GRADUATE HOLISTIC NURSING ROUND TABLE

HOLDING SPACE:
ADVANCED HOLISTIC NURSING

CONSTRAINTS,
VISION, AND ACTION

THE CONSENSUS MODEL TASK FORCE,
CHARGED BY
THE AMERICAN HOLISTIC NURSES CREDENTIALING CORPORATION
AND ENDORSED BY
THE AMERICAN HOLISTIC NURSES ASSOCIATION

AHNA CONFERENCE
BONITA SPRINGS, FL
JUNE 2, 2015

CONSENSUS MODEL TASK FORCE MEMBERS:
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AHNA CONFERENCE
ROUND TABLE ON ADVANCED HOLISTIC NURSING
JUNE 3, 2016

Dear Colleagues,

Thank you for joining us on this journey, investing time in learning about the work we are doing, and considering partnering with us in these processes. For those of you who plan to attend the Round Table on June 3, 2016, AHNA Conference, you will find the purpose of the Round Table below. Specifically, we aim to share the processes we've used to hold the space for Advanced Holistic Nurses and our vision for them. We also plan to have an interactive discussion with you, seek your input, and answer your questions. We hope that you will choose to join us in this work, and will share how you can do that. For example, those who wish to write letters, meet with groups, etc might enjoy knowing that we have already prepared examples of letters that can be used, and talking points for various types of stakeholders, and groups of colleagues.

The following outline was prepared to orient you to our work. You may enjoy reading some of the documents before you attend the Round Table. Since some of you will not be able to join us at the Round Table, we are also providing the slides that will be used, with highlights of the discussion added. These can be downloaded for you to use for review and/or presentation as you wish.

Finally, we value your expertise, wisdom, and foresight, and are very eager to get your feedback. Those attending the Round Table will have the opportunity to provide feedback immediately. Others may prefer to do it after the Round Table, or at a later time. For that reason, we have created a brief survey that you can access online at https://www.surveymonkey.com/r/AHNursing.

Thank you for your interest and assistance in this important work for all of Holistic Nursing, and for society.

A. PURPOSE OF THE ROUND TABLE

1. Share what we have done to hold the space for Advanced Practice Holistic Nursing (AHN).
2. Answer questions about our position as stated in the White Paper, and
3. Get your feedback, and ask for support in advancing this work through:

B. BACKGROUND

1. Identified the problem and responded to Consensus Model Workgroup at the Roundtable**, (AHNCC, 2007).**
2. Responded to Consensus Model Final Draft, (**AHNCC, 2008).**
3. Published *Holistic Nursing Examinations: Past, Present, Future*, JHN, **(Erickson, H. 2009)**.
4. Revised, validated, tested competencies and mapped according to Core Values, (AHNCC, **2010-2012).**
5. Position Statement on APHN nurse**, (AHNCC, 2013).**
6. Position Statement on Consensus Model, distributed to Round Table attendees, NCSBN and State Boards of Nursing **(AHNCC, March, 2013)**.
7. Responded to National Council State Boards of Nursing (NCSBN) & LACE Workgroup request for public feedback on Consensus Model, (**AHNCC, Fall, 2013)**.
8. Published *The Holistic Worldview in Action: Evolution of Holistic Nurses Certification Programs August, JHN, (*Erickson, H., Erickson, M., Sandor, Brekke, M**. 2013**).
9. Charged a task force (CMTF) to continue to pursue inclusion of AHNs in the Consensus Model (**AHNCC**, **Fall 2014).**
10. Initiated collaborative relationship with AHNA **(CMTF, Spring, 2015).**
11. Prepared and sent NCSBN/LACE a Position Paper on Advanced Holistic Nursing's inclusion in the Concensus Model, submitted under name of AHNCC/AHNA **(CMTF, March 12, 2015).**
12. Submitted a request for 5th role that recognized AHN-BC, APHN-BC with Attachment A: Components of the Consensus Model -- an alternative model proposed for AHNs. Submitted to NCSBN and LACE Workgroup by AHNCC/AHNA (**CMTF, April 2015).**
13. **Initiated campaign to disseminate request for 5th role. Identified Stakeholders, created talking points.**
13. CMTF Received a call from NCSBN Task Force regarding Request for 5th role: informed that we had to more clearly articulate how AHN is uniquely different from the four roles specified in the Consensus Model, **(September 18, 2015).**

14. CMTF concluded that it was necessary to:
    a. Draft a White Paper describing Holistic Nursing's position that would explain why/how AHN is unique, and disseminate with Talking Points;
    b. Seek feedback, support, and assistance from colleagues; and
    c. Concurrently, initiate drafting of the Essentials for Holistic Nursing, starting with Basic Holistic Nursing (HNB-BC); progressing to Advanced Holistic Nursing (AHN-BC); and concluding with the Advanced Practice Holistic Nursing (APHN-BC) which contains competencies for prescriptive authority.
15. *White Paper: Graduate Holistic Nursing* was completed and distribution initiated in **November, 2015**.
16. Introduction to Essentials draft #1 distributed to CMTF, **November, 2015.**
17. White Paper, letters of introduction, and talking points distributed to Endorsed Schools, AHNCC graduate certificants, **December, 2015**.
18. Revisited feedback, direction indicated. Planned to:
    a. Re-engage two Endorsed Schools for additional feedback, **February, 2016**.
    b. Strategize formatting, drafting, dissemination of Educational Essentials, **March, 2016-today.**
    c. Strategize for information dissemination and feedback avenues:
        i. Publications in Beginnings and Journal of Holistic Nursing, **ED:2016 & 2017.**
        ii. Round Table at AHNA Conference, **ED: June, 2016**
        iii. Dissemination of White Paper, Call for feedback, **ED June- 2016.**
19. Initiated drafting of Basic Essentials, **April, 2016.**
20. Initiated drafting of Graduate Essentials, **May, 2016.**

C. FEEDBACK REQUESTED

1. Request for feedback on 5th role request and White Paper: Graduate Holistic Nursing (http://ahncc.org/aboutahncc/ahncchottopics.html);
2. Essentials of AHN (http://ahncc.org/aboutahncc/ahncchottopics.html)

D. FUTURE PARTICIPATION REQUESTED (JUNE, 2016-TBD):

1. Writing a letter of support for the White Paper (example available upon request);
2. Group support (e.g. ask your faculty to send a letter of support from the group; same for a networker cohort or other group)
3. Assistance in dissemination of the White Paper & attachments[1] (e.g. take the White Paper to a staff meeting; share it at a faculty meeting; present it to an organization; make an appointment with your state legislator to discuss it; write about it in a blog or newsletter);
4. Feedback on the Essentials of Holistic Nursing (contact us if you are interested in reviewing/commenting on the Essentials after we have them drafted);
5. Assistance in navigating acceptance of the Essentials of Holistic Nursing (e.g. please let us know if you have ideas or resources that will help us introduce the Essentials for review and acceptance).
6. Complete survey to give us more information https://www.surveymonkey.com/r/AHNursing

[1] We have letters that can be used as a template for various stakeholders and related Talking Points. Contact ahncc@flash.net for assistance or more information.

