent to the Executive Director of the Board of Nursing in each jurisdiction. A total of 29 states responded to the survey for a response rate of 83%. As seen in Figure 8, the Boards of Nursing in 10 of the 29 states (34%) which responded to the survey indicated that they have decided not to participate in the compact at this time; the Boards of Nursing in nine states (31%) have decided to participate and will seek legislation to do so. The Boards in another seven states (24%) indicate that they currently are studying whether or not to participate; one state's Board of Nursing responded that it has not considered whether to participate; and two others indicated they are undecided at this time.

Figure 8
Responses Of State Boards Of Nursing In Those States Which Have Not Joined The Compact:
Current Position Regarding Compact Participation

Current Position of Board of Nursing Regarding Compact Participation	States
Have Decided Not To Participate At This Time	Alabama California Kansas Kentucky Louisiana[1] New Hampshire New York Pennsylvania Vermont West Virginia[2]
Decided To Participate and Will Seek Legislation To Do So	Alaska[3] Georgia[4] Massachusetts Minnesota Missouri[5] Nevada New Jersey Ohio Tennessee
Currently Studying Whether Or Not To Participate	Connecticut Hawaii Indiana Michigan New Mexico Oklahoma Oregon
Have Not Really Considered Whether or Not To Participate	Florida
Other	Rhode Island[6] Wyoming[7]

Notes:
1 Louisiana's response applies to LPNs only
2 West Virginia submitted separate responses (one for LPNs and one for RNs), because each response was the same, their responses were counted as one state response
3 Alaska has decided to participate, but wants to wait and see how compact works in other states before seeking legislation
4 Georgia's response applies only to RNs; response indicated "Other," but legislation was introduced
5 Missouri responded "Other," but indicated that a bill to implement the compact was introduced in the legislature
6 Rhode Island stated the Board of Nursing is undecided
7 Wyoming stated the Board of Nursing is monitoring the compact

Source: JCHC staff survey of other states

States' Reasons For Deciding To Join The Compact Include: Eliminating Duplicate Licenses For Nurses; Improving Continuity of Patient Care; Addressing Telenursing And Cross-State Practice; And Improving Timeliness Of Nurse Licensure And Disciplinary Information

Among the nine Boards of Nursing that indicated they intend to join the compact, there was a great deal of consistency in the reasons given for wanting to do so (Figure 9). The JCHC survey asked respondents to indicate which of five

Figure 9
Boards Of Nursing That Indicated They Plan To Join Multi-State Nurse Licensure Compact:
Main Reasons For Deciding To Participate In Compact

State	Main Reasons For Deciding To Participate In Compact				
	Eliminate Duplicate Licenses for Nurses	Improve Continuity of Patient Care	Address Telehealth & Cross-State Practice	More Timely Licensure & Disciplinary Information	Other
Alaska		✔			
Georgia (RN)*					
Massachusetts	✔	✔	✔	✔	
Minnesota	✔	✔	✔	✔	
Missouri	✔	✔	✔	✔	
Nevada		✔	✔	✔	
New Jersey			✔	✔	
Ohio	✔		✔		
Tennessee	✔	✔	✔	✔	
TOTALS	**5**	**6**	**7**	**6**	**0**

Note: States were asked to "check" all main reasons that factored into their decision
* Georgia's response did not include specific reasons for introducing legislation
Source: JCHC staff survey of other states

potential reasons for deciding to join the compact were considered "main reasons" in their decisions. Seven states cited "addressing telehealth and cross-state practice of nursing" as a main reason; six states identified "continuity of patient care" and "more timely nurse licensure and discipline information" as key reasons; while five states indicated "eliminating the need for nurses to maintain duplicate licenses" as a main reason for joining the compact. (The total number of responses to this survey question exceeds the number of responding states as respondents were asked to "check" all of the main reasons on the survey that applied to their respective decisions.)

Based on the decisions of the Boards of Nursing in those states which indicated they plan to seek legislation to join the compact, a total of 24 states (15 current; 9 planned) will be participating in the multi-state nurse licensure compact in the near future. (This assumes that each state which indicated they intend to seek legislation to join the compact is successful in getting the legislation passed.)

