Report of NPO Legislative Committee
October 2014

NPO Legislative Committee Structural Changes

ONA and NPO leadership made a joint decision to combine the NPO legislative committee with ONA's Cabinet on Health Policy. As such, two seats on the Cabinet of Health Policy will be designated for advanced practice nurses. This transition will remove duplicities that existed in the former structure, allowing ONA and NPO to work on legislative issues more efficiently. This structure will still rely on feedback from NPO leaders and members when making legislative decisions that will impact NPO members.

Federal Issue

Durable Medical Equipment (DME): H.R. 3833: As a result of a section within the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) stated that at an unspecified date in 2014, Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) would be unable to order certain durable medical equipment (DME) without a physician's signature confirming that a patient had a face-to-face visit with their provider within the last six months. CMS has twice delayed this requirement. ANA is working with Congressional leaders to pass a bill that would eliminate the physician co-signature requirement, allowing NPs and CNSs to order appropriate DME and document their own face-to-face encounters, as they have been doing for years.

The U.S. House Ways and Means Committee included a fix for this issue in their draft legislation, Protecting Integrity in Medicare Act of 2014 (PIMA). The bill was not introduced before the House recessed for the election, but it is likely to be re-introduced when Congress reconvenes in November.

The Senate Finance Committee is also considering legislative language that would address this issue.

Home Health Planning and Improvement Act H.R. 2504: The House Home Health Planning and Improvement Act would allow Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives, and Physician Assistants to order home health services for their Medicare patients without requiring a physician's approval. Current Medicare law prohibits advanced practice nurses from signing home health plans of care and from certifying Medicare patients for the home health benefit. A patient is able to see the provider of their choice in a face-to-face meeting before home health services can be authorized, but only a physician to sign the final plan of care. This places an undue burden on the patient, especially in underserved areas. Oregon Congressman Greg Walden introduced this legislation.

Protecting Access to Primary Care Act: H.R. 2986: The Protecting Access to Primary Care Act, introduced by Oregon Congresswoman Suzanne Bonamici, would ensure Nurse Practitioners receive the same incentives as physicians for primary care services rendered to Medicaid beneficiaries. The ACA set a floor for Medicaid payments to physicians for primary care services, requiring the payments be at least equal to Medicare. This legislation would create that same floor for Nurse Practitioners.

2015 Advanced Practice State Legislative Priorities

Payment Parity: Oregon was successful in passing the first NP reimbursement parity law in the country. It has been in effect since the beginning of 2014. With the law came the creation of a task force, asked to study and make recommendations on a payment structure that promotes the maintenance and expansion of primary care providers. The task force has met seven times this year and will continue into 2015. As of this point their recommendations have been limited. Since the implementation of the law, we've also run into problems with a handful of insurers testing the law, attempting to avoid compliance. Numerous complaints have been filed with the Insurance Division and NPO will continue to monitor this process to ensure proper implementation of the law.

ACA Provider Payment Fix: Under rules issued by CMS, patients who purchase insurance through the ACA will get a 90-day grace period to pay their outstanding premiums before insurers are permitted to drop their coverage. The rule applies to all consumers who purchase subsidized coverage through the ACA's health insurance marketplace.

Under the federal rule, insurance companies are required to cover payment for services provided during the first 30 days of the grace period. State law can require insurers to cover services provided during days 31-90 of the grace period. In Oregon, there is no state law that requires insurers to cover payments during days 31-90 of the grace period, so providers are not currently reimbursed for services provided during the last 60 days of the grace period.

NPO is working with the Oregon Medical Association on state legislation aimed at ensuring providers are reimbursed for services provided during the entire grace period.

Dispensing: During the 2013 session, the Oregon State Board of Pharmacy declared their intent to regulate all areas of provider dispensing, with some exception including samples, 48-hour supply, and full course therapies. Their proposed regulations included annual fees and inspections of acquisition, storage, labeling, and record keeping. NPO and others worked to encourage the board to suspend the implementation of their regulations and engage in a more open and collaborative discussion with providers. NPO has been working with the Oregon State Board of Pharmacy, as well as other state licensing boards and provider associations on rules that define a dispensing drug outlet. Through NPO's involvement, we hope to create rules that protect NPs from unnecessary burdens that impede their practice offer no improvement in patient safety.

Multipayer Strategy

ONA is working with the Oregon Medical Association and the Oregon Association of Family Physicians to insure that agreements made by health insurance carriers related to primary care incentives are implemented. NPO/ONA was a part of a Governor convened group that made agreements a year ago to incent primary care with additional resources.