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E. ACCESS TO DOCUMENTS (If your browser won't open the document, copy and paste it in your url address box.

1. Holistic Nursing Examinations: Past, Present, Future (#3 above in Background).

https://www.dropbox.com/s/lxttmh2f5jqnzt6/J%20Holist%20Nurs-2013-Erickson-Holistic..%20i%20Action.pdf?oref=e&n=39553281

2. Competencies of Advanced Holistic Nursing (#4 above).
www.dropbox.com/s/6jsk4o5z4807an6/3.%20ADVANCED%20ESSENTIAL%20COMPETENCIES%20BY%20STANDARDS%20AND%20CORE%20VALUES%20%20WITH%20%20MAPPING%2C%20DEC%2C%202012.pdf?oref=e&n=39553281

3. Position Statement on the Consensus Model (#4 & 6 above).
https://www.dropbox.com/s/y7601s1c5ap5fh2/2.%20APRN_POSITION_STATEMENT_delegation%2C_website_%2C_Nov_26.pdf?oref=e&n=39553281

4. Response to NCSBN on Consensus Model (#7 above).
https://www.dropbox.com/s/y7601s1c5ap5fh2/2.%20APRN_POSITION_STATEMENT_delegation%2C_website_%2C_Nov_26.pdf?oref=e&n=39553281

5. Erickson, H., Erickson, M., Sandor, K., Brekke, M. (2013, The Holistic Worldview in Action: Evolution of Holistic Nurses Certification Programs *Journal of Holistic Nursing.* (#8 above)
https://www.dropbox.com/s/y7601s1c5ap5fh2/2.%20APRN_POSITION_STATEMENT_delegation%2C_website_%2C_Nov_26.pdf?oref=e&n=395532819.

6. Position Paper on Advanced Holistic Nursing's inclusion in the Concensus Model, (#11 above)
https://www.dropbox.com/s/06oasulf4jyag0i/A_POSITION_STATEMENT%2C_APRN_for_NCSBN%2C_FINAL%283%29.pdf?oref=e&n=39553281

7. Request for 5th role that recognized AHN-BC, APHN-BC with Attachment A: Components of the Consensus Model -- an alternative model proposed for AHNs. (#12 above).
https://www.dropbox.com/s/pspskovby4chjj9/Request%20for%205th%20Role.pdf?oref=e&n=39553281

8. *White Paper: Graduate Holistic Nursing*
https://www.dropbox.com/s/zevbo8fhjhu66r6/1.%20LETTER%2C%20WHITE%20PAPER%20SENT%20TO%20NSCBN.pdf?oref=e&n=39553281

APRN Consensus Model
Frequently-Asked Questions

Below are frequently asked questions developed by LACE (Licensure, Accreditation, Certification and Education) to clarify the APRN Consensus Model. LACE is the implementation mechanism for the APRN Consensus Model.

1. **Why was the Consensus Model developed?**

   There is increased appreciation of the important role that APRNs can play in improving access to high quality, cost-effective care. However, the lack of common definitions regarding the APRN roles, increasing numbers of nursing specializations, debates on appropriate credentials and scope of practice, and a lack of uniformity in educational and state regulations has limited the ability of patients to access APRN care. The Consensus Model seeks to address these issues.

2. **Who developed the Consensus Model?**

   The document is the result of the collaborative work of the APRN Consensus Work Group and National Council of State Boards of Nursing (NCSBN) APRN Advisory Committee with extensive input from a larger APRN stakeholder community. A complete list of all the organizations that took part is found on pages 29-39 of the report.

3. **How is the role of APRN defined?**

   The document provides a detailed definition of an APRN (pp. 6-8). There are four APRN roles defined in the document (pp. 7-8):
   - certified registered nurse anesthetist (CRNA)
   - certified nurse-midwife (CNM)
   - clinical nurse specialist (CNS)
   - certified nurse practitioner (CNP)

4. **Will I still be able to practice as an APRN after the APRN Consensus Model is implemented?**

   The ability of an APRN to practice and the scope of that practice are determined by state law (i.e., the state's nurse practice act and Board of Nursing Rules). When a state adopts new eligibility requirements for licensure, currently practicing APRNs are expected to continue to practice within that state if they maintain an active license. In addition, the Model recommends that state boards adopt language that would allow APRNs to move from another state and be licensed in the new state if they meet the education criteria that were in place when that individual was originally licensed to practice. Model legislative language that stipulates that an APRN will be grandfathered and allowed to practice has been developed by NCSBN. It is anticipated that legislation to implement the Model in each state will employ this language. APRNs currently in practice should keep abreast of legislative efforts in their own states and engage in activities to ensure that a grandfather clause is included.

5. **How must APRNs legally represent themselves after the implementation of the APRN Consensus Model?**

   APRNs must legally represent themselves as APRN plus the specific role (i.e., CRNA, CNM, CNS, CNP). This representation includes the legal signature. The population and specialty may also be included in addition to the role (e.g., APRN, CNP, adult oncology). APRNs prepared and licensed for more than one role would use the relevant designations.

6. **How does an acute care NP fit into the APRN Consensus Model?**

   The certified nurse practitioner (CNP) is educationally prepared to meet core competencies for all NPs and competencies for a population focus. The competencies at the population focus may be primary care or acute care. Currently, the acute care NP preparation is available with an adult-gerontology or pediatric focus. The graduate of an adult-gerontology acute care NP program is eligible to sit for an acute care adult-gerontology NP certification exam. Similarly, the graduate of a pediatric acute care NP program is eligible to sit for an acute care pediatric NP certification exam. Graduates of acute care population focused NP programs are not eligible to sit for primary care population focused NP certification exams and vice versa. The certified NP would identify himself/herself as an APRN-CNP with either an adult-gerontology or pediatric acute care population focus.

7. **What is the difference between an APRN and a nurse with a graduate degree?**

   An APRN is a registered nurse who has completed a graduate degree or postgraduate program that has prepared him/her to practice in one of the four advanced practice roles (i.e., CRNA, CNM, CNS, or CNP). This includes the advanced knowledge and skills to provide direct patient care in the health promotion and maintenance of individuals. Nurses with advanced education in areas of practice that do not include direct care to individuals such as public health or administration are not APRNs and do not require the additional regulatory oversight beyond the RN license.

8. **Why is the APRN Consensus Model called a regulatory model?**

   The APRN Consensus Model is called a regulatory model based on the broad definition of regulation. According to *Webster's Dictionary*, regulation is defined as 'the control according to rule, principle or law.' For the APRN Consensus Model, this includes those entities that control the preparation and credentialing of the APRN including nurse educators, certifiers, and licensing regulators. It also includes the accreditors of nurse education programs.

9. **If the APRN's legal title is APRN plus role, how will the employer know in what population focus or foci the APRN is educated?**

   It will be the responsibility of the employer to verify the APRN's license. The license will identify the population focus or foci .

