



THE NURSING LICENSURE COMPACT AND APRN COMPACT: A BAD OPTION FOR WASHINGTON

I. INTRODUCTION

The National Council of State Boards of Nursing (NCSBN), a private, Chicago-based trade association, has recently proposed revised versions of two previously proposed compacts for multistate nursing practice: a Nursing Licensure Compact (NLC) for registered nurses and licensed practical nurses and an Advanced Practice Registered Nurse (APRN)* Compact.

The NCSBN Compacts are a bad option for Washington, for Washington nurses and for Washington patients. **Washington lawmakers should reject them.**

NCSBN portrays the Compacts as advancing public protection and access to care, but in fact they would do neither. The NLC and APRN Compacts authorize nurses in party states (states that participate in the compacts) to practice in all other party states. A nurse would hold a “multistate license” from her or his home state (defined as the state of residence) granting privileges to practice in all other party states. Both compacts define the site of a nurse’s practice as the state in which the patient is located at the time services are provided. This would apply not only to nurses who are physically present and providing care to patients in another state; it would also apply to nurses who are providing services through electronic communications. Thus, a nurse might be physically located in Washington but, if providing assessment, advice, counseling or other services via phone or computer to a patient in another state, she or he would be considered to be practicing in that other state.

* APRNs include nurse practitioners, certified nurse-midwives, certified registered nurse anesthetists and clinical nurse specialists – regulated in Washington as Advanced Registered Nurse Practitioners (ARNPs).

NCSBN proposed a prior version of the NLC in 1998 but found limited success in convincing states to adopt it. By 2010, twenty-four states had joined the NLC. In the five years since, one additional state joined. Twenty-five states and the District of Columbia, accounting for almost two-thirds of the U.S. population, declined to adopt it. Among the states rejecting the previous NLC are Washington, Oregon, Nevada, California, New York, Florida and NCSBN’s home state, Illinois. NCSBN’s prior APRN Compact, launched in 2002, was even less successful: it was adopted by only three states and never implemented.

However, since proposing the revised NLC and APRN Compact in 2015, NCSBN has launched an aggressive lobbying effort to convince lawmakers in several states, including Washington, to adopt them.

The Washington State Nurses Association (WSNA) and the American Nurses Association (ANA) are committed to reasonable, efficient regulation of nursing practice across states. But the current NCSBN Compacts pose several serious concerns:

- Despite claims that the Compacts will improve public protection and access to care, they will do neither.
- Instead, they create troubling new complications in regulating nursing practice by imposing unworkable approaches such as defining practice as occurring wherever the patient is located, even when care is provided remotely through electronic communication.
- The APRN Compact will create additional new complications for advanced practice and contains contradictory language regarding

whether Washington ARNPs will have to practice under physician oversight when practicing out-of-state;

- The Compacts erode Washington state sovereignty by creating powerful and unaccountable new private bureaucracies with significant power over the states.
- The Compacts will impose new but undetermined expenses and likely result in revenue losses that could result in decreased services or increased licensure fees.
- Proponents' comparisons to existing compacts—such as driver's license agreements/compacts and the Interstate Medical Licensure Compact—fall short; there are fundamental differences between them and the NCSBN Compacts.

II. THE NCSBN COMPACTS DO NOT IMPROVE PUBLIC PROTECTION

Proponents of the revised NCBSN Compacts argue that they will enhance nursing licensing boards' ability to protect the public. But the few improvements promised by the Compacts can be accomplished—and, to large extent, have already been accomplished—through less complex, intrusive and overreaching means than adopting the Compacts.

A. The Compacts' major protections are already in place or pending in Washington

For example, the Compacts call for states' participation in a coordinated licensing information system. But participation in such a system does not require states to adopt the NCSBN Compacts. In fact, almost all states (including Washington) already participate in the current information system, NURSYS. That system makes information on nurses' licensure status and discipline history available to the public. (Currently, NURSYS makes information on significant investigations

available only to Compact states. This could be expanded to include other states).

The Compacts require criminal background checks, including fingerprinting or other biometric testing. (The prior versions of the Compacts did not include this requirement). But states can require this without adopting the Compacts. A growing number of states already do. Washington requires federal criminal background checks on out-of-state applicants, and a proposal to require them for all applicants is pending. The Uniform Licensing Requirements put forward by NCSBN in 2011 include this requirement, together with other standards and practices designed to improve public protection. NCSBN has urged all boards of nursing--not just those who participate in the Compacts--to adopt the Uniform Licensing Requirements.

