Health and Human Services Committee: Interim

Presented by Gloria Doherty PhDc, MSN, RN, ACNP-BC, Adult Nurse Specialist

President New Mexico Nurses Association

Member at Large: New Mexico Nurse Practitioner Council

September 16, 2020

Thank you Chairman Ortiz y Pino and members of the committee for allowing the time for this presentation.

Mr. Chair and Members of the Committee:

On behalf of the Advanced Practice Nursing Council and New Mexico Nursing Association, we come to you with the following Advanced Practice Registered Nurse (APRN) considerations for the upcoming 2021 Legislative Session.

A short history.

In 1993, the nurse practitioners of this state, with bipartisan and bicameral support of this legislative body, were able to achieve independent practice including prescriptive authority. Twenty-seven years ago, few, if any states had independent practice AND prescriptive authority. Prior to 1993, NM had a collaborative agreement. This means a nurse practitioner had to have a physician to officially collaborate in order to see patients. Prescriptive authority back in those archaic days only included non-controlled substances.

During this time, the nursing community stood united with Colleges of nursing, the Medical Society and other community partners to achieve one goal: improve access to care for the citizens of New Mexico. Members from each of these groups provided expert testimony to legislators.

Today, 28 states have achieved independent practice.

Today, there are over 2000 advanced practice nurses licensed in the state of New Mexico. We practice in every specialty and touch all walks of life and periods of life. Much of our rural state are covered predominantly by nurse practitioners. Many APRN's have their own practices and others work within groups in a variety of healthcare settings. Access to high quality care has been improved for the citizens of New Mexico. The vast majority of NP's practice in primary care and certainly providing safe, high quality care to the citizens of New Mexico. There are numerous studies exist showing the safety and efficacy of nurse practitioners being equal to other healthcare providers. The satisfaction of patients receiving care under a nurse practitioners also remains very high.

During the time of negotiation for independent practice and full prescriptive authority, compromises were made for legislation to pass. This includes two things which I am speaking about today.

1. The need for a formulary being submitted to the Board of Nursing
2. The inability to dispense medications.

Today, I would like to ask for your support in eliminating the need for a formulary to be submitted to the Board of Nursing. This is an antiquated practice which is not followed, monitored or enforced. Today's healthcare and medication choices are mandated through the formularies created by insurance companies, the facilities and institution where we practice and individual healthcare plans. Additionally, science and research has improved greatly with more frequent additional medication classes and medications to treat both acute and chronic illnesses. You can see this during any television show with commercials from the pharmaceutical companies. It is impossible to keep up with all the medications and classes and the paperwork trail affiliated with it.

This can be found in the Nursing Practice Statute (NMSA 61-3-23.2):

C. Certified nurse practitioners who have fulfilled requirements for prescriptive authority may prescribe in accordance with rules, regulations, guidelines 'and formularies for individual certified nurse practitioners promulgated by the board.'

This can also be found in 61-3-23.3. E. This part of the statute requires certified registered nurse anesthetists to submit a formulary.

And finally in 61-3-23.4. D.

We do not anticipate any issues with bringing this statute to reflect current practice. This includes communications with the Executive Director of the Board of Nursing through the New Mexico Nurse Practitioner Council and conversations with the NM Medical Society.

The next piece regards the addition of 'dispensing' to the statute.

Currently, 61-3-23.2.D. allows a nurse practitioner to distribute to their patients, scheduled II-IV scheduled medications that have been prepared, packaged or fabricated by a registered pharmacist or dose prepackaged by pharmaceutical means in accordance with the Pharmacy Act (61-11-1 NMSA 1978) and the NM Drug, Device, & Cosmetic Act (26-1-1 NMSA 1978).

We propose that dispensing be added to this paragraph. Representative Gail Armstrong sponsored this bill in the last session but it was not germane. There are nurse practitioners in rural areas providing care to patients, your constituents that would benefit from this ability. A nurse practitioner from Magdalena has brought this to attention. Additionally, psychiatric nurse practitioners can improve care to their clientele with this ability.

Both the medical society and the BON have been communicated with. All agree this provides better access for the citizens of NM and the continuum of care.

Precedent exists with the Board of Medicine's statute for physician assistants. This statute was updated during the 2019 session. IT includes the Definitions distinguishing between 'dispense' and 'distribution' (can be found in 16.10.16.7.)

A. Administer: apply a drug to the body by any means
B. Dispense: means to deliver a drug directly to a patient and includes the mixing, labeling, and repackaging of a drug from a bulk or original container.

C. Distribute: to administer or supply a patient under direct care of the distributing physician assistant prepared or repackaged drugs or the manufacturers original container(S) containing a quantity suitable for the prescribed treatment or condition.