The Main Reasons Cited By States For Deciding Not To Join The Compact Include: Loss In Nurse Licensure Fees; Concern As To Whether There Is A Need For The Compact; Concern Regarding Dual Disciplinary Actions; And Concern About Potential Impact On State Licensing Standards

Among the 10 Boards of Nursing that indicated they had decided not to join the compact, there was more variation in the reasons given for their decisions (Figure 10). The JCHC survey asked respondents to indicate which of seven potential reasons for deciding not to join the compact were considered "main reasons" in their decisions. The reason cited most often by these states was "concern/uncertainty regarding dual disciplinary actions." (This concern relates to the provision within the compact that nurses who are licensed in one compact state and working in another compact state are subject to possible disciplinary action in both the "home" state of licensure as well as the "remote" state in which the alleged violation occurs.) Nine of the ten states cited this as one of the main reasons for deciding not to participate in the compact. Loss of licensure fees was cited by six states; five states questioned the need for the compact; five states also cited "other" concerns; four states cited concern/uncertainty over impact on state licensure standards; two states indicated that more information was needed before a decision could be made to participate; and, lastly, two states cited opposition from state nursing organization(s) as a main reason for deciding not to participate.

Figure 10

Boards Of Nursing That Indicated They Have Decided Not To Join Multi-State Nurse Licensure Compact: Main Reasons For Deciding Not To Participate In Compact

	Reasons For Deciding Not To Participate In Compact*						
	Loss of License Fees	Question Need for Compact	Dual Discipline Actions	Impact on Licensure Standards	Need More Info	Nurses Opposed Compact	Other
Alabama[1]			✔				✔
California	✔		✔			✔	
Kansas[2]							✔
Kentucky	✔		✔				
Louisiana[3]	✔	✔	✔	✔			✔
N. Hampshire	✔	✔	✔	✔			
New York	✔	✔	✔			✔	
Pennsylvania[4]	✔		✔		✔		✔
Vermont		✔	✔	✔			
West Va.[5]		✔	✔	✔	✔		✔
TOTALS	6	5	9	4	2	2	5

Notes:

* States were asked to "check" all main reasons that factored into their decision

1 Alabama's "Other Reason" related to concerns regarding resolution of complaints

2 Kansas' "Other Reason" related to Attorney General opinion that compact was unconstitutional

3 Louisiana's "Other Reason" related to concern that the Board would not know who is practicing in state

4 Pennsylvania's "Other Reason" related to subpoena powers

5 West Virginia's information combines responses from two separate Boards (LPN & RN); "Other Reason" was cited by RN Board and related to concern regarding knowing who is practicing in the state

Source: JCHC staff survey of other states

IV.
Potential Impact Of Virginia's Participation In The Multi-State Nurse Licensure Compact

The Virginia Board Of Nursing Adopted A Resolution In September, 2000 To Join The Multi-State Nurse Licensure Compact And To Request That The Governor Introduce The Necessary Legislation

The issue of Virginia's participation in the multi-state nurse licensure compact was addressed by the Board of Nursing during 2000. On September 26, 2000, the Board adopted a resolution to join the compact, and to request that the Governor have legislation introduced during the 2001 General Assembly to authorize its participation. Among the reasons cited by the Board to participate in the compact were addressing the issues of cross-state practice of nursing and "telenursing." However, the Administration did not have legislation introduced to join the compact.

The Joint Commission On Health Care Had Legislation Drafted To Authorize Virginia's Participation In The Multi-State Nurse Licensure Compact; However, The Department Of Health Professions Expressed Concern That Participation In The Compact Would Have A Negative Fiscal Impact On The Budget Of The Board Of Nursing

As noted in Section I of this report, the Joint Commission on Health Care (JCHC) conducted a study during the 2000 interim on actions that the Commonwealth could take to recruit, train and educate qualified nurses in Virginia. One of the policy options included in the report and initially supported by the JCHC was to introduce legislation to authorize Virginia's participation in the compact. At the time, this action was viewed by the JCHC as supporting the Board of Nursing's desire to participate in the compact. During the December, 2000 public comment period for the JCHC's 2001 draft legislation, comments were received in support of the compact legislation. However, the Department of Health Professions (DHP) commented that participation in the compact would result in a reduction in nurse licensure renewal fees of approximately $532,000 biennially. DHP indicated the revenue loss would result from the compact provision that requires nurses to hold only one license to practice in the compact states, and that the license be issued by the state of residence. DHP stated that while its analysis was not final, an estimated 7,600 nurses who are licensed in

Virginia, but live out-of-state, would no longer require a Virginia license resulting in the revenue loss.