In other words, currently any nurse who wishes to practice in Washington must obtain a Washington license and meet Washington's standards, which already include screening their licensure history, federal criminal background checks for out-of-state applicants, and are anticipated to include such background checks for all applicants. The Compacts are not needed for any of these measures—these provisions in the Compacts would do nothing to improve public protection in Washington.

B. Despite these protections, important gaps remain

In addition, while criminal background checks and participation in NURSYS are important steps toward protecting the public, they leave some significant gaps that the Compact does not address. States vary in their disciplinary procedures and standards: **conduct that would result in investigation and discipline in one state may not do so in another state. Depending on the state in which that conduct occurs, it may not be reported at all.** And NURSYS depends on each state board to enter discipline data efficiently—if a state fails to do

so, other states cannot be notified in a timely manner.

C. The Compacts would allow out-of-state nurses to practice without meeting Washington’s requirements

Although the Compacts require that a nurse 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, the parameters of this requirement are not made clear.

The NLC allows any nurse with an unencumbered license in her or his home state to practice in other party states. But some states differ in regard to nursing education program requirements, including requirements for supervised clinical experiences. And states vary widely in their requirements for license renewal. For example, in 2011, the Washington State Nursing Care Quality Assurance Commission (NCQAC) adopted continuing competence requirements: Washington nurses must have at least 531 hours of active practice and 45 hours of continuing education every three years. And in 2014, the legislature approved new requirements that RNs, LPNs and most ARNPs—among other health professionals—complete an approved, one-time training of at least 6 hours in suicide assessment, treatment, and management.

The NCSBN Compacts do not directly address continued competence issues, but there is ample reason to believe that Washington’s requirements for continued competence would not apply to out-of-state nurses practicing here if the Compacts are adopted. In a 2012 document regarding the prior version of the NLC, the Nursing License Compact Administrators (NLCA) emphasized that nurses are not held to the continued competence requirements of any state other than their home state—if they are licensed in their home state, they qualify to practice in any other party state¹. There is no reason to expect that the language of the current NLC will lead to a different

interpretation. Yet some states have no requirements at all for continued licensure beyond paying a renewal fee. Some have other requirements that may fall short of Washington’s—e.g., having no requirements for recent active nursing practice or no requirements for continuing education. No state other than Washington requires training in assessing, treating and managing suicide.

If Washington adopts the Compacts, we will have ceded our right to determine and enforce the standards for practice that our policy-makers have determined are necessary to ensure safe practice. *Why set clear standards for competent practice if they will apply to some nurses practicing in our state but not others?*

D. There is no reason to expect the Compacts to improve access to care in Washington

Despite claims that the Compacts will improve access to care, there is no evidence to suggest that they would do so for Washington. Out-of-state nurses who want to practice in Washington are able to do so without significant delay: NCQAC processes endorsement of out-of-state licenses rapidly. Nor is there evidence that the Compacts will increase access to telehealth services (i.e., services provided through electronic communications technologies) in Washington. Further, Washington is a pioneer in authorizing ARNPs to practice without the unnecessary restrictions that have imposed barriers to access in other states. The Compacts would do nothing to promote access to their services.

III. THE COMPACTS CREATE TROUBLING NEW COMPLICATIONS IN REGULATING NURSING PRACTICE

While the Compacts would offer no real improvement in public protection or access, in several respects they would create significant new complications in regulating nursing practice.

A. Defining practice as taking place in patient’s location is an unworkable approach

The issues sound simple: Nurses are increasingly mobile, but current state-based licensure requires multiple licenses for nurses who practice in more than one state. And the increasing use of electronic communications technologies means that many nurses are practicing across state lines. The Compacts, we are told, will provide a clearer legal basis for their practice.

The NLC and APRN Compact both define nursing practice as taking place in the location where the patient is receiving services. This may be logical when a nurse is providing care while physically present in another state. *But when providing care remotely through electronic technologies, it creates significant complications.*

Some nurses work in settings such as call centers or advice lines that are set up as “telehealth” practices that primarily use communications technologies to assess, advise and/or counsel patients remotely in their homes. These nurses provide services to patients from multiple states, often in the course of a few hours. Because the Compacts say that practice takes place where the patient is located, these nurses would be expected to be familiar with the practice acts, rules and policies of each of those states.

