How Portable is Your Nursing License, Anyway?

Learning about the Nurse Licensure Compact

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OBJECTIVES:

The learner will be able to:

1. Identify the fundamentals of the Nurse Licensure Compact (NLC)
2. Recognize individual and employer responsibilities under the NLC
3. Identify how the Nursys system is used under the NLC
4. Recognize how technology is being used to facilitate the NLC

Background Information on the Nurse Licensure Compact

The Tenth Amendment to the U.S. Constitution provides states with the power to establish laws to protect its citizens. An element of this protective mandate is states' responsibility to establish standards for health care professionals. America has a well-established system for granting states the right to issue licenses to health care professionals. However, no state is given the right to grant authority for professional practice other states. With the advent of multistate delivery systems and nursing call centers, the nurse and the patient are more often in different locations. As a result, the state-based licensure structure is now being challenged by technology and entrepreneurial care delivery systems.

The Nurse Licensure Compact (NLC) allows a nurse to hold a license in one state and practice in other states, both physically and electronically. The process for creating a nurse licensure compact began in 1996 at the National Council of State Boards of Nursing (NCSBN) Delegate Assembly. At the 1997 Delegate Assembly, there was unanimous agreement to endorse a mutual recognition model of nursing regulation. Since 1998, the compact has included Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Vocational Nurses (VNs). The RN/LPN/VN compact began on January 1, 2000, when it was passed into law by the first participating states: Maryland, Texas, Utah and Wisconsin. The NLC is subject to each state's laws and regulations, with the goal of moving states from individual licensing provisions to a series of coordinated provisions ensuring a higher quality of care and greater professional opportunities for practicing nurses.

On August 16, 2002, the NCSBN Delegate Assembly approved the adoption of a licensure compact for advanced practice registered nurses (APRNs). Those states that have already adopted the RN/LPN/VN NLC may implement a compact for APRNs. On March 15, 2004, Utah was the first state to pass APRN Compact legislation.

States entering the compact also adopt administrative rules and regulations for implementing it. After the compact is enacted, participating states appoint a Nurse Licensure Compact Administrator (NCLA) whose job it is to share information with other participating states. The NLCA defines primary residence in the compact rules and regulations. Sources used to verify a nurse's primary residence for the NLC may include driver's license, federal income tax return and voter registration.

Licensing

A nurse's home state is the state in which they declare residency. This is also where they receive their license that allows participation in other NLC states. According to NLC regulations, a nurse

changing their primary state of residence from one NLC state to another, can continue to practice under the former state license for a period no longer than 30 days, after which the new nursing license must be active.

A nurse living in a NLC state may obtain a license from a non-NLC state. A license from an NLC state allows a nurse to practice in any other NLC state; however, a license from a non-NLC state is only good in that state. Therefore, nurses living in NLC states must have only one license. This helps reduce barriers to interstate practice. One license also improves tracking for disciplinary purposes, promotes cost effectiveness and simplifies the licensing application process for nurses. Finally, the one license provision also serves as a listing of licensed nurses that can be used in planning for disaster preparedness, without risk of duplications.

Nurses are responsible for complying with the nursing practice laws in the state where the patient is receiving care. It is similar to drivers' licensing, in that people are held to the driving laws in the state where they are driving, not the state where their license was issued. The licensing authority in the state where an application is made may choose not to issue a license if the applicant does not meet the qualifications or standards for a license.

Nurses have access to the policies of their respective state's board of nursing. The NLC has no responsibility for informing nurses of these policies. Many state boards make this information available to nurses utilizing web sites and news letters. It is the nurses responsibility to keep up-to-date on your state board of nursing policies and procedures.

Disciplinary Action

Violations are processed in the state the violation is reported to have occurred. The NLC has no authority over the primary state of residency in disciplinary matters. Many states choose to investigate the complaint in the state in which the incident occurred and transfer that information to the resident state's licensing board for action. Only a nurse's state of residency can take legal action against their license. However, both the residency state and the state where the patient is located may take disciplinary action and directly discipline any nurse licensed through the NLC.

The Nurse Practice Act in states participating in the NLC, as well as non-participating states, authorizes the resident state's board of nursing to take action based on actions taken in other states. This means that any nurse facing disciplinary actions in one state is likely to face actions in other states as well.

Additionally, the NLC allows boards of nursing to access investigative complaints sooner than is possible in non-NLC states, thanks to a communications system called Nur*sys*™. This improves a nursing board's ability to act in a timely manner and in many states prevents nurses with pending actions from moving to another state that does not have access to this information, until a final action has been rendered. To date, there have been a limited number of disciplinary cases involving more than one state.