In response to DHP's comments, the JCHC decided not to introduce the legislation during the 2001 General Assembly Session, and to conduct further analysis of the compact and its potential impact on licensure fees. This section of the report presents the results of further analyses on the fiscal impact of Virginia's participation in the compact as well as a review of the fiscal impact that the licensure compact has had in other states.

DHP Staff Indicate That The Agency Is Not Opposed To The Concept Of The Compact, But That They Would Not Support Raising Licensure Fees To Offset The Loss Of Revenue That Would Result From Participation In The Compact

DHP staff interviewed for this study indicated that the agency did not oppose the concept of the compact. However, the agency is concerned that licensure fees would have to be raised to offset the lost revenue from out-of-state residents no longer needing to have a license issued by Virginia to practice in Virginia. The agency stated it does not support increasing the fees. This position is consistent with the Department's opposition to raising fees to pay for the collection of nursing workforce data as proposed in SB 488 and HB 1249 of the 2000 General Assembly Session. (In response to DHP's concerns, the bills were amended to use general funds rather than licensure fees to support the data collection.)

DHP's concerns are based in large part on the significant increase in fees that took effect in April, 2000 when RN and LPN renewal fees increased from $40 to $70 (See Figure 2). DHP indicates that a further increase, even if it is only $5.00 per renewal, would be problematic and that nurses would oppose the increase. As noted in Section III, DHP's concerns were echoed by six of the ten states which indicated in the JCHC survey that they had decided not to participate in the compact. These six states mentioned concern over a loss of licensure fee revenues as one of the main reasons why they decided not to participate.

Information Provided By DHP In May, 2001 Indicates That There Are Approximately 7,900 Nurses Licensed In Virginia Who Live In A Current Compact State; These Nurses No Longer Would Pay Virginia Licensure Fees Under The Compact Resulting In Reduced Revenues For The Board Of Nursing

DHP provided JCHC staff with an updated state-by-state analysis which indicated there are 7,861 RNs and LPNs who are licensed in Virginia, but who live outside of Virginia in a current compact state. Under the provisions of the compact, these nurses no longer would pay Virginia licensure fees because of the compact provisions that require nurses to be licensed in their state of residence. Figure 11 identifies the number of nurses licensed in Virginia who live in each of the current compact states.

Figure 11

Nurses Licensed In Virginia Who Live In Current Compact States

State	RNs	LPNs	Total
Arizona	155	23	178
Arkansas	44	9	53
Delaware	88	17	105
Idaho	18	3	21
Iowa	44	4	48
Maine	51	8	59
Maryland	3,421	768	4,189
Mississippi	85	10	95
Nebraska	27	3	30
North Carolina	1,910	404	2,314
North Dakota	10	5	15
South Dakota	8	1	9
Texas	555	92	647
Utah	29	2	31
Wisconsin	57	10	67
TOTALS	6,502	1,359	7,861

Source: Department of Health Professions (May 2, 2001 data)

Impact on Renewal Fees: Each of the nurses identified in Figure 11 currently pay a biennial license renewal fee of $70.00 to maintain a Virginia license. However, if Virginia were to join the compact, these nurses no longer would obtain a license from Virginia resulting in a loss of revenue of approximately $550,270 in each biennium. Under the compact, Virginia would continue to be responsible for disciplining these nurses should there be a need to do so. Inasmuch as the cost of pursuing disciplinary actions is one of the most significant regulatory costs of the Board of Nursing, licensure fees would have to be increased to replace the lost revenue. Based on an expected loss of $550,270 each biennium, the fees paid by those nurses who live in Virginia would have to be increased approximately $5.47 per biennium. While there may be some efficiency savings from participating in the compact, to date, there has not been sufficient experience upon which to base any firm savings estimates.