10. Why does the APRN Consensus Model require APRN educational programs to be pre-approved?

Having APRN educational programs pre-approved will eliminate barriers of not being eligible for certification and/or licensure. By having accrediting bodies pre-approve APRN educational programs before students enter the program, accreditors can ensure that programs meet established educational standards and that graduates of the program will be eligible to sit for national certification.

11. How can APRN educational programs be sure that their graduates meet the eligibility criteria for APRN certification and licensure?

The pre-approval process conducted by the nursing accrediting bodies will help to ensure that new graduates meet eligibility requirements for certification and licensure. Existing programs should keep students informed of certification and licensure requirements.

12. I am an APRN. What will happen to my practice if I am grandfathered to practice by my state after the implementation of the APRN Consensus Model?

Because of a commonly-used regulatory mechanism called grandfathering, it is anticipated that there will be no difference in your practice. Grandfathering is a provision in a new law exempting those already in the existing system that is being regulated. When states adopt new eligibility requirements for APRNs, currently practicing APRNs will be permitted to continue practicing within the state of their current license. It is also anticipated that APRNs applying for licensure by endorsement in another state would be eligible for grandfathering if they meet certain criteria. In addition, it is important to remember that grandfathering is an individual process for each state, so eligibility requirements for practice may vary state by state. Employers also may establish new or separate requirements for professionals granted credentials to practice in that facility. For more information about grandfathering, see the Consensus Model report (p. 14).

13. If I want to specialize as an APRN in an area such as oncology, palliative care, or nephrology, how would I do so after the APRN Consensus Model is implemented?

Areas such as oncology, palliative care, and nephrology are among the many specialty areas of APRN practice and are not one of the population foci in the APRN Consensus Model. To be eligible for APRN licensure and certification, the APRN must complete his/her educational program in a role and population focus (or foci) as defined in the Consensus Model but can also specialize in a more specific area of practice. Preparation in a specialty area of practice is optional, but, if included in the educational program, it must build on the APRN role/population focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus. Educational programs may concurrently prepare individuals in a specialty providing they meet all of the other requirements for APRN educational programs, including preparation in the APRN core, role, and population core competencies. A specialty area of practice is developed by the professional organization and is not regulated by boards of nursing. Professional organizations determine the expected competencies for the specialty and establish

certification or assessment requirements. It is not required but recommended that the APRN practicing in a specialty area of practice seek specialty certification if available.

14. Will the Model define age parameters for each population focus?

The APRN Consensus Model does not define the age parameters for any of the population foci. Definitions may exist in other processes such as educational competencies and/or certification requirements.

15. What is the timeline for transition from adult-focused educational programs to the combined adult-gerontological population focus now included in the APRN Consensus Model?

A target date for full implementation of the Consensus Model and all embedded recommendations is the year 2015. A process is currently underway to identify the competencies for the merged adult-gerontology foci in the CNS and NP roles. When these competencies are available, the expectation is that adult and gerontology NP and CNS programs will proceed with a merger to a single adult-gerontology NP or CNS program. In fact, many programs have already begun to merge the two foci. These merged programs will prepare graduates to provide comprehensive care to the entire adult population which includes the young adult through the older adult including the frail elderly. The NP and CNS certifying bodies will also develop certification exams that comprehensively assess this merged population focus. Certification entities have indicated that they will have these expanded exams to meet the Model requirements.

16. What is the timeline for needed educational changes to be made in all APRN programs for congruence with the Consensus Model?

As identified in the in the Consensus Model a target date for full implementation is the Year 2015. To meet this target date it is anticipated that changes in many educational programs may occur before 2015 to ensure that graduates are prepared to meet certification and licensure criteria. However, it is important to note that not all APRN groups are operating on the same timeline and so there will likely be various dates when full implementation will occur for all APRNs. Educational programs must continue to monitor changes in licensure requirements in individual states, as well as, changes in certification and accreditation requirements that may occur prior to or after 2015.

17. What should the academic transcript include?

The transcript is official documentation from the academic institution and is a complete record of the individual's academic history at the institution. The transcript must specify the role and population focus of the APRN educational program as completed by the individual. The transcript should also include sufficient detail to enable verification that the individual completed core educational requirements. For example, in implementing the Consensus Model, the NCSBN APRN Model Act/Rules and Regulations specify that the transcript should include the 3 P courses. A transcript (or other similar official documentation) must be available for degree-granting and postgraduate certificate programs.

18. What can be done to move academic institutions to providing the needed transcripts?

The accrediting and certifying bodies can place such requirements on educational programs to motivate academic institutions to move forward with providing the necessary official documentation for graduates of both degree-granting and certificate programs.

19. What is LACE?

LACE is proposed as a communication network to include organizations that represent the Licensure, Accreditation, Certification, and Education components of APRN regulation. LACE is intended to be a transparent process for communicating about APRN regulatory issues, facilitating implementation of the APRN Consensus Model, and involving all stakeholders in advancing APRN regulation.

20. Are LACE and the APRN Consensus Model the same thing?

No. The APRN Consensus Model stands alone as a product of the work done jointly by the NCSBN APRN Advisory Committee and the APRN Consensus Work Group. LACE (see # 19 above) is broader in nature and is a mechanism to include all interested stakeholders representing the components of LACE in ongoing communications and implementation of the Model.

21. How do LACE and the APRN Consensus Model relate to the DNP?

The educational criteria within the APRN Consensus Model relate to the preparation of all APRNs, regardless of whether a master's or doctoral degree is conferred. A Doctor of Nursing Practice (DNP) program that is preparing an individual for entry into an APRN role must meet all of the criteria put forth in the Model. The Model does not require or preclude the DNP as an entry level degree for APRNs.

22. Are there advocacy tools available for use in explaining the Consensus Model to others, particularly state legislators?

Organizations participating in LACE have developed presentations and other resources to address questions specific to their members/stakeholders.

23. How realistic is the 2015 target implementation date?

2015 is a target date for full implementation of the APRN Consensus Model. The organizations participating in LACE have agreed to work towards this target date. Therefore, we encourage action now towards this implementation, recognizing that some components will take longer than others to accomplish.

24. Does the Consensus Model require a graduate degree in Nursing?

No, the Consensus Model specifically states that "APRN education must be formal education with a graduate degree or post-graduate certificate (either post-master's or

post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing-related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA)" (pg 10). Although many types of nurse practitioners must have a graduate degree in nursing in order to take their national certification exams, this is not the case for nurse-midwives or nurse anesthetists. Many accredited programs in nurse-midwifery and nurse anesthesia confer graduate degrees in nursing-related fields such as midwifery or health sciences, and the national certification processes for both nurse-midwives and nurse anesthetists do not require a graduate degree in nursing. The Consensus Model recognizes the validity of these other degrees.