Nur*sys*™ - The Licensure Information System

NCSBN has developed a coordinated licensure information system called Nur*sys*™ to assist in sharing information. The purpose of Nur*sys*™ is to provide centralized license information to boards of nursing that use it in the following ways:

- To verify applicant license information.
- To enter and review disciplinary actions.
- To send electronic communications between boards of nursing for information requests.

Through Nur*sys*™, all information involving any legal action is accessible to every NLC state. Information in Nur*sys*™ is also available to participating non-compact states. Final actions on nurse licensure that are publicly available by all participating states in Nur*sys*™ are also available to the public for a small fee. Non-residency and practice states participating in the NLC also report any actions taken to the Nur*sys*™ database. The non-residency and practice states participating in the NLC also report any significant current investigative information which could result in an action by that state. Nur*sys*™ is used to notify the residency and licensure state of any significant investigative information and any actions on the privilege to practice.

Enactment of the NLC does not change a state's Nurse Practice Act in any way. The NLC gives states additional authority in such areas as granting practice privileges, taking actions and sharing information with other NLC states. The individual RN or LPN/VN residing in an NLC state can practice in all the NLC states by virtue of the multi-state privilege to practice, unless there is some restriction placed on the license, and thus not granting the multi-state privilege. Nurses living in a state with an NLC agreement can obtain a license in a state that does not have an NLC agreement. A license from a state with an NLC agreement allows a nurse to practice in any state with a NLC agreement. However, a license from a state that does not have an NLC agreement is restricted to practicing in that state alone. It is the employer's responsibility to verify the licensure of their employed nurses. Under the Nur*sys*™ system, employers can check nurses' status at *www.nursys.com*.

The following Boards of Nursing provide nurse licensure information to Nur*sys*™:

Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin.

The Employer's Role in Nursing Practice

Under the NLC, one special challenge for nurses is in understanding nursing regulations in each state where they practice. State boards of nursing generally keep licensees informed of changes in practice requirements and board policies through mailings or internet postings. The basic outline may not differ significantly from state to state, but certain aspects of practice do. The nurse's ability to function as an effective patient advocate may be compromised by this lack of access. The American Nursing Association is concerned with establishing mechanisms for ensuring that nurses have access to information about state practice acts, regulations, labor laws and other informational resources that the employer may not make readily available. It will also be more important than ever to monitor employers' compliance with all applicable licensing laws, to ensure that some employers do not seek to take advantage of out-of-state nurses' lack of access to current information and board policies on utilization of unlicensed personnel and other relevant issues.

Tele-Nursing and Licensure

At the heart of tele-nursing, is the question of whether nursing care provided electronically constitutes nursing care. The most widespread misperception about tele-nursing is that, while "tele" care has the capacity to be a highly interactive practice, it is not "hands on", and therefore does not meet the standards for nursing practice. However, others argue that the role of nursing is an essential part of tele-health practice. Some tele-health programs are based almost completely on the provision of nursing care while others focus on improving physicians' ability to provide diagnostic services to patients. The following areas offer significant growth potential to nursing practice:

- Care via telephonic triage/ call center nursing
- Care using two-way interactive video, commonly used in home care settings
- Care using high tech equipment, found in military settings

In some cases, nurses in call centers have been challenged about whether they are practicing nursing, since one element of their practice utilizes physician-approved protocols. Some speculate that telephone triage is actually delegated medical practice, not nursing practice, so licensure is not an issue.

Despite these arguments, tele-nursing is offered by a growing number of hospitals, HMOs, medical practice groups, and even individual physicians. There are other models of tele-nursing that involve the transfer of medical data, such as home care visits and chronic disease monitoring. For example, the Visiting Nurse Association uses tele-nursing to augment its disease management program. This program puts tele-health units into the homes of patients suffering from congestive heart failure. Nurses communicate with patients via telephone from a base station and can take the patient's blood pressure, assess heart and lung sounds, take a pulse oximeter reading, and visually assess the patient.

Regardless of location, tele-nursing increases healthcare access to those in remote areas and increases the quality and availability of patient education. A typical telephone triage event involves an evening call from a parent with a sick child. They may be trying to decide whether to take the child to an urgent care facility. In such instances, tele-nurses can use software programs to guide them through a series of questions to help determine a possible diagnosis. The tele-nurse may also recommend that the patient seek medical attention immediately. If the patient’s condition does not appear life-threatening, a tele-nurse may also offer standardized self-care advice for the patient that will save a trip to the hospital. Self-care advice can also be given to the patient with instructions to arrange a follow-up with their primary care provider. The triage is documented in the patient's chart for the primary healthcare provider to review later. Tele-nursing offers clear advantages to both the patient and the sponsoring health care entity by offering the patient reliable medical advice and reducing unnecessary visits to healthcare facilities.