If Virginia Joined The Compact, Some Nurses Who Currently Live In Virginia But Work In Another Compact State And Whose Only License To Practice Is Issued By The Other Compact State Would Be Required To Obtain Their License From Virginia; These Nurses Would Represent Some Additional Licensure Fee Revenue

While Virginia would lose licensure fee revenues from nurses who are licensed in Virginia but live in other compact states, some additional licensure revenue also would be generated that partially would offset this loss. This new revenue would come from nurses who live in Virginia but work in another compact state and currently maintain only a license to practice in that state (i.e., do not currently have a Virginia license). An example of this situation would be a nurse who lives in a border area of Virginia, and works in another compact state, such as North Carolina or Maryland.

To estimate the impact of this additional revenue, JCHC staff contacted the Maryland and North Carolina Boards of Nursing and requested information on those nurses licensed in their respective states who have Virginia mailing addresses. This information was matched against Virginia's Board of Nursing licensee files to determine how many of these nurses are not licensed in Virginia. Based on this analysis, a total of 1992 nurses (286 licensed in North Carolina and 1706 licensed in Maryland) live in Virginia but currently do not have a Virginia license. Under the compact, these nurses would have to obtain their licenses from Virginia, resulting in an estimated $139,440 in additional license renewal fee revenues for Virginia. If this amount is applied against the estimated $550,270 loss of revenue, the net loss would be $410,830 which would lower the projected fee increase from $5.47 per biennium to approximately $4.00. (See Figure 12)

Figure 12

Estimates Of Lost Licensure Revenues And Licensure Renewal Fee Increases

Method of Analysis	Estimated Revenue Loss	Estimated Increase in Nurse Biennial License Renewal Fees
No Adjustment for "Gained Licensees[1]"	$550,270	$5.47
Adjusted For "Gained Licensees[1]" from N.C. and Maryland	$410,830	$4.00

Notes:
[1] "Gained Licensees" refers to nurses who: (i) are licensed in NC or Maryland; (ii) live in Virginia; and (iii) currently do not have a Virginia license

Source: JCHC staff analysis

It should be noted that there are some limitations in this analysis. For instance, not all licensee records had full social security numbers (SSN), particularly Maryland records (some had no SSN). As such, not all licensees with a Virginia address were analyzed. This may have reduced the number of nurses identified by the analysis as having to obtain a license from Virginia. On the other hand, if a record contained a 9-digit number but it was not a valid SSN (and the records appeared to include some like this), the nurse was identified as not having a Virginia license, when, in fact, the nurse could have had a Virginia license. This would have incorrectly increased the number of nurses identified as having to obtain a Virginia license. Additionally, there may be other intervening variables that could result in a lower or higher number of nurses who would be required to obtain a Virginia license under the compact. Nonetheless, this analysis does provide a rough estimate of some additional revenue that Virginia would realize that would partially offset the amount of lost license fee revenues.

Data were not available from the other compact states to conduct a similar analysis. However, as seen in Figure 11, Maryland and North Carolina represent

the most significant revenue impact on Virginia in terms of both potential revenue losses and gains.

As More States Join The Compact, The Impact On Fees Is Expected To Increase

Based on the JCHC survey of other states, 9 additional states plan to join the compact. Assuming these states are successful in passing the required legislation, the number of compact states will increase to 24 in the next few years. While 10 states indicated they do not plan to participate in the compact at this time, it is likely that at least a few other states will join in future years. As the number of compact states increases, the impact on licensure fees will increase. Inasmuch as North Carolina and Maryland (two of Virginia's major border states) already are in the compact and factored into the impact on licensure fees, the additional impact of other states joining the compact likely will be in small increments. Further, any increase would occur over time as opposed to all at once. Nonetheless, as more states join the compact, the impact on licensure fees would be expected to increase.

There Are Some Virginia Nurses Who Will See A Reduction In Fees If Virginia Joins The Compact

While the renewal fees would increase for a significant majority of Virginia nurses, those who hold multiple licenses to practice in the compact states would see a reduction in the total amount of fees they pay. For example, a nurse who lives in Virginia and has licenses in Virginia and Maryland would save money through the compact as he/she would only have to maintain his/her Virginia license to practice in both Virginia and Maryland. NCSBN estimates that approximately 12% of nurses nationally hold multiple licenses. While the number of Virginia nurses who would fall into this category is not known, based on the NCSBN estimates, it would not be an insignificant number.