However, under the Compacts, *any* use of communications technologies across state lines *would be considered interstate practice*. When the NLC says “A nurse 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,” it does not distinguish designated telehealth practices—those in which nurses practice primarily through electronic communications technologies—from settings in which larger numbers of nurses work, such as

outpatient clinics and practices, emergency departments, surgical practices, case management, and other settings or roles in which nurses often have preadmission, post-discharge or ongoing contact with patients.

Some of those patients may reside out of state. And virtually any patient may be out of state or even out of the country temporarily—on vacation, on a business trip, or visiting family. The ubiquitous use of mobile communications devices, such as smart phones, tablets, and laptop computers, means that a nurse may be providing services to a “local” patient who happens to be in another state or country at the time. The nurse may not even be aware that the patient is temporarily out of state.

Consider these scenarios:

An out-of-state patient seeking treatment in Washington: A patient from Eastern Idaho chooses to seek elective surgery at a Spokane hospital. Shortly after discharge, the patient calls to ask questions about follow-up care and speaks to a wound care nurse. Later, the patient alleges that the nurse gave incorrect advice and that the patient suffered complications as a result. Although the patient chose to receive care from Washington providers, the nurse will now need to answer to the Idaho Board of Nursing, and possibly to the Idaho court system as well—in addition to Washington State.

A local patient temporarily out of state: A patient who lives in Olympia is seen in the emergency department of an Olympia hospital. A few days later, while visiting family in Montana, the patient receives a follow-up call on her cell phone from a nurse at the hospital. The patient later alleges that the nurse gave advice that exceeded her scope of practice. The nurse would be considered to be practicing nursing in Montana, perhaps without even knowing it. She would be subject to Montana’s jurisdiction and judged according to Montana’s scope of practice laws.

A nursing faculty member with students who are out of state: Because the Compacts state

that the site of practice is the location where the client is receiving services, nursing faculty in Washington could find themselves subject to the jurisdiction of other states if they have students who are located in other Compact states, either as residents or visitors. This would apply to faculty who teach on-line courses—and potentially to any course if the faculty member is in contact via email, telephone or the Web with a student who is out of state at the time.

B. Regulating practice while physically out of state does not require a complex new regulatory mechanism

In care that involves the nurse’s physical presence, identifying the site of practice as the location where the patient is receiving services is less complicated, since it is also the site where the nurse is located at the time. However, the limited instances in which a nurse is temporarily located in another state do not warrant a whole new complex regulatory mechanism. Some nurses may practice occasionally in a neighboring state. When “traveling” nurses, who work for agencies that assign nurses to hospitals around the country, require multiple licenses, that detail and expense is generally the responsibility of the nurse’s employing agency. When nurses seek to volunteer assistance following a disaster, states will generally permit out-of-state nurses to practice on a temporary basis.

Of course, a far more common scenario is when a nurse changes residence from one state to another and plans to practice in the new state. Currently that nurse needs to obtain a license in her new state. Under the NCSBN Compacts, this requirement would not change: a nurse who changes her state of residence would still be required to obtain a license in her new home state.

C. The Compacts will mean losing opportunities to ensure that nurses practicing here are familiar with Washington nursing practice

Each state in the U.S. enacts and enforces its own nurse practice act. These practice acts reflect some differences from state to state. As noted earlier, these often include differences in curriculum and clinical experience requirements, especially for basic practice. States differ in standards for delegating tasks or assigning functions to other nursing personnel. They differ with regard to scopes of practice, particularly for licensed practical nurses (LPNs), which has implications not only for out-of-state LPNs practicing in Washington, but also for RNs who work with them.

Requiring nurses to be licensed in Washington before practicing here provides an opportunity to educate them about the specifics of nursing practice and regulation in Washington and to inform them of changes in relevant state legislation, regulation or policy related to nursing practice. If Washington adopts the Compacts, it means that almost any nurse licensed in another party state—literally hundreds of thousands of nurses—would be authorized to practice here without any official notice or any contact at all with the Nursing Care Quality Assurance Commission.

D. The Compacts’ definition of “home state” is confusing and illogical

Under the Compacts, a nurse’s “home state”—the state in which the nurse resides—is the state that issues her or his license. That state authorizes the nurse’s multistate privileges. Thus, a nurse who lives in Oregon or Idaho and commutes into Washington for work could no longer be licensed in Washington. The nurse would instead need to be licensed in her or his state of residence and be authorized by that state to practice in other party states, including Washington. If a nurse who lives and works in Washington moves across the state border while remaining at the same job in Washington, the nurse would need to inactivate her or his Washington license and obtain a license in the new state of residence, even if she or he has no intention of practicing there. **A nurse might spend her entire career practicing in**

Washington yet be required to be licensed in another state.