Experience by Tell-A-Nurse, LLC, based in Medford, Oregon, is one example of the challenges faced when navigating the NLC licensure process for telephonic triage nurses. Medford is located in southern Oregon, making it one of the larger cities close to many Northern Californians. Dr. Bill Dunn, Tell-A-Nurse's founder and CEO, recalls that ten years ago most call centers were using Centramax software, which was designed to handle daytime scheduling, referrals and telephone triage. However, the price for the software has been spiraling out of control for many medical practices and healthcare plans The initial set-up cost is close to $100,000 for the software, add to that $5,000 per month in maintenance costs and an additional $4,000 to train each new user, making it a costly venture. As a result, many call centers were run at a loss, and as budget cuts have become increasingly common in recent years, call centers have been among the first services to be cut.

Tell-A-Nurse provides telephonic triage nursing 24 hours a day to patients of subscribing physicians and other medical groups. As the service has expanded to other states, these nurses have had to obtain a license to practice in each of those states, resulting in substantial costs. A call center employing 7-10 nurses means between $700-1,000 per year for licensure in each state. While the hurdles for obtaining licensure in both Oregon and California did not prevent Tell-A-Nurse from marketing its services in other states, non-acceptance of the NLC in both states has been a costly and time consuming barrier.

The NLC has been adopted by an increasing number of states; however, similar agreements are not even on the horizon for physicians. In fact, it appears to be moving in the opposite direction. In 1995 the National Federation of State Medical Boards sought support for a "Model Act to Regulate the Practice of Medicine Across State Lines"; however, it was not able to get the resolution accepted. There is wide-spread support for this resolution, yet an organized national licensure policy is still missing, and individual states continue to pass their own legislation regulations. To date,

approximately 30 states have adopted laws regulating physicians practicing out-of-state telemedicine. Several states require full licensure for an out-of-state physician who practices telemedicine. California, Hawaii, Montana, Oregon and Texas, have slightly less restrictive laws permitting arrangements from out-of-state physician registration to a special license for out-of-state telemedicine practitioners. Non-participating states frequently include language that may be interpreted as viewing telemedicine as the practice of medicine, without explicitly stating it. However, because medical practice without a license is punishable by a lengthy prison term and significant fines, physicians most often err on the side of caution when providing any type of care to patients in these states.

The contrast between nursing and physician practice of telemedicine across states lines is considerable. In states where the nursing compact has been adopted, interaction between nurses and patients is held to a standard of accountability when allegations of malpractice are brought to a nursing board's attention. However, in states where the NLC has not been adopted, licensing is difficult and redundant. Prospects are even less optimistic for physicians, since a national plan for mutual recognition of physicians' license to practice telemedicine is still in its infancy.

Growth Opportunities in Tele-Nursing

The proliferation of nursing call centers providing telephone triage, health information and referral services has seen significant growth in recent years. Some call center systems maintain large centralized operations serving multiple states, while others provide "off hours" support for clinics, smaller hospitals and medical facilities. This 24 hour access to health care resources has proven so popular that many insurance providers are now providing their members with access to a nurse via a toll-free telephone number.

The American Telemedicine Association (http://www.americantelemed.org) notes that Canada has established a nationwide healthcare call center, provided free to all of citizens. International competition for outsourcing call centers has also grown significantly since the turn of the century, with India and the Philippines now tying as leaders in the industry.

A number of homecare providers have begun supplementing home care services with two-way interactive video encounters with patients. A recent Kaiser Permanente study showed cost savings, positive health outcomes and a high degree of patient satisfaction, particularly in the area of gerontology. Kaiser is also using tele-health for home care professionals. One recent study of cardiopulmonary, cancer, wound, and/or diabetic home health care patients' visits via a video system staffed by trained home care nurses utilized a device called the Personal Telemedicine System. This system allows home health nurses to see the patient in real time, listen to heart and chest sounds, and check to see if a patient is taking medications as prescribed. It was reported that cardiopulmonary disease patients received the greatest benefit from the system. Additionally, patients in end-stage pulmonary disease used their units to contact the home care nurses whenever they felt short of breath. This research supporting the project's success has prompted Kaiser to begin using a new tele-care system that allows store-and-forward snapshots that enable nurses to track wounds and compare a series of snapshots over time.

The growth of inmate populations presents another opportunity for more correctional nurses to work in the telehealth field. One example of added opportunities can be found in Texas, where tele-nursing training includes both the skills needed to present patients to the video camera and also to identify tests physicians are most likely to request before a consultation and the reasons for these recommendations. The physicians working with these nurses have found the program to be key in improving access to quality care in the state's prison settings. Allan Sapp, Assistant Director of the Texas Correctional Managed Healthcare Committee, has also noted that the correctional facilities have better mid-level providers because of better communication and interaction in daily, virtual consultations.