NCSBN
National Council of State Boards of Nursing

APRN Compact

Katherine Thomas, MN, RN, FAAN
Lance Brenton, JD

NCSBN ANNUAL MEETING · CHICAGO· AUGUST 13 – 15, 2014

Overview

- Licensure Portability Efforts
- Drivers of New Model of Nursing Regulation
- Compact Concepts
- APRN Compact

Licensure Through Interstate Compacts

- National Council of State Boards of Nursing
    - Nurse Licensure Compact for RNs and LVNs since 1997; 24 states have adopted
- Federation of State Medical Boards
    - Drafting underway; expect to have language by 2015
- National Association of EMS Officials
    - Drafting underway; expect to have language by 2015
- Federation of State Boards of Physical Therapy
    - Advisory phase; drafting expected to begin later this summer through fall
- Association of State and Provincial Psychology Boards
    - Advisory phase; drafting expected to begin later this summer through fall

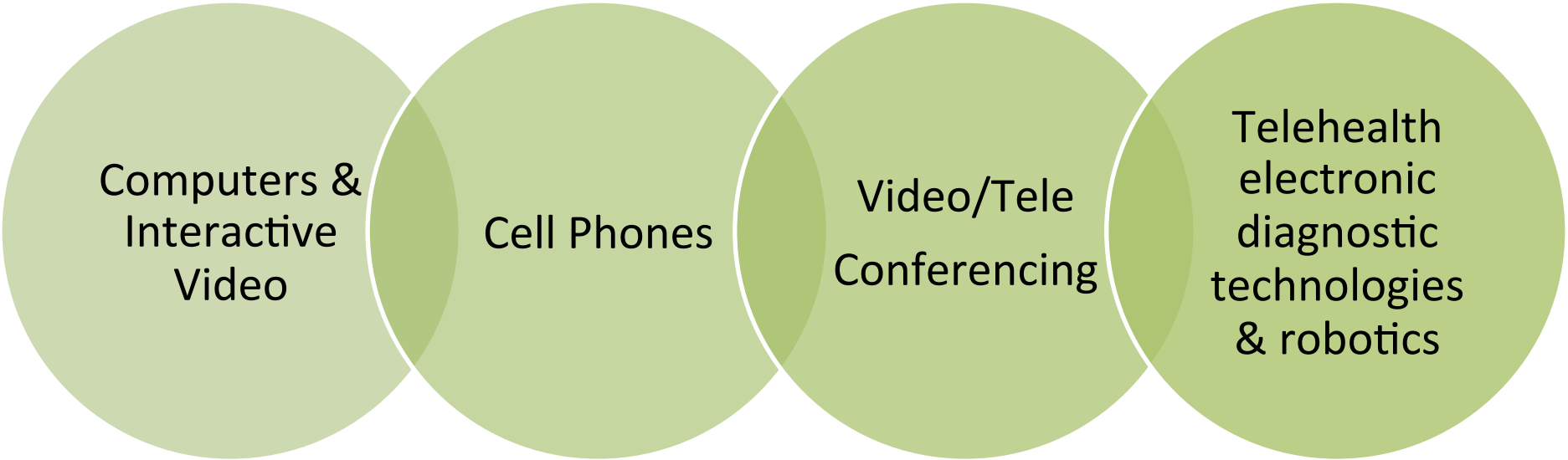
Source: Council on State Governments

Factors Influencing Review of Regulation & Licensure – 21st Century

- Mergers & acquisitions resulting in large, integrated health care delivery systems beyond state borders
- Emergence of Call Centers & Telephone Triage
- On line faculty directing students providing care
- Population growth and aging population
- ACA

Current models not adequate for the demand for access to care

Technological Advances



Solution --- Mutual Recognition

State Based License → Nationally Recognized → Locally Enforced

What is an Interstate Compact?

- Black's Law Dictionary:

  Formal agreement between 2 or more states to remedy a problem of mutual concern

- Each state enacts the Compact through legislation
- Affords states the opportunity to develop self regulatory adaptive structure to meet challenges over time

Interstate Compact

- Compacts not new
- Nurse Licensure Compact One of 200+ Compacts

(Emergency Management; Child Welfare; Water Resources; Parole; Education for Military Children)

- Average Compacts Per State: 25

How the Interstate Compact Works

- Each State Enacts IDENTICAL Compact
- Mutual Recognition of those who meet the requirements outlined in the Compact
- Example - Driver's License Model

Key Concept --- Licensure

Why One License in Primary State of Residence?

- Policy decision to enhance public protection while retaining state based authority & reducing administrative burden
- Determining state of practice would be challenging in an era of multiple employers, multiple organizational sites beyond borders & through telenursing
- Tracking a nurse through primary residence better accomplished than employment link

Key Concepts --- Discipline

- Complaint filed where violation occurs
- Complaints in party state are processed & reported to home state
- Significant Investigative Information is entered in database to alert other states
- Discipline
    - Against license – home state
    - Against privilege to practice – home & party state

APRN COMPACT

History of APRN Compact

- **2002** — NCSBN Adoption of APRN Compact
- **2005-2006** — Development of Vision Paper by NCSBN APRN Advisory Committee
- **2006** — Collaboration Between NCSBN and APN Consensus Workgroup
- **2007** — Formation of Joint Dialogue Group
- **2008** — Adoption of Consensus Model for APRN Regulation

Previous APRN Compact

- First adopted in 2002
- Passed by 3 states: Texas, Utah, Iowa
- Was not implemented
  - A major weakness of the previous APRN Compact was the lack of uniformity in APRN licensure requirements among the states.

APRN Compact Working Group

- Katherine Thomas, MN, RN, Texas BON
- Sandra Evans, MAEd, RN, Idaho BON
- Debra Hobbins, DNP, APRN, LSAC, CARN-AP, Utah BON
- Joey Ridenour, MN, RN, FAAN, Arizona BON
- Lorinda Inman, MSN, RN, Iowa BON
- Kathleen Weinberg, MSN, RN, Iowa BON
- Lance Brenton, JD, Texas BON
- Mitchell Jones, JD, Utah BON
- Roger Gabel, JD, Idaho BON
- Sara Scott, JD, Iowa BON

- Advised by NLCA Counsel, Rick Masters
- Staff: Jim Puente

Goals to Improve the APRN Compact

- **Retain or improve positive results of NLC**
  - Promote cooperation and information exchange between states
  - Facilitate mobility and access to care while providing for public protection
- **Address lessons learned from the previous Compact**
- **Encourage adoption of the APRN Consensus Model**
- **Respond to changes in the profession and health care delivery**
- **Consult with stakeholders throughout process to encourage more widespread support for the APRN Compact before state legislatures**.