The National Council Of State Boards Of Nursing Has Drafted An Optional Compact Provision Allowing States To Recover Enforcement Costs From Affected Nurses; This Provision Could Be Used To Offset Revenue Losses

The National Council of State Boards of Nursing (NCSBN) has drafted several optional enabling act provisions that states can include in their legislation, if desired. One such provision would authorize the state to recover from the affected nurse the cost of investigations and disposition of cases resulting from adverse actions taken by the state. Currently, Virginia does not require affected nurses to pay these costs. The revenue generated from this

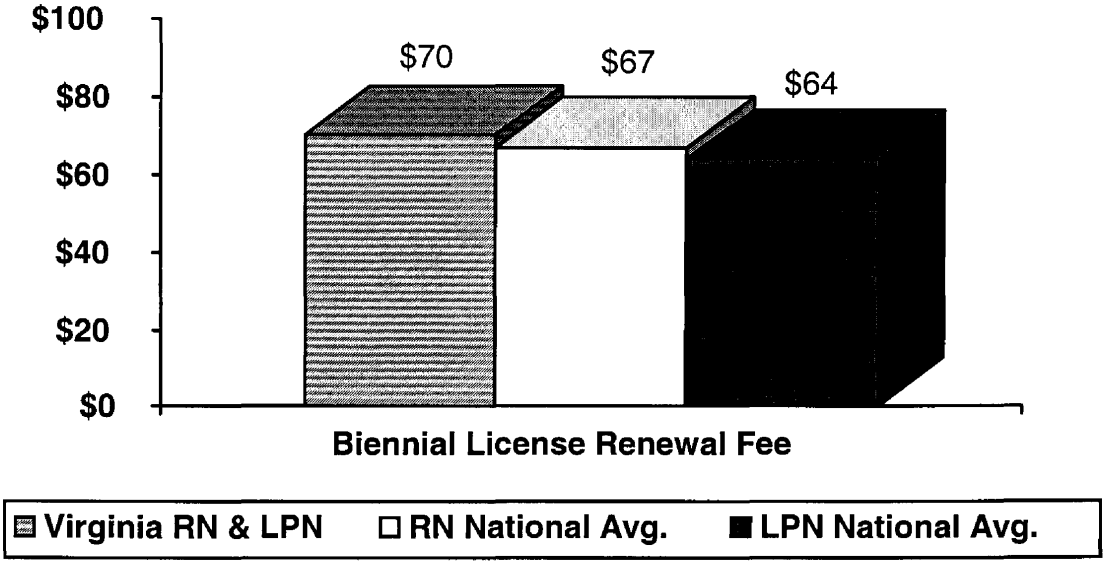
provision could be used to offset a portion of the expected loss in license fee revenues.

Virginia's RN And LPN Biennial Renewal Fees Are Slightly Higher Than The National Average

JCHC staff obtained the RN and LPN renewal fees in all other states to compare with Virginia's current renewal fee. In comparison to other states, Virginia's biennial renewal fee of $70 is slightly higher than the national average of $67 for RNs and $64 for LPNs (see Figure 13). Increasing fees to participate in the multi-state nurse licensure compact would push Virginia's fees further above the national average.

Figure 13

Virginia's RN And LPN License Renewal Fee Compared To National Average



Note: Some states' renewal fees are annual; these amounts were doubled to equal a biennial amount

Source: JCHC staff analysis of fee information provided by other states

Virginia RN And LPN Renewal Fees Were Compared To Five Other Types Of Health Care Professionals Who Earn Relatively Comparable Salaries

The license renewal fees for RNs and LPNs are based on the costs incurred by the Board of Nursing and the Department of Health Professions (DHP) to regulate the profession, and not based on income level. As such, comparing RN and LPN fees to other health care professionals has somewhat limited applicability because the fees of other health care professionals also are based on the costs incurred by the respective Board and DHP, rather than income level or some other measure. Nonetheless, some of the reluctance to impose a fee increase on RNs and LPNs generally rises out of concern about the ability of a nurse to pay a higher fee. For illustrative purposes, JCHC staff compared RN and LPN renewal fees to several other health care professionals who earn salaries that fall within the range of a RN and LPN. According to information maintained by the Virginia Employment Commission (VEC), the average annual salary for a RN in 1999 was $41,310; the average salary for a LPN was $26,680. JCHC staff identified five other types of health care professionals included in the VEC data who earn salaries between these amounts, and compared the biennial renewal fees to that for RNs and LPNs. As seen in Figure 14, nurses pay a lower renewal fee than Physician Assistants, Respiratory Therapists, and Radiologic Technologists. The RN and LPN renewal fees are the same as that for a Physical Therapist Assistant, and are $10 higher than the fee paid by an Audiologist.