Other ONA Priorities

Nurse Staffing Legislation: ONA is having conversations with the major organizations that are likely to partner with us or oppose our improvements to Oregon's Nurse Staffing Law. These conversations are aimed at garnering support and creating partnerships when possible, and minimizing opposition when possible. We've also continued our work with legislators on this issue. ONA has been convening meetings with key legislators and ONA members to give legislators an opportunity to hear what nurses in their community are experiencing in regards to staffing. Legislative Council is in the process of drafting a bill based on ONA's member-approved staffing framework and ONA staff is working with the Senate Health Care Committee to schedule an interim hearing during legislative days in December.

Professional Standards Committee

Chair James Sims

The Professional Standards Committee has focused on the following issues during this last year.

Availability and Capacity of NP Student Preceptors in Oregon

NPO has become aware that students are often required to find their own preceptors and deal with the requirements of both the practice setting as well as the academic programs. Added to the local programs, many online programs have students who are based in Oregon and need to have a local clinical experience. While no major solutions have been reached, NPO continues to hold the position that the schools are responsible for securing qualified preceptors as well as insuring that both the program and student meet all legal requirements. NisPO has also implemented a voluntary process whereby students can post a needed experience on the website and if the faculty of record is also identified advertise for a preceptor. This has not been used to any significant extent but is a potential for students who have not received the support from their academic program.

Clinical Education – "Residency, Fellowship"

The committee has deliberated the issue of assisting NP students into clinical practice. While some Oregon programs assert that they imbed a "residency' like experience within the academic program, there remains concerns that these part s of the education program to not provide sufficient clinical experience particularly in primary care. The committee has explored a post graduate "fellowship" for new NP graduates to insure clinical competency. These discussions are ongoing.

Related to the issue of adequacy of clinical experience is the question of RN practice as preparation for NP practice. The early data about outcomes of NP care was based on a cohort of NPs who were experienced RNs. RN experience has become less consistent with the advent of accelerated programs. While many accelerated students possess strong academic traits, the committee members as well as many current expert NPs believe that the preparation gained by RN clinical practice is both valuable and necessary. The committee is developing new recommendations which would institute a period of 2080 hours of RN clinical practice before entry into an NP program.

Of interest, ONA/NPO introduced legislation in which would have required a specified period of clinical experience as an RN before entry. At that time, ONA/NPO was

concerned about the role and focus of new NPs. The proposal was aggressively opposed by the NP academic programs which had instituted accelerated programs.

Titling

The Professional Standards Committee has reviewed and evaluated proposed changes to Division 56 which relates to Nurse Practitioner authority to Prescribe and Dispense and Division 50. We have commented to the Board of Nursing on new requirements for prescribing controlled substances and our recommendations have been positively received by the Board of Nursing. However, we have taken a position opposing the title change from specific categories – Nurse Practitioner, Clinical Nurse Specialist and Certified Registered Nurse Anesthetist. Although the national voluntary consensus document uses Advanced Practice Registered Nurse as a generic title, it is the committee's believe that this is confusing to the public and policy makers. Legal authority under current law is tied to the specific titles.

Non-Pharmacy Dispensing

The committee has reviewed proposals by the Oregon Board of Pharmacy related to dispensing by providers. NPO/ONA has worked with other professional association s and has proposed modification to the initial proposal. The Board of Pharmacy has not yet announced its acceptance however, NPs are regulated by the Board of Nursing and any change will need to be done in conjunction with our own regulatory board.

Nurse Practitioners of Oregon

Independent Practice and Business Owners Committee

Chair, Shelda Holmes FNP

During this last year, the committee has focused on assessing needs of NP business owners for support services. In December, a meeting was held with an outside consultant to discuss the potential for NPO to establish an Independent Provider Association. Given the diverse business arrangements that NPO members have implemented statewide, and given that some are already members of a local IPA, this may not be a viable option for NPO.

A survey was conducted during the summer and the top request from members is assistance with negotiating contracts with carriers. The committee is exploring how that might be accomplished outside of an IPA.

The Committee has also been focused on implementation of HB 2902 payment parity for Nurse Practitioners. A web conference with the Insurance Division was hosted through the ONA office to provide members with information about how the new law will be enforced.

NPO Education Committee Report
37th Annual NPO Education Conference
October 16-18, 2014
The Sentinel

There are approximately 230 people in attendance!

The NPO Education Committee worked hard this year to provide a relevant, evidence-based educational offering that reflected the information from last year's evaluation forms. As a result, we encourage you to complete the conference evaluation forms and to be sure to let us know of topics and/or speakers that you would like to see included in upcoming programs.