Stakeholder Involvement

- **The draft APRN Compact has been reviewed and commented on by several groups:**
  - NCSBN Board of Directors
  - NCSBN Executive Officer Leadership Council
  - NCSBN APRN Advisory Committee
  - Nurse Licensure Compact Administrators (NLCA) Executive Committee
  - NLCA
  - National APRN organizations and members

Proposed APRN Compact: Key Changes

- Inclusion of APRN Consensus Model – LACE
- Strengthened Enforcement Provisions
- Rulemaking Authority
- Grandfathering
- Full Practice Authority/Independent Practice and Prescriptive Authority
- Criminal Background Check Requirement
- Eligibility of All States: RN Compact not Required

Key Changes to Proposed APRN Compact: *APRN Consensus Model*

Inclusion of Consensus Model Licensure Requirements

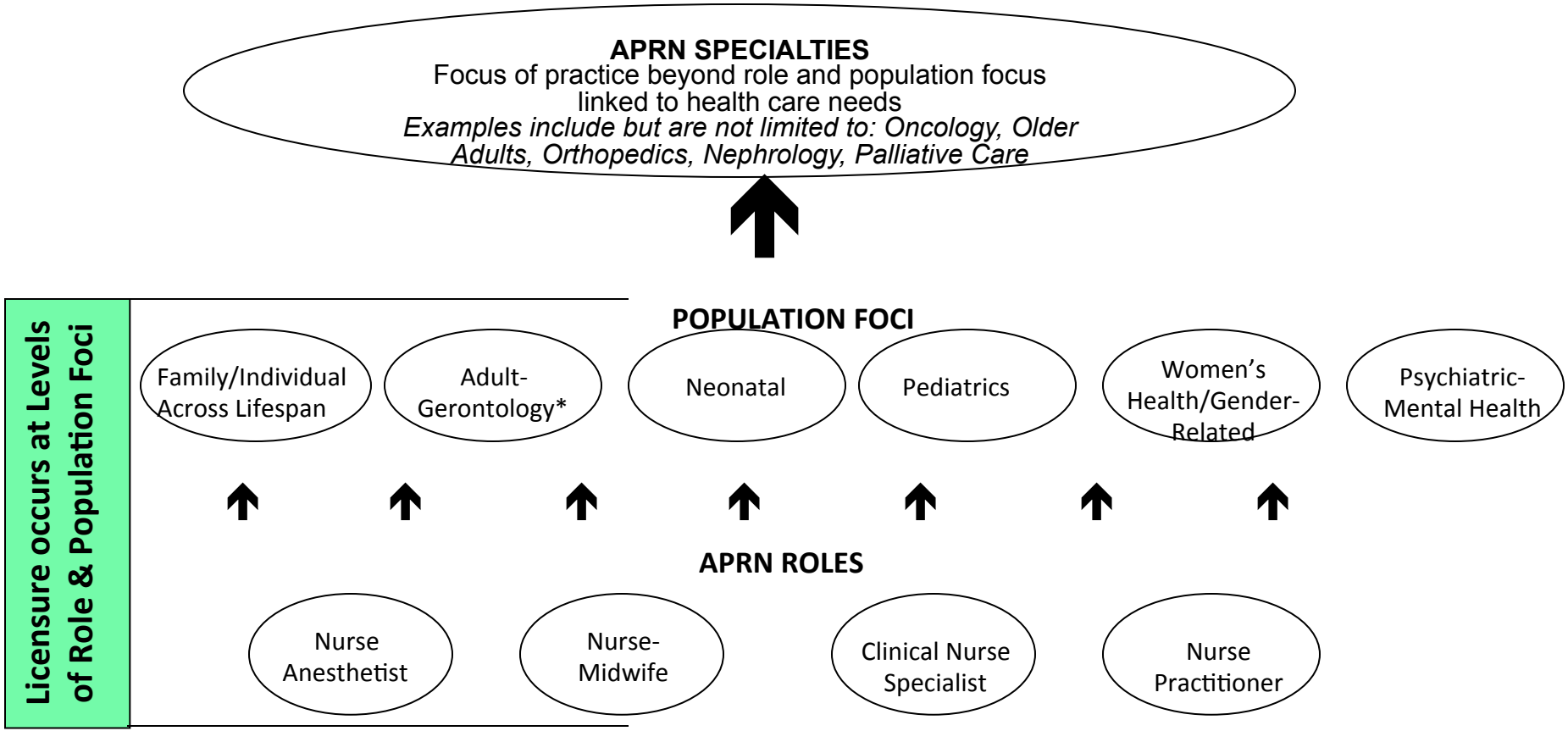
- Ensure common language
- Establish minimum requirements for licensure across jurisdictions
  - Licensure
  - Accreditation
  - Certification
  - Education
- Facilitate interstate APRN practice, including telehealth

Key Changes to Proposed APRN Compact: *APRN Consensus Model*

Inclusion of Consensus Model Licensure Requirements in Statute and Rule

- Graduate Education
- One of 4 roles and one of 6 population foci
- Accredited Program
- Certification Required
- Licensure is the authority to practice

APRN REGULATORY MODEL



Key Changes to Proposed APRN Compact: *Enforcement Provisions*

- **Strengthened Enforcement Provisions**
  - Oversight of Compact Administrators
    - Powers to Enforce the Compact
    - Legal standing
  - Default, Technical Assistance, and Termination
  - Dispute Resolution

Key Elements of the Proposed APRN Compact: *Rulemaking*

- Under the previous APRN Compact and the NLC, potential rules required individual adoption by all Compact states to have binding effect
  - Impractical to rely upon each individual state BON to adopt rules
  - Without uniform licensure requirements or a realistic process for adopting such requirements by rule, interstate cooperation in APRN licensure is highly problematic

Rulemaking Authority

- Rulemaking by the Interstate Commission of APRN Compact Administrators
    - Rules may be adopted directly by Compact Administrators
        - Legally binding in all party states
        - No requirement that rules be ratified or adopted by individual states
    - However, rules may be withdrawn through action by a majority of member state legislatures

Rulemaking Authority

- **Legal Justification for Rulemaking Provisions**
  - Rulemaking authority has been permitted and exercised by other interstate compacts
  - The procedural requirements are based on the Model Administrative Procedures Act, which is similar to most state APAs and includes the relevant procedural requirements for excercising rulemaking authority

Grandfathering

- **Consensus Model recommends**:
  - Currently practicing APRNs be permitted to continue practicing in current state of licensure;
  - If APRN applies for endorsement, the APRN should be eligible if the Consensus Model requirements are met or if not, that the APRN would have met requirements in place at the time completed educational program
  - Once model implemented, all new graduates must meet new requirements

Grandfathering

- APRN Compact Mirrors the Consensus Model
  - Compact license with a privilege to practice in another Compact state limited to APRNs who meet the Consensus Model
  - For those who do not:
    - Retain a single state license
    - Apply for multiple single state licenses in party states
  - Party states may consider single state licensure through endorsement for qualifying APRN license holders if they would have met requirements at the time of initial APRN licensure

Key Changes to Proposed APRN Compact: *Scope of Practice and Prescriptive Authority*

Goal: Full Practice Authority

- **Avoid the need to research and comply with 50 states' laws regarding scope**
- **Increase access to care**
- **Basing scope of practice on education and certification**

  Institute of Medicine's Report on the Future of Nursing

Key Changes to Proposed APRN Compact: *Prescriptive Authority*

The Proposed APRN Compact includes prescriptive authority for APRN Compact licensees that is limited to legend drugs

- Consideration of controlled substance authority shall remain with the state of practice as required by federal law
- Prescriptive authority for legend drugs may be excercised in the home state as well as any remote state while working under a privilege to practice
- Prescriptive authority will not be granted under the compact to APRNs who were previously licensed but not granted prescriptive authority

Key Changes to Proposed APRN Compact: *Biometric CBC Requirement*

- **Criminal Background Check Requirement**
  - **Compact membership is limited to states that conduct CBCs for all applicants for initial APRN licensure or APRN licensure by endorsement.**
    - Does not affect current licensees that may have been licensed prior to CBC fingerprinting by their Board
    - Does not address the effect of specific criminal history on licensure decisions. Retains authority in the state.
    - If APRN has previously submitted to a fingerprint CBC for LVN and/or RN licensure, not required under the Compact to submit again. However, state may do so according to its own policies.
  - **Conservative Approach to Begin With**
    - If more specific requirements regarding CBCs for previous licensees or effect of certain criminal history is deemed necessary, the Commission may address this issues through rulemaking once the Compact goes into effect.