Estimates Of The Impact On Licensure Fees Calculated By Compact States Are Generally Consistent With The Estimates Calculated For Virginia; However, At This Time, Only One State Is Increasing Its Fees As A Result Of Participation In The Compact

JCHC staff interviewed the Executive Directors in 13 of the 15 states which have adopted the compact. Each of the nursing executives indicated that their respective states were concerned about the impact on licensure fee revenues when they were considering participation in the compact. However, each stated it was not an overriding concern, and the impact would be felt gradually over time as more states joined rather than a significant one-time hike in the fees.

Figure 14

Virginia's RN And LPN License Renewal Fee Compared To Other Health Care Professionals Licensed In Virginia Earning Salaries Between RNs And LPNs

Health Care Professional	Mean Annual Salary	Biennial License Renewal Fee
RN/LPN	$41,310/$26,680	$70
Physician Assistant	$34,070	$135
Audiologist	$38,040	$60
Respiratory Therapist	$37,190	$135
Radiologic Technologist	$35,250	$135[1]
Physical Therapist Asst.	$34,570	$70

Note: Fees represent "active" license renewals

[1] Effective June 6, 2001; renewal fee for a Technologist-Limited is $70

Source: Virginia Employment Commission, 1999 State Occupational Employment and Wage Estimates, Virginia Health Regulatory Boards

While several states did not provide a specific estimate of the impact, several completed "rough analyses." The estimates generally ranged from about $5.00 per biennium to $7.30 per biennium. Three states whose estimates were in the $7.00 range indicated the amount assumed all states would join the compact. One state's initial estimate was $10-$15 per biennium; however, the estimate did not include any adjustment for new revenue from nurses who live in their state but are licensed only in another compact state. Also, the nursing executive in this state indicated that, so far, the need for this level of increase has not materialized. While virtually all of the nursing executives interviewed for this study indicated that fees likely would have to increase eventually, only one state, Maine, reported that its fees will increase as a direct result of participating in the compact. Maine plans to increase its biennial renewal fee by $ 5.00. Because the compact has been in effect for a short period of time, and there are relatively few states currently participating, most of the other states are monitoring license fee revenues and taking a "wait and see" approach.

Virginia Nursing Organizations Support The Multi-State Nurse Licensure Compact And Believe Nurses Would Not Oppose A Modest Increase In Their Renewal Fees

Representatives of the Virginia Partnership for Nursing (which represents many specialty nursing organizations), the Virginia Nurses Association (VNA), and the Virginia Organization of Nurse Executives (VONE) indicated that their organizations support the mutual recognition model, and that nurses likely would not oppose a modest fee increase to join the compact. (No survey of nurses was conducted to determine their position on a potential fee increase.) These same organizations, however, also stated in interviews with JCHC staff that if fees were going to be increased, they would prefer that the additional revenue be used to pay for enhanced nurse workforce data collection and analysis.

Several Virginia Health Care Organizations Also Expressed Support For The Multi-State Nurse Licensure Compact

In addition to the Virginia nursing organizations who support participation in the compact, several other health care organizations in Virginia also have expressed support. The Virginia Hospital & Healthcare Association, the Virginia Health Care Association, and the Virginia Association of Non-Profit Homes for the Aging advised JCHC staff that they support participation in the compact as a means of improving their ability to hire nurses quickly and efficiently.

V.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue regarding the issue of whether Virginia should participate in the multi-state nurse licensure compact.

Option I **Take No Action**

Option II **Introduce legislation authorizing Virginia to join the multi-state nurse licensure compact**

- **The bill could be drafted to include a provision allowing the Board of Nursing to recover from the affected nurse the cost of investigations and disposition of cases resulting from adverse actions taken against the nurse.**

- **If enacted, RN and LPN license renewal fees would need to be increased approximately $4-$5 per biennium**

Option III **Direct JCHC staff, in cooperation with the Board of Nursing, to monitor the implementation of the multi-state nurse licensure compact in other states and its impact on their respective license fee revenues**

APPENDIX A

A BILL to amend and reenact § 54.1-3007 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 30 of Title 54.1 an article numbered 6 consisting of sections numbered 54.1-3030 through 54.1-3040, relating to multistate licensure for nurses; Nurse Licensure Compact.