E. The APRN Compact creates additional complications for advanced practice nursing

Washington is a pioneer in recognizing the critical role that APRNs play in ensuring access to high quality, affordable health care. Our state has been a model for the rest of the nation in promoting APRNs' ability to practice to the full extent of their education and training. It is vitally important that we continue to play a leadership role in advanced nursing practice. Unfortunately, adopting the APRN Compact would pose some serious concerns.

The APRN Compact defines APRN as "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 . . . , and who is licensed to perform advanced nursing practice." In other words, the new Interstate Commission would "recognize or define" educational standards for APRN practice, and Washington would be bound by those standards, which have not yet been determined.

Washington imposes no legal requirements for APRNs to practice under the supervision of or in collaboration with another health professional. The APRN Compact seems at first to be consistent with Washington law when it states that "[a]n 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." However, the APRN Compact *also* states that "[a]n 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."

It is not clear how these two provisions can be reconciled. There are still several states in which practice laws require a supervisory or collaborative relationship with a physician. Will Washington APRNs be expected to comply with these requirements? Since APRNs are considered to be practicing in the state where the patient is located, does this mean that even APRNs who are physically located in Washington but providing services remotely will need to comply with a remote state's requirements for supervision or collaboration? Would a collaborative or supervisory relationship need to be established with a physician in the remote state?

F. Adopting the Compacts could result in significant loss of state revenue

Adopting the NCSBN Compacts would threaten a significant potential loss of revenue for supporting nursing practice and regulation in Washington State. The Nursing Care Quality Assurance Commission is supported by licensing and renewal fees. The Washington Center on Nursing is supported by a surcharge on those fees. Under the Compacts, out-of-state nurses practicing in Washington (including those who commute to Washington to work) would no longer be licensed here; they would be licensed in their states of residence instead, so they would no longer pay fees for licensing and renewal here. (This loss of revenue might be partially offset by fees from Washington residents who practice in other states and would need to be licensed here).

In other states, potential loss of licensing revenue has been a major factor in deciding not to adopt the prior NLC. For example, in 2002 the Virginia General Assembly's Joint Commission on Health Care estimated a total loss of revenue to their Board of Nursing of more than \$400,000 biennially if Virginia joined the NLC². (Virginia subsequently joined, raising their licensing fees for all Virginia-licensed nurses in order to avoid this substantial revenue loss). In 2014, the Kansas Board of Nursing predicted a \$376,667 loss of revenue if

it joined the NLC³ (which it declined to do). A 2013 report to the California board that licenses licensed vocational nurses (equivalent to LPNs in Washington) also noted that joining the NLC would result in a “substantial loss of revenue” to that state’s nursing licensure boards⁴.

There is no mechanism for charging fees to out-of-state licensees practicing in the state in order to recoup these losses. Indiana sought to join the NLC and enacted a provision authorizing a \$25 filing fee for out-of-state privileges. Their attempt to join the NLC was rejected and Indiana subsequently repealed the legislation. Today, Indiana remains a non-Compact state.

In addition to probably revenue losses, Washington would likely face set-up expenses in joining the Compacts as well as fees to the Interstate Commissions created under the compacts (fees which have yet to be determined). Faced with revenue loss and additional expenses resulting from joining the NCBSN Compacts, the only options would be to reduce services or to increase fees for Washington nurses.

IV. THE COMPACTS WOULD SIGNIFICANTLY ERODE WASHINGTON’S STATE SOVEREIGNTY

A. Interstate compacts are powerful instruments; adopting them requires careful deliberation and balancing

In the U.S., states regulate health care practice within their borders, in keeping with the basic tenets of federalism. The NCSBN Compacts purport to build on existing state regulatory structures, but they would actually *erode* states’ powers by superimposing new and complicated regulatory mechanisms that create two powerful and unaccountable “Interstate Commissions,” one for the NLC and one for the APRN Compact.