Other Notable Provisions of Proposed APRN Compact: *Eligibility of non-NLC States*

- Under the Proposed Compact, Membership Is Open to non-NLC States
- Drivers
    - Momentum of the Consensus Model
    - Telehealth Practice Growing
    - Increased demand for telehealth and access to care under the ACA
    - Political environment may support adoption of APRN Compact, but not NLC in some jurisdictions

Next Steps

- **Adoption by NCSBN Delegate Assembly**
- **Consideration by State Legislatures**
  - The goal is for the Compact to be adopted by January of 2016, which coincides with the Consensus Model timeline

Compact Information

Visit NCSBN website:
http://www.ncsbn.org
Click on Nurse Licensure Compact

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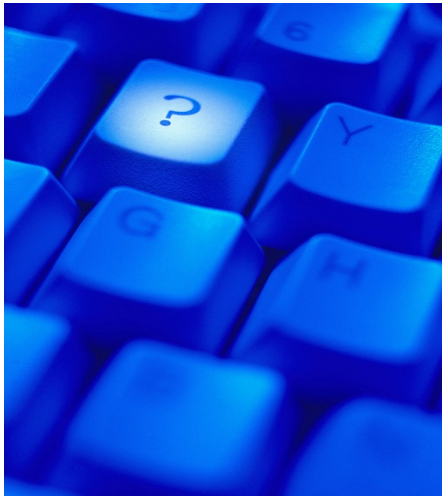
The world is not static, and the status quo is not sacred.

--- Harry Truman

Questions?



Advanced Practice Registered Nurse Compact

Approved by the May 4, 2015 Special Delegate Assembly

ARTICLE I

Findings and Declaration of Purpose

a. The party states find that:

1. The health and safety of the public are affected by the degree of compliance with APRN licensure requirements and the effectiveness of enforcement activities related to state APRN licensure laws;
2. Violations of APRN licensure and other laws regulating the practice of nursing may result in injury or harm to the public;
3. The expanded mobility of APRNs and the use of advanced communication technologies as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of APRN licensure and regulation;
4. New practice modalities and technology make compliance with individual state APRN licensure laws difficult and complex;
5. The current system of duplicative APRN licensure for APRNs practicing in multiple states is cumbersome and redundant for both APRNs and states;
6. Uniformity of APRN licensure requirements throughout the states promotes public safety and public health benefits.

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 APRN licensure and regulation, including promotion of uniform licensure requirements;
3. Facilitate the exchange of information between party states in the areas of APRN regulation, investigation and adverse actions;
4. Promote compliance with the laws governing APRN practice in each jurisdiction;

5. Invest all party states with the authority to hold an APRN 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;
6. Decrease redundancies in the consideration and issuance of APRN licenses; and
7. Provide opportunities for interstate practice by APRNs who meet uniform licensure requirements.

ARTICLE II

Definitions

As used in this Compact:

a. "Advanced practice registered nurse" or "APRN" means a registered nurse who has gained additional specialized knowledge, skills and experience through a program of study recognized or defined by the Interstate Commission of APRN Compact Administrators ("Commission"), and who is licensed to perform advanced nursing practice. An advanced practice registered nurse is licensed in an APRN role that is congruent with an APRN educational program, certification, and Commission rules.

b. "Adverse action" means any administrative, civil, equitable or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against an APRN, including actions against an individual's license or multistate licensure privilege such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting an APRN's authorization to practice, including the issuance of a cease and desist action.

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

d. "APRN licensure" means the regulatory mechanism used by a party state to grant legal authority to practice as an APRN.

e. "APRN uniform licensure requirements" means minimum uniform licensure, education and examination requirements as adopted by the Commission.

f. "Coordinated licensure information system" means an integrated process for collecting, storing and sharing information on APRN licensure and enforcement activities related to APRN licensure laws that is administered by a nonprofit organization composed of and controlled by licensing boards.

g. "Current significant investigatory information" means:

1. Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the APRN 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 APRN represents an immediate threat to public health and safety regardless of whether the APRN has been notified and had an opportunity to respond.

h. “Encumbrance” means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

i. “Home state” means the party state that is the APRN’s primary state of residence.

j. ”Licensing board” means a party state’s regulatory body responsible for regulating the practice of advanced practice registered nursing.

k. “Multistate license” means an APRN license to practice as an APRN issued by a home state licensing board that authorizes the APRN to practice as an APRN in all party states under a multistate licensure privilege, in the same role and population focus as the APRN is licensed in the home state.

l. ”Multistate licensure privilege” means a legal authorization associated with an APRN multistate license that permits an APRN to practice as an APRN in a remote state, in the same role and population focus as the APRN is licensed in the home state.

m. “Non-controlled prescription drug” means a device or drug that is not a controlled substance and is prohibited under state or federal law from being dispensed without a prescription. The term includes a device or drug that bears or is required to bear the legend “Caution: federal law prohibits dispensing without prescription” or “prescription only” or other legend that complies with federal law.

n. “Party state” means any state that has adopted this Compact.

o. “Population focus” means a specific patient population that is congruent with the APRN educational program, certification, and Commission rules.

p. “Prescriptive authority” means the legal authority to prescribe medications and devices as defined by party state laws.

q. “Remote state” means a party state that is not the home state.

r. “Single-state license” means an APRN license issued by a party state that authorizes practice only within the issuing state and does not include a multistate licensure privilege to practice in any other party state.

s. “State” means a state, territory or possession of the United States and the District of Columbia.

t. “State practice laws” means a party state’s laws, rules, and regulations that govern APRN practice, define the scope of advanced nursing practice, including prescriptive authority, and create the methods and grounds for imposing discipline. State practice laws do not include the requirements necessary to obtain and retain an APRN license, except for qualifications or requirements of the home state.