There are several other states who have this also in their Nurse Practice Act. Examples given here are New Hampshire and Minnesota.

New Hampshire: An APRN shall have plenary authority to possess, compound, prescribe, administer and dispense and distribute controlled and non-controlled medications within the scope of the APRN's practice.

Minnesota: APN's can prescribe, procure, sign for, record, administer and dispense over the counter, legend, and controlled substances, including sample drugs.

Next we would like to provide an update to legislation successfully passed last year in the 2019 Legislative season, specifically on Nurse Practitioner/Nurse Midwife Parity (HB280) requiring all health facilities, unless required by federal law, to apply the same criteria to CNP's, CNM's, and CNS's as applied to physicians with regards to granting patient admission/discharge privileges and authorizing continuing care. It also requires APRN's are acting in accordance with the professional's scope of practice and are eligible to serve on the facility's medical staff, credentialed under the same procedures as the facility has established for physicians and authorized APRN's to conduct peer review of their professional colleagues.

There are still difficulties with many facilities failing to comply with this law that took effect July 1, 2020. We may need additional legislation to clarify the intent of the existing law. Other institutions have complied. For example, I currently am working at Sandoval Regional Medical Center where I hold admitting privileges and am considered part of the Medical Staff. The archaic culture remaining in existence in many facilities and must be transformed so the improved access to quality of care that has been afforded to the citizens of our state through rendered APRN independent practice can be further enhanced through allowing APRN's to admit, follow and discharge their own patients throughout the continuum of healthcare. Cystic fibrosis example.

The last item I would like to share with you all surrounds another multistate Compact. If you recall, there was bipartisan, bicameral action to expedite passing the Registered nurse multi-state compact to avert a healthcare crisis in our state. The bill was passed in 24 hours. Many legislators had the same concerns the nursing community had with the Compact. Attempts to right those concerns in legislation introduced in 2019 were not passed secondary to threats by the National Council of the State Boards of Nursing, a for profit entity administering the COMPACT. During the time some of the nursing community had concerns regarding the RN licensure compact and prior to its passage, the previous Executive Director of the Board of Nursing attempted to push an agenda on passing the APRN Compact. The APRN nursing community stands against the enactment of the APRN Compact. Last month, the NCSBON met and changed some items related to the Compact. This includes naming the number of hours an APRN must practice before eligibility with independent practice occurs. This type of language does not belong in a statute and would have implications for Colleges of nursing and practice restrictions for our APRN's of this state. It would be a step backwards. Our state could end up losing the momentum we have gained.

Additionally, and without rationale, the National Council decreased the number of states needed to enter the Compact to make it official from 10 to 7. Discussion did not complete before a roll was called. There are numerous issues with this compact. Included is the concept of APRN's being able to come to this state and set up their own practice without the BON ever knowing they were here. How will DEA and PMP participation be enforced if the BON does not even know the practitioner is here? It proves a safety issue for the public.

We propose, in the setting of the public health emergency, or the declaration of a state of emergency, the NPA has verbiage added allowing other nurse practitioners to come from states with independent practice and prescriptive authority under emergency licensure. The Board of Medicine has this provision. The statute addition should require the emergency licensure to be administered by the BON or through the Department of Health and the Department of Homeland Security. This would allow knowledge of the provider's presence within our state and maintain public safety for our citizens. There is also the issue of how much revenue the NMBON will lose and instill upon APRN's with licensing fees to make up the difference. There are also unknown fiscal implications related to disciplinary hearings and the Commissions Assessment fees related to 'operations' completed retrospectively.

There are also concerns regarding the use of proprietary data with identifying information that the Commission comes to 'Own." What they are requiring may be unlawful to distribute by our own state laws. What will they do with this information? How will the state learn of the information when considering an APRN for licensure?

Finally, not all states enrolled in the compact necessarily may have prescriptive authority. Creating a safety issue and a potential healthcare disparity amongst those receiving care from these providers. Doing an emergency provision we can as our state, make it easier for APRN's to come from other states, we can have reciprocity averting the month's waits for attaining a license to practice here.

Another fear of the Compacts implications resulting in steps backward for APRN practice surrounds the idea of "The Commission by rule shall identify the APRN roles and population foci for licensure." Why should the Commission determine or have the authority with regard to the population foci? This is specific to our education, training, and certifying body. Psychiatric nurse specialists.

