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

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

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

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

Subsequently, they directed a task force be formed to look at these transitions to practice and ancillary provisions and to make some recommendations. The task force presented recommendations at the mid-

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

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these provisions, and if there are any ancillary provisions in place when the compact is adopted, they would be superseded by the compact.

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

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

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

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

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

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

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

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

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

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

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

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

- I think states would handle that very differently.

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

- That's correct.

- Okay. Thank you.

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

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

Could you comment on that, please?

- Do you all want to respond to that?

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

So, yes, we did receive feedback, and it was discussed, I think and there was 625.9i discussed, 9s were compiled ar

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

- But I figured...

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

You're welcome.

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

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

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