SUBJECT: Texas' participation in the Nurse Licensure Compact

COMMITTEE: Public Health — committee substitute recommended

VOTE: 7 ayes — Gray, Coleman, Capelo, Glaze, Maxey, McClendon, Uresti

0 nays

2 absent — Delisi, Hilderbran

WITNESSES: For — Lynn Wieck, Texas Nurses Association

Against — None

BACKGROUND: Texas, like every other state, has its own system of licensing and regulating the practice of nursing. The Board of Nurse Examiners (BNE) regulates the practice of registered nurses (RNs) under the authority of arts. 4513-4528, VACS, and the Board of Vocational Nurse Examiners (BVNE) regulates the practice of licensed vocational nurses (LVNs) under art. 4528(c), VACS.

DIGEST: CSHB 1342 would add art. 4528(b), VACS, to authorize Texas to enter into a Nurse Licensure Compact with other states, which would allow a multistate licensing privilege for both RNs and LVNs. The bill would take effect January 1, 2000, unless the governor, on the recommendation of the BNE and BVNE, determined that a later effective date would be in the best interest of the state. The compact would expire on December 31, 2005, unless this section of the article were repealed or the expiration date were extended.

Multistate licensing privilege. The bill would define as "party state" any state that has enacted the compact and as "home state" the party state that is the nurse's primary residence. Under the terms of the compact, a nursing license issued in a home state would be recognized by each party state as authorizing the privilege to practice in each party state. To obtain or retain a license, the applicant would have to meet the qualifications and all applicable laws of the home state. A nurse practicing in a party state would have to comply with the practice laws of the state in which the patient was located and would be subject to the jurisdiction of that state's nurse-licensing boards and courts.

The party state's licensing board would have to ascertain specific information on each licensing applicant through a coordinated licensure information system (CLIS) run by a nonprofit organization controlled by state nurse-licensing boards. A nurse could hold only one license at a time, issued by the home state, but could maintain a license of a nonparty state if allowed by the laws of that state.

Enforcement. A party state, in accordance with its own laws, could limit or revoke the multistate licensing privilege of a nurse to practice in that state. When a party state took this action, it would have to inform the CLIS administrator promptly.

A "remote state" would be defined as a party state other than the home state in which a patient or recipient of nursing care was located. The licensing board of a remote state would have to notify the CLIS of all administrative, civil, criminal, or injunctive actions imposed on a nurse and report all significant investigative information. The CLIS administrator would have to notify the home state about these reports promptly.

A remote state could take action against the nurse that would adversely affect the multistate licensing privilege to practice in that state, but only the home state could take action against the license issued by the home state. CSHB 1342 would specify that reported conduct from a remote state would receive the same priority as reported conduct from a home state and would authorize party states to take alternative actions to licensing actions against a nurse.

Coordinated licensure information system. All party states would have to participate in creating a single, coordinated database that would include information on licensing and disciplinary action for all nurses. All party-state licensing boards would be required to report promptly all adverse actions, application denials, and significant investigative information. The licensing board of a party state could designate information not to be shared with nonparty states or disclosed otherwise without the expressed permission of the party state. No personal identifiable information could be shared with nonparty states nor with other entities, and any information expunged by laws of the contributing party state would have to be expunged from the CLIS. On request and payment of a reasonable fee, the BNE and BVNE would be required to provide a licensed Texas nurse with a copy of information about that nurse maintained by the CLIS.

Compact administration. The executive directors of the BNE and BVNE would administer the compact for Texas. The compact would be severable if declared contrary to the constitution of a party state or of the U.S. or if the applicability of the compact were held invalid. CSHB 1342 would specify provisions for an arbitration panel to handle disputes between party states. A party state could withdraw from the compact by enacting a statute repealing the compact that would take effect six months after the date the withdrawing state gave notice.

Conforming language. CSHB 1342 also would change current law to allow the BNE and BVNE to recognize and implement the Nurse Licensure Compact and to take disciplinary and other actions if a person's privilege to practice nursing in another state were subject to disciplinary action.

Evaluation of compact. The BNE and BVNE would be required to conduct an evaluation of the compact, to begin by January 1, 2000, and continue at least through June 1, 2004, and to submit a report to the Legislature by October 1, 2004.

SUPPORTERS SAY:

In this era of telemedicine and managed care networks, CSHB 1342 would help Texas better regulate nurses who care for Texas residents. The bill also would improve the detection of nurses with substance-abuse problems or poor practice records, some of whom are sometimes able to cross state lines to practice before their records catch up with them and to avoid being caught by the other state's licensing board.