Arguments Against the NLC

Some states oppose the NLC, largely due to pressures from nursing unions and nursing board associations. Many of these concerns stem from a fear that individual states will lose licensure revenue, and control over the working condition demands of nursing unions. While it is true that moving to the NLC model could reduce state revenues, states have been able to avoid this problem by increasing licensure fees to offset losses. Still some complain that this is an undue burden to individual nurses. However, regarding the question of interfering with nursing unions' demands in the workplace, the NLC has stated that it does not facilitate strikebreaking in any way.

As mentioned above, a lot of the initial and continuing interest in NLC practice comes from concern about tele-health nursing practice. In many cases, this means providing services in states where a nurse does not hold a current license. Many tele-health employers and nurses may not regard the provision of tele-health services as "practicing," or may consider it impractical to obtain licenses in every state where patients receive their services. This poses the potential problem of unlicensed practice and presents a challenge for individual boards of nursing. Regulations asserting jurisdiction over out-of-state nurses are often unclear.

NCSBN's interstate compact provides one potential mechanism for regulating tele-health nursing practice. The American Nursing Association's legal opinion notes the purposes of the compact may only be met once a significant number of states have signed on to the NLC. It would provide a means for regulating tele-health practice in member states (assuming the nurse is also a resident of a NLC state), but not in others; in non-NLC states, issues of regulation and jurisdiction will continue. Nurses should obtain licenses in those states, but the same concerns about non-compliance (and unlicensed practice) that currently exist may continue in non-NLC states.

The NLC provides a means for residency states to assert jurisdiction over a nurse licensed in a remote state; however, it does not provide a means for identifying or tracking nurses. A state board can know who is *authorized* to practice in the state, but it will not know who actually is *practicing*. Currently, state boards may not know who among its licensees is currently practicing in the state. However, a nurse will generally not be licensed in a state unless she is practicing, has practiced, or plans at some point to practice in that state. Under the NLC, the universe of nurses who may be practicing in a member state will not be limited to those who have applied for and received a license in that state, but will include *every* nurse licensed in *every* member state.

The NLC has the potential to create a less effective means for regulating tele-health practice. An alternative approach to the issue may include an interstate compact focused specifically on tele-health practice This type of compact would still require multi-state participation in order to be effective, but it may be more achievable with a more narrowly focused compact.

Conclusion

There are many players in support of the NLC. The American Association of Occupational Health Nurses and the U.S. Department of Commerce (DOC) are both supporters of the NLC. The DOC formally recognized the NLC in its February 2004 report to Congress, entitled, "Innovation, Demand and Investment in Tele-health.

On an individual level, there are many reasons to support the NLC. It provides clarification of a nurse's right to practice tele-nursing and interstate care, and it offers greater mobility for nurses across the 50 states. The NLC also improves disciplinary response and information-sharing between NLC states. Once all states agree to participate in the NLC, the NLCA intends to produce the first, unduplicated record of actively licensed nurses in the United States.

Many nurses and healthcare facilities view the NLC as a tremendously beneficial resource in promoting the quick hire of qualified nurses, and encouraging out-of-state practitioners to relocate or temporarily travel and work in areas where there is significant need for skilled nursing staff.

A Brief Overview of Tele-health Technologies

Interactive audio and video telecommunications are used in the delivery of some tele-health services. This technology permits synchronous, or real-time, communication between the practitioner and patient. Other technologies allow the use of what is called asynchronous, or "store and forward" technology. Asynchronous technology allows medical information to be reviewed by a healthcare practitioner, in a separate location, at a later time.

There are various technologies used to conduct tele-health services. The following is a list of the most common types of connective services used in tele-health.

T-1:. A full T-1 line transmits data at a rate of 1.54 megabits per second. It is typically purchased in tele-health applications as a leased line that is dedicated from point-to-point 24 hours a day. These lines are typically available in most parts of the country.

Fractional T-1: Some phone companies have tariffs approved by their state to purchase a fraction of a T-1 line. The most common fractions are ½ and ¼ T-1. The price of fractional T-1 and a full T-1 often varies significantly in different regions of the country.

Integrated Service Digital Network (ISDN) Primary Rate Interface (PRI): ISDN lines provide the same level of bandwidth as a T-1 or Fractional T-1, but they can be dialed like a phone, as opposed to being dedicated to tele-health communications.

ISDN Basic Rate Interface (BRI): This service is not common in many rural areas and only provides dial up connectivity.

Plain Old Telephone Service (POTS): This is the typical analog line used in most homes and typically used in offices for faxing information. It is strongly recommended that each tele-health room from which the patient will be seen have access to a secure fax machine, so that information (e.g., Rx Scripts, test results) can be faxed to the patient's location.

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