ARTICLE III

General Provisions and Jurisdiction

a. A state must implement procedures for considering the criminal history records of applicants for initial APRN licensure or APRN licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by APRN applicants for the purpose of obtaining an applicant’s criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state’s criminal records.

b. By rule, the Commission shall adopt the APRN Uniform Licensure Requirements (“ULRs”). The ULRs shall provide the minimum requirements for APRN multistate licensure in party states, provided that the Commission may adopt rules whereby an APRN, with an unencumbered license on the effective date of this Compact, may obtain, by endorsement or otherwise, and retain a multistate license in a party state.

c. In order to obtain or retain a multistate license, an APRN must meet, in addition to the ULRs, the home state’s qualifications for licensure or renewal of licensure, as well as, all other applicable home state laws.

d. By rule, the Commission shall identify the approved APRN roles and population foci for licensure as an APRN. An APRN issued a multistate license shall be licensed in an approved APRN role and at least one approved population focus.

e. An APRN multistate license issued by a home state to a resident in that state will be recognized by each party state as authorizing the APRN to practice as an APRN in each party state, under a multistate licensure privilege, in the same role and population focus as the APRN is licensed in the home state. If an applicant does not qualify for a multistate license, a single-state license may be issued by a home state.

f. Issuance of an APRN multistate license shall include prescriptive authority for noncontrolled prescription drugs, unless the APRN was licensed by the home state prior to the home state's adoption of this Compact and has not previously held prescriptive authority.

    1. An APRN granted prescriptive authority for noncontrolled prescription drugs in the home state may exercise prescriptive authority for noncontrolled prescription drugs in any remote state while exercising a multistate licensure privilege under an APRN multistate license; the APRN shall not be required to meet any additional eligibility requirements imposed by the remote state in exercising prescriptive authority for noncontrolled prescription drugs.
    2. Prescriptive authority in the home state for an APRN who was not granted prescriptive authority at the time of initial licensure by the home state, prior to the adoption of this Compact, shall be determined under home state law.
    3. Prescriptive authority eligibility for an APRN holding a single-state license shall be determined under the law of the licensing state.

g. For each state in which an APRN seeks authority to prescribe controlled substances, the APRN shall satisfy all requirements imposed by such state in granting and/or renewing such authority.

h. An APRN issued a multistate license is authorized to assume responsibility and accountability for patient care independent of a supervisory or collaborative relationship with a physician. This authority may be exercised in the home state and in any remote state in which the APRN exercises a multistate licensure privilege. For an APRN issued a single-state license in a party state, the requirement for a supervisory or collaborative relationship with a physician shall be determined under applicable party state law.

i. All party states shall be authorized, in accordance with state due process laws, to take adverse action against an APRN's multistate licensure privilege such as revocation, suspension, probation or any

other action that affects an APRN's authorization to practice under a multistate licensure privilege, including cease and desist actions. 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.

j. An APRN practicing in a party state must comply with the state practice laws of the state in which the client is located at the time service is provided. APRN practice is not limited to patient care, but shall include all advanced nursing practice as defined by the state practice laws of the party state in which the client is located. APRN practice in a party state under a multistate licensure privilege will subject the APRN to the jurisdiction of the licensing board, the courts, and the laws of the party state in which the client is located at the time service is provided.

k. 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 satisfying any state law requirement for registered nurse licensure as a precondition for authorization to practice as an APRN in that state.

l. Individuals not residing in a party state shall continue to be able to apply for a party state's single-state APRN license as provided under the laws of each party state. However, the single-state license granted to these individuals will not be recognized as granting the privilege to practice as an APRN in any other party state.

ARTICLE IV

Applications for APRN Licensure in a Party State

a. Upon application for an APRN multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held or is the holder of a licensed practical/vocational nursing license, a registered nursing license or an advanced practice registered nurse license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant and whether the applicant is currently participating in an alternative program.

b. An APRN may hold a multistate APRN license, issued by the home state, in only one party state at a time.

c. If an APRN changes primary state of residence by moving between two party states, the APRN must apply for APRN licensure in the new home state, and the multistate license issued by the prior home state shall be deactivated in accordance with applicable Commission rules.

   1. The APRN may apply for licensure in advance of a change in primary state of residence.
   2. A multistate APRN license shall not be issued by the new home state until the APRN provides satisfactory evidence of a change in primary state of residence to the new home state and satisfies all applicable requirements to obtain a multistate APRN license from the new home state.

d. If an APRN changes primary state of residence by moving from a party state to a non-party state, the APRN multistate license issued by the prior home state will convert to a single-state license, valid only in the former home state.

ARTICLE V

Additional Authorities Invested in Party State Licensing Boards

a. In addition to the other powers conferred by state law, a licensing board shall have the authority to:

   1. Take adverse action against an APRN's multistate licensure privilege to practice within that party state.
      i. Only the home state shall have power to take adverse action against an APRN's license issued by the home state.
      ii. For purposes of taking adverse action, the home state licensing board shall give the same priority and effect to reported conduct that occurred outside of the home state as it would if such conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.
   2. Issue cease and desist orders or impose an encumbrance on an APRN's authority to practice within that party state.
   3. Complete any pending investigations of an APRN who changes primary state of residence during the course of such investigations. The licensing board shall also have the authority to take

appropriate action(s) 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.

4. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, as well as, the production of evidence. Subpoenas issued by a party state licensing board 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 that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing licensing board shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state in which the witnesses and/or evidence are located.
5. Obtain and submit, for an APRN licensure applicant, fingerprints or other biometric-based information to the Federal Bureau of Investigation for criminal background checks, receive the results of the Federal Bureau of Investigation record search on criminal background checks and use the results in making licensure decisions.
6. If otherwise permitted by state law, recover from the affected APRN the costs of investigations and disposition of cases resulting from any adverse action taken against that APRN.
7. Take adverse action based on the factual findings of another party state, provided that the licensing board follows its own procedures for taking such adverse action.

b. If adverse action is taken by a home state against an APRN's multistate licensure, the privilege to practice in all other party states under a multistate licensure privilege shall be deactivated until all encumbrances have been removed from the APRN's multistate license. All home state disciplinary orders that impose adverse action against an APRN's multistate license shall include a statement that the APRN's multistate licensure privilege is deactivated in all party states during the pendency of the order.

c. Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the

multistate licensure privilege under the multistate license of any APRN for the duration of the APRN's participation in an alternative program.

ARTICLE VI

Coordinated Licensure Information System and Exchange of Information

a. All party states shall participate in a coordinated licensure information system of all APRNs, licensed registered nurses and licensed practical/vocational nurses. This system will include information on the licensure and disciplinary history of each APRN, as submitted by party states, to assist in the coordinated administration of APRN licensure and enforcement efforts.

b. The Commission, 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.

c. All licensing boards shall promptly report to the coordinated licensure information system any adverse action, any current significant investigative information, denials of applications (with the reasons for such denials) and APRN participation in alternative programs known to the licensing board regardless of whether such participation is deemed nonpublic and/or confidential under state law.

d. Current significant investigative information and participation in nonpublic or confidential alternative programs shall be transmitted through the coordinated licensure information system only to party state licensing boards.

e. Notwithstanding any other provision of law, all party state 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.

f. Any personally identifiable information obtained from the coordinated licensure information system by a party state licensing board shall 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.

g. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing the information shall be removed from the coordinated licensure information system.

h. The Compact administrator of each party state shall furnish a uniform data set to the Compact administrator of each other party state, which shall include, at a minimum:

   1. Identifying information;
   2. Licensure data;
   3. Information related to alternative program participation information; and
   4. Other information that may facilitate the administration of this Compact, as determined by Commission rules.

i. The Compact administrator of a party state shall provide all investigative documents and information requested by another party state.