The Education Committee paired up with ONA to present this year's conference. This was a new partnership and by all accounts was very successful. The ONA staff completed the CE application and worked with the certifying agency, took responsibility for the exhibitor hall and working with the vendors, provided all of the AV support, developed the brochure and updated and maintained the website materials.

The CE was approved by the Ohio Nurses Association which is an accredited approver by the ANCC commission on accreditation. This year's conference consists of a possible 23.6 CE hours.

We were very fortunate, thanks to financial support from Optum, to be able to welcome back Dr. Margaret Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP, FAAN, DCC. This was the 6th consecutive year that we have featured Dr. Fitzgerald as our keynote speaker.

There are 41 vendors in the exhibit hall.

The NPO Education committee continues to work toward paperless conferences. This year all conference handout materials were made available online for attendees. Online registration is continually being streamlined for user ease. In addition, we now encourage completion of evaluations online.

We have contracted for evaluation services through X-CD Technologies, Inc. and are hopeful that this new venture will be positive for the conference attendees as well as the committee.

The 5th Annual NPO Pharmacology Update will be held on Saturday April 11, 2015 at the Holiday Inn in Wilsonville.

The 38th Annual NPO Education Conference will be held at Sunriver Resort October 8-10th, 2015.

The NPO Education Committee continues to recruit for volunteers.

OREGON NURSES ASSOCIATION
ACTION REPORT

License Jurisdiction for Interstate Practice
Approved by the ONA House of Delegates

May 21, 2014

Action:

ONA adopts the following criteria for development of any statute or policy regarding the location of license jurisdiction for interstate practice including telehealth:

The regulatory approach that will best support current and future practice and protect the public must:

1. Support the evolution of practice and legal authority
2. Promote and support high standards for the profession
3. Promote patient access to safe and effective care
4. Promote access to nursing services in all geographic locations
5. Preserve state authority
6. Promote the least cost for regulated professionals
7. Promote cost efficiency
8. Require the least infrastructure
9. Afford the simplest regulatory structure and processes possible
10. Recognize mobility of health care consumers and providers

Rationale for Reference Proposal

State Boards of Nursing are adopting policies or attempting to enact statutory requirements that may inhibit the provision of nursing care across state lines**.** As there is no clear consistent state or federal policy regarding the location of license jurisdiction, it is imperative that the profession, through state and specialty organizations and in partnership with state Boards of Nursing, influence the development of appropriate policy for this traditional and growing practice.

While many states have enacted legislation or have established policies for licensing those who provide nursing care within their borders (Rotenberg and Greenberg, 2012), this approach lacks applicability and feasibility when care is provided across borders. It is not clear that such policies are enforceable because states likely do not know which providers are interacting with their residents. In many cases, with the advent of cell phone and internet contacts, providers may not know the location of their patients

Requiring a license in each state where a patient receiving “telehealth” services might be located, even on a brief episodic basis, creates new barriers to both established and emerging practices, and increases costs in a changing health care environment.

Any policy that endorses the need for licensure in every state in which a patient might be physically located at the time of the encounter with a nurse will inhibit nurses from sharing information with patients and adopting best practices. Such requirements would come at a time when we, as a nation, are working to create increased efficiencies in our health care delivery system by facilitating the transfer of information from nurses to their patients, thereby increasing timely access to care.

Background:

Nurses have used technology for decades to interact with patients. Follow-up phone calls to determine the condition of a patient discharged from a hospital have been a routine practice. Poison Control Centers, which provide services to a multi-state region, have provided valuable and timely lifesaving care to patients with intentional or accidental exposures. Both of these practices have historically involved nurses talking with patients in the same state and in states different from that of the nurse. While past use of remote patient contact has primarily been by telephone, more advanced technologies are now available and others, such as robots, real-time video, and electronic mail are being developed.

The appropriate use of technology to provide care will facilitate efficiency particularly for patients in remote areas, for those with physical and transportation challenges, and for those who choose to utilize alternatives to traditional face-to-face consultations. An increasingly mobile population that communicates with health care providers with cell phones and the internet is very likely to receive health care services from a provider located in another state. For example, many retired individuals choose to live part of the year in warm climates of the Southwest United States. If their primary provider is located in Oregon and they need advice about a health care situation, their care will occur via the telephone, video technology, or e-mail. Simple follow-up calls such as those made by ED nurses are often made to cell phones, making it difficult or impossible to know in which state the patient is located. In both scenarios, holding a license in all states in which a patient might be located lacks feasibility.