Telemedicine, managed care networks, and the Internet have established systems by which patients often receive nursing care or advice over a telephone or a video or computer monitor. For example, a Texas enrollee of a large health-maintenance organization may call an 800 number for advice about what to do for her feverish baby, not knowing that the call could be answered by a nurse in Illinois or New Jersey. Although nurses in other states must be licensed by Texas if they are providing such care to Texas residents, the Texas boards of nursing have trouble ensuring compliance with this law and identifying and taking appropriate measures against out-of-state nurses who practice negligently or unlawfully.

Participation in the compact would modernize regulation by using the tools of the times and would resolve problems related to tracking nurse performance

from state to state. CSHB 1342 would establish the CLIS specifically for regulators to determine a nurse's performance and to take appropriate action in a timely manner. The CLIS would be designed to include information reported to other data banks and to prevent duplicative reporting. The CLIS would have strong confidentiality protections and would maintain public information as under existing Texas laws.

The compact would not change due-process rights of nurses nor the due-process obligations of any state. No state could discipline a nurse without undertaking its own investigation into the facts of the situation and applying those facts to its own nurse practice act.

Participation in the compact would not change nursing practice in Texas because nursing standards are the same in every state. What is considered good practice for nursing a heart patient at the Mayo Clinic in Minnesota is considered good practice for nursing a heart patient in Muleshoe. Every state uses the same national exams to license its nurses, and license requirements are practically identical. Because of this, it is relatively easy for a nurse to obtain a license from another state, but this process is time-consuming and costly for the nurse, usually because of fees. It can take up to six months for a nurse to obtain a license in a new state of residence, and even then the state's boards may not have had access to records that thoroughly depicted the nurse's previous performance.

Participation in the compact would not hinder Texas in setting its own nursing-related laws and regulations, nor would it expand the scope of nurse practice in Texas. Texas participation in the Nurse Licensure Compact would be comparable to its participation in the existing interstate driver's license compact. A nurse, whether licensed in Texas or another party state, would have to comply with Texas laws and regulations and could be penalized for infractions under Texas laws and regulations.

Strong protections and safeguards are built into CSHB 1342 to keep Texas in charge of regulating nurses who practice on Texas residents and to retain Texas' right to withdraw from the compact at any time. No other state attorneys general have raised the constitutional objection that the Kansas attorney general raised — that the compact would supersede a state's authority to regulate nursing. The Kansas opinion reflects a radically limited approach to the question of state control that also could be construed to

negate the interstate driver's license compact in which Kansas participates. The Nurse Licensure Compact as proposed in CSHB 1342 has severability and other provisions similar to those used in Texas' Driver's License Compact (Transportation Code, chpt. 523), which has not been found constitutionally objectionable.

Although the Nurse Licensure Compact is still in formative stages, regulators and nurses have studied and developed this concept over several years. The idea has won widespread support from national nursing and regulator groups and from local and statewide nurse's organizations. Utah and Arkansas already have enacted the necessary legislation to participate, and six or seven states besides Texas are considering legislation this year. The ultimate goal is participation by all states. If Texas enters the compact now, it can play an instrumental role in developing the administrative rules and organizational structure, which could further protect any interests unique to Texas.

CSHB 1342 includes good safeguards — a sunset clause, governor's oversight, evaluation and reporting requirements, and a compact severability provision — to protect Texas' interests in case the compact does not receive approval from enough states to be effective in improving nurse regulation, or if unforeseen circumstances cause delays in the development of the compact or the CLIS. CSHB 1342 would ensure that Texas' participation is enacted in a prudent and carefully thought-out manner.

OPPONENTS SAY:

Changing nurse regulation in Texas as proposed by CSHB 1342 may not be necessary or useful at this time because the compact is untried and not fully formed. Problems in interstate nursing practices and regulation could be handled by other means, such as by expediting endorsement of out-of-state licenses.

CSHB 1342 could allow another jurisdiction to influence Texas nursing laws and standards. The Kansas attorney general recently ruled in Opinion 99-3 that Kansas' participation in the compact would authorize an unconstitutional delegation of legislative authority to set licensing requirements. Texas should approach participation in the compact cautiously to guarantee that laws and regulations peculiar to Texas are not changed and that the scope of nurse practice is not expanded.

Also, because the compact is still being formed, the CLIS, which is key to the compact's success, has no track record by which Texas can measure its effectiveness in improving nurse regulation and in keeping from public disclosure sensitive information relating to nurse investigations and other confidential matters.

NOTES:

The main difference between the committee substitute and the original bill is that the committee substitute would clarify art. 10(b) to specify that a state's withdrawal from the compact would not affect the validity or applicability by the licensing boards of states remaining in the compact of any report of adverse action occurring before the withdrawal.

The companion bill, SB 981 by Moncrief, has been referred to the Senate Human Services Committee.