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-3007 of the Code of Virginia is amended and reenacted, and that the Code of Virginia is amended by adding in Chapter 30 of Title 54.1 an article numbered 6 consisting of sections numbered 54.1-3030 through 54.1-3040 as follows:

§ 54.1-3007. Refusal, revocation or suspension, censure or probation.

The Board may refuse to admit a candidate to any examination, refuse to issue a license or certificate to any applicant and may suspend any license, certificate or multistate licensure privilege for a stated period or indefinitely, or revoke any license, certificate or multistate licensure privilege, or censure or reprimand any licensee, certificate holder or multistate licensure privilege holder, or place him on probation for such time as it may designate for any of the following causes:

1. Fraud or deceit in procuring or attempting to procure a license;

2. Unprofessional conduct;

3. Willful or repeated violation of any of the provisions of this chapter;

4. Conviction of any felony or any misdemeanor involving moral turpitude;

5. Practicing in a manner contrary to the standards of ethics or in such a manner as to make his practice a danger to the health and welfare of patients or to the public;

6. Use of alcohol or drugs to the extent that such use renders him unsafe to practice, or any mental or physical illness rendering him unsafe to practice;

7. The denial, revocation, suspension or restriction of a license, certificate or multistate licensure privilege to practice in another state, the District of Columbia or a United States possession or territory; or

8. Abuse, negligent practice, or misappropriation of a patient's or resident's property.

Article 6.

Nurse Licensure Compact.

§ 54.1-3030. Definitions.

As used in the Nurse Licensure Compact, unless the context requires a different meaning:

"Adverse action" means a home or remote state action.

"Alternative program" means a voluntary, non-disciplinary monitoring program approved by a nurse licensing board.

"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 licensing boards.

"Current significant investigative information" means:

1. 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

2. 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.

"Head of the nurse licensing board" means the Executive Director of the Board of Nursing as used to define the compact administrator.

"Home state" means the party state which is the nurse's primary state of residence.

"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.

"Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

"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 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.

"Nurse" means a registered nurse or licensed practical nurse, as those terms are defined in § 54.1-3000.

"Party state" means any state that has adopted this Compact.

"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 the nursing practice is located.

"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.

"State" means a state, territory, or possession of the United States, the District of Columbia or the Commonwealth of Puerto Rico.

"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. "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.

§ 54.1-3031. Findings and declaration of purpose for compact.

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 advance 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.

§ 54.1-3032. 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 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 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 advance 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.

§ 54.1-3033. 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.

§ 54.1-3034. Adverse actions.

In addition to the general provisions described in § 54.1-3032, the following provisions apply:

1. 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.

2. 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 actions, 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.

3. 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.

4. 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.

5. 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.

6. 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.

§ 54.1-3035. Additional authorities invested in party state nursing licensing boards.

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

1. 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;

2. 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.

3. Issue cease and desist orders to limit or revoke a nurse's authority to practice in their state;

4. Promulgate uniform rules and regulations as provided for in subsection C of § 54.1-3037.

§ 54.1-3036. Coordinated licensure information system.

A. All party states shall participate in a cooperative effort to create a coordinated database of all licensed registered nurses and licensed practical 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 state's 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.

§ 54.1-3037. Compact administration and interchange of information.

A. The head of the nurse licensing board, or his designee, of each party state shall be the administrator of this Compact for his 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 by subdivision 4 of § 54.1-3035.

§ 54.1-3038. 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.

§ 54.1-3039. 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.

§ 54.1-3040. 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.