Interstate compacts are very powerful instruments. They are adopted in statute by participating states, but they also function as

contracts. The provisions of a compact have the force of law. They take precedence over existing laws that may conflict with it. By adopting a compact, the state willingly gives up some of its own autonomy. Clearly, a step like this requires very careful deliberation and balancing—evaluating how much autonomy is surrendered, under what circumstances, and whether the purported benefits justify the risks to the state and its citizens. A careful examination of the NLC and APRN Compact reveals that purported benefits do not justify the risks.

B. The Compacts create unaccountable new private bureaucracies with significant power over participating states

Both the NLC and the APRN Compact create an “Interstate Commission” with broad implementation and enforcement powers, including adopting rules and assessing payments from participating states. Each state would have a representative to the NLC’s Interstate Commission and the APRN Compact’s Interstate Commission. That representative would be the head of the state licensing board or designee, who also serves as the administrator of the Compacts for each party state. (Each state would have one vote on each of the Interstate Commissions, regardless of the state’s population or number of licensees).

The Interstate Commissions’ rules and decisions are binding on all member states. The Compacts include procedures for notice-and-comment rulemaking, although they include no specific length for the comment period. The Compacts also provide for emergency rulemaking, using a notably broad approach to determining when “emergency” rules are needed: it includes not only actions to respond to an imminent threat to public health, safety or welfare, but also to prevent a loss of Commission or party state funds or to meet a deadline for the adoption of an administrative rule that is required by federal law or rule.

The Interstate Commissions also have the power to adopt budgets and collect annual assessments from each party state to cover the cost of their operations, based on a formula that they will determine. The Commissions can terminate a state for defaulting in the performance of its obligations or responsibilities under the Compacts or Commission rules.

In other words, by adopting the Nurse License Compact and the APRN Compact, *Washington would be bound by decisions to adopt rules and to assess payments to fund yet-to-be-determined budgets, based on a yet-to-be-determined formula.*

Compounding this problem, **there is no oversight or accountability** for the Commission's decisions. While each state's representative is accountable to her or his own state, *the Commissions themselves are accountable to no one.* And there is no mechanism to appeal their decisions, with one narrow exception: the right to appeal a decision to terminate a state from the Compact. (And that appeal can only be filed in the U.S. District Court for the District of Columbia or the federal district in which the Commission has its principal offices).

A state can withdraw voluntarily from either Compact only by adopting a new statute to do so, at least six months before withdrawing. The state remains bound by the Compact (and responsible for paying assessments) until then.

C. Washington nurses would be subject to other states' jurisdiction

As noted earlier, according to the NCBSN Compacts, a nurse who practices in a party state under a multistate licensure privilege will be subject 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." This means that a nurse might be located in Washington and communicating via telephone, computer or other electronic communications technology with a patient in

another state and find herself or himself subject to that state's licensing board, courts and laws.

Not only could that state revoke the nurse's privileges to practice there; the Compacts authorize licensing boards in one party state to issue subpoenas for hearings and investigations for attendance and testimony from another party state. So a Washington nurse could be compelled to travel to another state to participate in a hearing or to respond to an investigation for alleged conduct that occurred while she was in Washington providing services remotely. While the Compact does state that the board or court in the other state would pay fees and travel expenses, this does not address the unnecessary disruption and burden involved—let alone the fact that the nurse would be subject to that state's procedures and standards for investigation and discipline. And this would also represent a new financial burden for states.

Investigation and discipline procedures vary from state to state. While the Compacts say that the home state will apply its own state laws to determine appropriate action to take against a nurse's license, Washington nurses could still face investigations and hearings in another state based on alleged conduct that occurred in Washington, even if those allegations would not have been sufficient for Washington to take action against the nurse's license.

And, of course, it would be ironic (to say the least) to think that a nurse might be compelled to make a personal appearance in a distant state because of allegations arising from providing services to a patient in that state remotely via telephone or computer.

The Compact language granting jurisdiction to other states is notably broad: It is not limited to authority over the nurse's ability to practice nursing. The plain language suggests that this would apply to civil and criminal liability as well.

V. COMPARISONS TO OTHER COMPACTS FALL SHORT

A. A nursing license is *not* like a driver's license

Proponents often draw an analogy between the NCSBN Compacts and driver's licenses, based on the fact that a driver's license issued in one state permits the license holder to drive in any other state, subject to motor vehicle laws of the state in which she or he is driving. But this comparison is very limited at best.