ARTICLE VII

Establishment of the Interstate Commission of APRN Compact Administrators

a. The party states hereby create and establish a joint public agency known as the Interstate Commission of APRN Compact Administrators.

   1. The Commission is an instrumentality of the party states.
   2. Venue is proper, and judicial proceedings by or against the Commission shall be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.
   3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

b. Membership, Voting and Meetings

   1. Each party state shall have and be limited to one administrator. The head of the state licensing board or designee shall be the administrator of this Compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the Administrator is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the party state in which the vacancy exists.

2. Each administrator shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. An administrator shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for an administrator's participation in meetings by telephone or other means of communication.
3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws or rules of the commission.
4. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article VIII.
5. The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:
    i. Noncompliance of a party state with its obligations under this Compact;
    ii. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;
    iii. Current, threatened, or reasonably anticipated litigation;
    iv. Negotiation of contracts for the purchase or sale of goods, services or real estate;
    v. Accusing any person of a crime or formally censuring any person;
    vi. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
    vii. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
    viii. Disclosure of investigatory records compiled for law enforcement purposes;
    ix. Disclosure of information related to any reports prepared by or on behalf of the Commission for the purpose of investigation of compliance with this Compact; or
    x. Matters specifically exempted from disclosure by federal or state statute.
6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe

all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

c. The Commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this Compact, including but not limited to:

    1. Establishing the fiscal year of the Commission;
    2. Providing reasonable standards and procedures:
        i. For the establishment and meetings of other committees; and
        ii. Governing any general or specific delegation of any authority or function of the Commission.
    3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy votes allowed;
    4. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;
    5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the personnel policies and programs of the Commission;

6. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of this Compact after the payment and/or reserving of all of its debts and obligations;

d. The Commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the website of the Commission;

e. The Commission shall maintain its financial records in accordance with the bylaws; and

f. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

g. The Commission shall have the following powers:

1. To promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all party states;
2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any licensing board to sue or be sued under applicable law shall not be affected;
3. To purchase and maintain insurance and bonds;
4. To borrow, accept or contract for services of personnel, including but not limited to employees of a party state or nonprofit organizations;
5. To cooperate with other organizations that administer state compacts related to the regulation of nursing, including but not limited to sharing administrative or staff expenses, office space or other resources;
6. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;
7. To accept any and all appropriate donations, grants and gifts of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

8. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, whether real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;
9. To sell convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, whether real, personal or mixed;
10. To establish a budget and make expenditures;
11. To borrow money;
12. To appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives, and consumer representatives, and other such interested persons;
13. To provide and receive information from, and to cooperate with, law enforcement agencies;
14. To adopt and use an official seal; and
15. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of APRN licensure and practice.

h. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.
2. The Commission may levy on and collect an annual assessment from each party state to cover the cost of the operations and activities of the Interstate Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule that is binding upon all party states.
3. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the party states, except by, and with the authority of, such party state.
4. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the

Commission shall by audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

i. Qualified Immunity, Defense, and Indemnification

1. The administrators, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional, willful or wanton misconduct of that person.
2. The Commission shall defend any administrator, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error or omission did not result from that person's intentional, willful or wanton misconduct.
3. The Commission shall indemnify and hold harmless any administrator, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional, willful or wanton misconduct of that person.

ARTICLE VIII

Rulemaking

a. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Article and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment and shall have the same force and effect as provisions of this Compact.

b. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

c. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a notice of proposed rulemaking:

    1. On the website of the Commission; and
    2. On the website of each licensing board or the publication in which each state would otherwise publish proposed rules.

d. The notice of proposed rulemaking shall include:

    1. The proposed time, date and location of the meeting in which the rule will be considered and voted upon;
    2. The text of the proposed rule or amendment, and the reason for the proposed rule;
    3. A request for comments on the proposed rule from any interested person; and
    4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

e. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

f. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

g. The Commission shall publish the place, time, and date of the scheduled public hearing.

    1. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request.

2. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

h. If no one appears at the public hearing, the Commission may proceed with promulgation of the proposed rule.

i. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

j. The Commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

k. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in this Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety or welfare;
2. Prevent a loss of Commission or party state funds; or
3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule.

l. The Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the Commission, prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

ARTICLE IX

Oversight, Dispute Resolution and Enforcement

a. Oversight

1. Each party state shall enforce this Compact and take all actions necessary and appropriate to effectuate this Compact's purposes and intent.
2. The Commission shall be entitled to receive service of process in any proceeding that may affect the powers, responsibilities or actions of the Commission, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact or promulgated rules.

b. Default, Technical Assistance and Termination

1. If the Commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:
    i. Provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and
    ii. Provide remedial training and specific technical assistance regarding the default.
2. If a state in default fails to cure the default, the defaulting state's membership in this Compact may be terminated upon an affirmative vote of a majority of the administrators, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.
3. Termination of membership in this Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor of the defaulting state and to the executive officer of the defaulting state's licensing board, the defaulting state's licensing board, and each of the party states.

4. A state whose membership in this Compact has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.
5. The Commission shall not bear any costs related to a state that is found to be in default or whose membership in this Compact has been terminated, unless agreed upon in writing between the Commission and the defaulting state.
6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district in which the Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

c. Dispute Resolution

1. Upon request by a party state, the Commission shall attempt to resolve disputes related to the Compact that arise among party states and between party and non-party states.
2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes, as appropriate.
3. In the event the Commission cannot resolve disputes among party states arising under this Compact:
    i. The party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the Compact administrator in each of the affected party states and an individual mutually agreed upon by the Compact administrators of all the party states involved in the dispute.
    ii. The decision of a majority of the arbitrators shall be final and binding.

d. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.
2. By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district in which the Commission has its principal offices against a party state that is in default to enforce compliance with the provisions of this Compact

and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

ARTICLE X

Effective Date, Withdrawal and Amendment

a. This Compact shall come into limited effect at such time as this Compact has been enacted into law in ten (10) party states for the sole purpose of establishing and convening the Commission to adopt rules relating to its operation and the APRN ULRs.

b. On the date of the Commission's adoption of the APRN ULRs, all remaining provisions of this Compact, and rules adopted by the Commission, shall come into full force and effect in all party states.

c. Any state that joins this Compact subsequent to the Commission's initial adoption of the APRN uniform licensure requirements shall be subject to all rules that have been previously adopted by the Commission.

d. Any party state may withdraw from this Compact by enacting a statute repealing the same. A party state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

e. A party state's withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.

f. Nothing contained in this Compact shall be construed to invalidate or prevent any APRN licensure agreement or other cooperative arrangement between a party state and a non-party state that does not conflict with the provisions of this Compact.

g. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon any party state until it is enacted into the laws of all party states.

h. Representatives of non-party states to this Compact shall be invited to participate in the activities of the Commission, on a nonvoting basis, prior to the adoption of this Compact by all states.

ARTICLE XI

Construction and Severability

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 th e United States, or if 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 to be contrary to the constitution of any party state, this 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.