APPENDIX B

Interstate Nurse Licensure Compact

Survey Of Other States

State: _____

Person Completing Survey: _____

- Which of the following statements best describes the current posture of your Board of Nursing regarding participation in the interstate nurse licensure compact? *(Please check only one)*
  - ❑ Decided not to participate at this time
  - ❑ Decided to participate and will seek legislation to do so
  - ❑ Currently studying whether or not to participate
  - ❑ Have not really considered whether or not to participate
  - ❑ Other _____

- If your state has decided to participate in the compact, what were the main reasons for doing so? *(Please check all that apply.)*
  - ❑ Eliminate need for nurses to maintain duplicate licenses
  - ❑ Improve continuity of care for patients
  - ❑ Address issue of telehealth, cross-state practice, etc.
  - ❑ Obtain more timely nurse licensure and discipline information
  - ❑ Other _____

- If your state has decided **NOT** to participate in the compact at this time, what were the main reasons for doing so? *(Please check all that apply.)*
  - ❑ Loss in nurse licensure fees to support regulatory functions
  - ❑ Concern/uncertainty regarding need for an interstate compact
  - ❑ Concern/uncertainty regarding dual disciplinary actions
  - ❑ Concern/uncertainty regarding impact on your license standards
  - ❑ Need more information on compact before participating
  - ❑ Concerns/opposition voiced by state nursing organization(s)
  - ❑ Other _____

❑ PLEASE SEND ME A COPY OF THE SURVEY RESULTS AND REPORT

FAX RESPONSE TO: PAT FINNERTY (804) 786-5538

APPENDIX C

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Multi-State Nurse Licensure Compact Study

Organizations/Individuals Submitting Comments

A total of four organizations and individuals submitted comments in response to the report on the multi-state nurse licensure compact study:

- Virginia Hospital & Healthcare Association,
- Virginia Organization of Nurse Executives,
- AARP, and
- Mr. Gregory J. Huber

Policy Options Included in the Multi-State Nurse Licensure Compact Issue Brief

Option I — **Take No Action**

Option II — **Introduce legislation authorizing Virginia to join the multi-state nurse licensure compact**

- **The bill could be drafted to include a provision allowing the Board of Nursing to recover from the affected nurse the cost of investigations and disposition of cases resulting from adverse actions taken against the nurse.**
- **If enacted, RN and LPN license renewal fees would need to be increased approximately $4-$5 per biennium**

Option III — **Direct JCHC staff, in cooperation with the Board of Nursing, to monitor the implementation of the multi-state nurse licensure compact in other states and its impact on their respective license fee revenues**

Overall Summary of Comments

Two of the four commenters (Virginia Hospital & Healthcare Association and the Virginia Organization of Nurse Executives) commented in support of Option II. AARP and Mr. Huber commented in favor of Option III.

Summary of Individual Comments

Virginia Hospital & Healthcare Association (VHHA)
Virginia Organization of Nurse Executives (VONE)

The VHHA and VONE submitted their comments in the same letter, and expressed support for Option II. VHHA and VONE noted that "[P]articipation in the compact provides needed flexibility in recognition of qualified nurses, facilitating the hiring of nurses by health care facilities, particularly those situated near the borders between Virginia and neighboring states." VHHA and VONE also commented that "[M]ulti-state practice and regulation also responds to concerns about regulation of telehealth practice. Implementing this option potentially enlarges the pool of nurses available to work in Virginia in all health care settings."

AARP

AARP commented in support of Option III. AARP noted that while it recognizes there would be certain advantages to individual RNs and LPNs if Virginia joined the compact, it "has concern whether other states in the compact would have licensure standards equal to Virginia's. Whereas revenue impact may be important, AARP believes it is secondary to assuring quality of care and assuring that licensure and training requirements in the other compact states are equal to or higher than Virginia's requirements." In supporting Option III, AARP also recommended a study of the comparability of licensing and training standards.

Mr. Gregory J. Huber

Mr. Huber commented that "[T]he compact attempts to deal with some issues in depth, such as discipline and adverse actions, yet other areas are left unclear, such as overall administration. Basically, this compact tries to implement some central control while maintaining state autonomy. Since all states have to legislate changes, problems will be hard to correct." His recommendation is that "the Commission and the Board of Nursing should monitor overall administration along with the impact on license fee revenues."

JOINT COMMISSION ON HEALTH CARE

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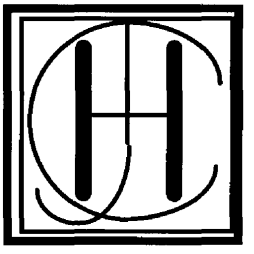

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