Driving in another state invariably means that the driver is *physically present* in that state. But nursing services are increasingly provided remotely, through electronic communication technologies. In fact, this is a major argument offered for adopting the NCSBN Compacts). **This is a fundamental difference between nursing licenses and driver's licenses.**

A driver's license authorizes an individual to *engage in an activity*—operating a motor vehicle. A nursing license authorizes an individual to *practice a profession*. It involves a broad range of cognitive and psychomotor skills and functions based on a specialized body of knowledge acquired through an approved academic program. Also, determining violations of motor vehicle laws is largely based on facts. Penalties are often prescribed in law. Determining violations of nurse practice acts and deciding appropriate penalties often requires evaluating a wide range of circumstances, particularly when a nurse is suspected of practicing incompetently.

B. The Interstate Medical Licensure Compact includes important differences with the NCSBN Compacts

In addition to the NCSBN Compacts, interstate compacts for other health professions have been developed or are being developed. Of these, the Interstate Medical Licensure Compact (IMLC), which addresses interstate licensure and practice of physicians, has drawn the most

attention. It has been adopted by eleven states so far.

Unlike nursing, there are virtually no differences from state to state in the scope of practice for medicine. Furthermore, the IMLC differs from the NCSBN Compacts in several significant ways:

- Rather than granting a multistate license to practice in all other party states, the IMLC *still requires a physician to be licensed in each state in which she or he seeks to practice*. The IMLC authorizes a physician to apply for an expedited license from that state or states. The board of medicine in that state then evaluates whether the physician is eligible for an expedited license. If granted, the physician is licensed in that state, pays fees to that state and must renew the license periodically.
- Unlike the NCSBN Compacts, which specify that a nursing license is issued in the nurse's "home state"—i.e., the state of residence—the IMLC provides that a physician has a "state of principal license," which can be *the state of residence, a state in which the physician practices at least 25% of the time, or the state of the physician's employer*. The physician may later redesignate another state as the state of principal license.
- The IMLC specifies that physicians *must comply with the state's continuing education requirements* in order to renew the license. The NCSBN Compacts do not directly address whether out-of-state nurses will be required to comply with states' continuing competence rules (such as continuing education) but, as noted earlier, it appears that they will not.
- The IMLC provides that if its Interstate Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the Compact,

that action “shall be invalid and have no force or effect.” The NCSBN Compacts include no such limitation.

- The IMLC provides that anyone may *file a petition for judicial review of any rules* adopted by its Interstate Commission. The NCSBN Compacts include no provision for challenging their Interstate Commissions’ rules.
- The IMLC states explicitly that decisions of the actions of its Interstate Commission *shall not override existing state authority* to regulate the practice of medicine. The NCSBN Compacts contain no similar provision regarding regulation of nursing practice.

VI. THE ALTERNATIVE: FOCUS ON TELEHEALTH

Telehealth—delivering services through electronic communication technology—offers great potential for increasing access to care, enhancing patient engagement and experiences of care and reducing costs. Nurses have provided advice, counseling and triage via telephone for many decades; this was never seen as posing regulatory complications. It is the development and proliferation of computer technologies and handheld devices have transformed telehealth practice and raised questions about how best to regulate the interstate use of these technologies.

The NCSBN Compacts represent a flawed attempt to address these regulatory challenges. WSNA agrees that they must be addressed. But doing so does not require adopting a comprehensive change in regulating nursing practice—especially not the broad, complex, cumbersome and inflexible mechanisms proposed by the NCSBN Compacts. **Instead, efforts should focus on the discreet issues posed by interstate telehealth practice.**

VII. CONCLUSION: ADOPTING THE NCSBN COMPACTS IS A BAD OPTION FOR WASHINGTON

Unfortunately, Washington lawmakers who have concerns about any provisions in the NCSBN Compacts have no opportunity to do anything about them at this point: In order to join the NLC and/or the APRN Compact, Washington would have to adopt them as they are, without any substantive changes. The Compacts could be amended later, but that would require every Compact state to enact a new statute to do so.

Thus, the only two options available to Washington are:

- To adopt each Compact as is, despite multiple concerns; or
- To reject the Compacts.

WSNA and the American Nurses Association (ANA) remain committed to finding common ground with NCSBN and others on effective regulatory measures, particularly with regard to interstate telehealth practice, that are workable and realistic, that offer real solutions, and that respect state sovereignty. None of this, unfortunately, describes the NCSBN Compacts. The Compacts are a bad option for Washington. **Washington lawmakers should reject them.** We can and must work toward better, more effective approaches.

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