While reimbursement policies for such technology-based “visits” have lagged, the use of electronic and other media for giving and receiving health care services is expected to continue growing. Standards for primary care are increasingly incorporating a variety of patient interactions, including phone and e-mail.

Providing care to a patient who is not in the same location as the provider raises questions about where the encounter is actually occurring. Some assert that because the patient is choosing the provider, he or she is “coming to the visit” by electronic means rather than being physically present with the provider. Alternatively, others believe that the “visit” takes place at the patient’s location. While this may seem a small distinction, it raises the question of license jurisdiction (Hutcherson, 2001).

Licensure requirements for nurses who provide technology-enabled care across state lines can vary. This coupled with a lack of statutory authorization in some cases can make them unclear. For example, the Oregon State Board of Nursing advises nurses that they must be licensed in Oregon to provide care via the telephone or other technologies but no statutory authorization or Board policy exists to support such advice. The Washington State Department of Health Nursing Commission reportedly gives similar advice, despite verbally acknowledging the lack of statutory or policy authority. Conversely, in California "telephone medical advice" was made part of the Business and Professions Code and requires California licenses for employees of businesses with at least five full-time equivalent staff. Massachusetts has statutory authority requiring a state license for nurses from another state who provide telecommunication care to patients in Massachusetts.

At the federal level, in 1998 the Health Care Financing Administration developed reimbursement policies for "telehealth". These policies determined that the site of practice is the site where the provider is located. In 2011, the Centers for Medicare and Medicaid Services (CMS) issued a final rule for "Hospitals and Critical Access Hospitals Conditions of Participation: Telemedicine Credentialing and Privileging," which required licensure in the state where the patient is receiving telemedicine services. In the agency's comments, however, it defers to state laws related to licensure.

Proposed Implementation:

- Advocate for the proposed policy with the Oregon State Board of Nursing, professional associations for other health care professionals, Oregon legislative and regulatory bodies, and members of Congress and federal agencies.
- Provide to members to assist in advocating for the proposed policy in state legislatures and agencies.
- Publish information about innovative nursing practice activities that use technology and assess their impact on quality, access, and cost.

Financial Impact

Proposed implementation activities are within the scope of existing ONA activities including partnership with the Oregon State Board of Nursing, professional associations in nursing and other disciplines and in government relations activities with legislative and regulatory systems.

References

American Nurses Association, Nursing World: Interstate Nurse Licensure Compact: States Participating in the Nurse Licensure Compact; linking to the National Council of State Boards of Nursing (NCSBN) map (2012): http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/LicensureCompact.

California Business and Professions Code. Division 2, Chapter 15, Section 4999-4999.7. Retrieved from http://www.leginfo.ca.gov/.html/bpc_table_of_contents.html.

Gaffney, T. (May 31, 1999). The regulatory dilemma surrounding interstate practice. *Online Journal of Issues in Nursing*, *Vol 4,* No. 1, Manuscript 1.

Hutcherson, C. M. (September 30, 2001). Legal considerations for nurses practicing in a telehealth setting. *Online Journal of Issues in Nursing, Vol 6,* No. 3, Manuscript 3.

King, S. E. (May 31, 1999). Multistate licensure: Premature policy. *Online Journal of Issues in Nursing, Vol 4,* No. 1, Manuscript 3.

Massachusetts Statute. 244 CMR: Board of registration in nursing. Section 9.02 and 9.03(4). Retrieved from http://www.mass.gov/eohhs/docs/dph/regs/244cmr009.pdf

Oregon Health Authority (2011). Standards for recognition: Patient centered primary care home. Retrieved from http://www.oregon.gov/oha/OHPR/pages/healthreform/pcpch/standards.aspx

Rutenberg, C. & Greenberg, M. E. (2012). *The art and science of telephone triage: How to practice nursing over the phone* (pp. 81-106 & pp. 607-633). Pitman, N.J.: Anthony J. Jannetti, Inc.

State of Washington Administrative Code, Title 246, chapter 2460840, Section 246-840-700:

Standards of Nursing conduct or Practice, http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-700

State of Washington Nursing Practice Act, RCW 18.79.030: Licenses required – Titles: http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79

U.S. Government Printing Office. Conditions of participation: Medical staff. *Electronic code of federal regulations, Title 42,* Part 482.22. Retrieved from: http://www.ecfr.gov/cgi-bin/text-idx?c=ecfrbrowse/Title42cfr482 main02.tpl