The following is a synapsis of the current endorsement within New Mexico for provision:

The Department of Health and the Department of Homeland Security and Emergency Management shall credential out-of-state professionals who can render aid and necessary services during the pendency of this order. NMSA 1978 §§ 12-10-10.1 through 12-10-13. • NM Stat § 12-10-11: During an emergency, a person who holds a license, certificate or other permit that is issued by a state or territory of the United States and that evidences the meeting of qualifications for professional, mechanical or other skills may be credentialed, if appropriate and approved by the department of health or the homeland security and emergency management department, to render aid involving those skills to meet an emergency, subject to limitations and conditions as the governor may prescribe by executive order or otherwise. Status – Active until gubernatorial rescission, currently scheduled for September 18, 2020 per Public Health Order from 8/28/2020

In conclusion, the APRN community does not want to see this legislation moved forward if re-introduced. It is premature and wrought with uncertainty. Consider if the Board of Medicine decided to

allow any doctor to practice in NM; to open a practice without the knowledge or consent of the BOM. The Board would not know they were here. The same visions of potential harm to the public exist if this were to be allowed through the Board of Nursing.

Both the NMNA and NMNPC strongly feel reciprocity is a realistic way to expedite licensure to those in good standing AND meeting ALL the requirements of licensure in New Mexico, our state. The appropriate licensing entity would be aware of the provider practicing in our state delivering care to our citizens. This allows the ability to ensure providers are following the NPA and affiliated rules and regulations and that they meet the minimum license requirements to independently practice in this state. The public wins.

We are constantly finding things within NM laws, statutes, and rules and regulations state 'physicians' instead of 'licensed independent providers.'

For example, an NP had a police officer who shot a perpetrator had a blood transference. She asked OMI regarding the HIV status of the deceased. OMI stated by a physician only. This is one example of how language can impede care. We will continue to present these as they are found here to our legislators.

I sit before you now for questions and commentary.

The following offers bullet points of the other issues the nursing community and its partners find with this compact for your future reading:

- When you have a compact, you don't know who is coming into the state and practicing within it. This is a public safety concern.
- The definition of APRN lacks definition of specific types of APRN's.
- Uniform license requirements, education, and examination requirements can put states in contradiction with the Compact because of existing statutes.
- Rules will be established and unknown until 7 states join this compact.
- Provisions and Jurisdiction require that "By rule, the commission shall adopt the APRN Uniform Licensure requirements." Rules do not exist in a united way. What if the home state qualifications for licensure and the party state qualifications are different?
- "The Commission by rule shall identify the APRN roles and population foci for licensure." Why should the Commission determine or have the authority with regard to the population foci?
- {Prescriptive authority is fraught with politics. While some states have prescriptive authority, this legislation does not grant it to those state who do not. How will DEA and PMP participation be enforced?

- There are differing continuing education needs from state to state. The practicing APRN would be mandated to meet these requirements, but how would APRN's file with a state that does not know the APRN is there?
- As some states do not allow for licensure in advance, this compact may cause an application for single state license and then a multistate license causing more bureaucracy, not less.
- The cost to the Board is unknown. A BON issuing subpoenas must pay various fees, witness expenses, and travel expenses. IF a state chooses an alternate program that is non-disciplinary, the home state must deactivate multistate licensure privilege. Not consistent with the definition of a non-disciplinary action. A remote state has authority to cease and desist order or limit the practice of an AORN from another state. Only the home state can remove the APRN licenses. Subpoenas from other states shall be enforces in the other states court. This would result in further unknown costs.
- Coordinated licensure information system and exchange of information. Who will pay for this? The Compact requires every BON submit identifying information for any information requested by the Compact. There are no restrictions. The Compact owns the data. What is the system going to do with the information? Even if NM law prohibits release of information, the board must submit information to the data base. The fiscal implication is potentially huge.
- Establishment of the Interstate Commission of APRN compact administrators. All lawsuits against the commission must be in the jurisdiction of the principal office. The Commission has sovereign immunity. NM will have one member on the Commission. The Commission will write their own by laws and all the rules; they may carry on closed meetings.
- The commission will have total power to write any rules within the scope of the legal authorization and have the force of law in all party states. They have total power to set the budgets, borrow money, lease, etc. The Commission may then levy and collect an annual assessment from each party state to cover the cost of 'operations.' The fiscal impact on New Mexico and subsequently to APRN's is unknown.
- Rulemaking: "Rulemaking shall be done by the Commission members." AT least 60 days in advance, states would publish the proposed rules on websites. A public hearing will be held. Few, if any, comments from NM would be able to be given in person. IT is concerning that NM would enter the Compact without the extent of the rules and have only one vote on the Commission
- The Compact is also adding a number of "hours" to the requirements for the APRN to receive multistate licensure. This also poses problems to reduce the autonomy APRN;'s in this state have achieved. Additionally, Colleges of nursing will also be impacted. This can potentially create an even slower entry into practice in our state which is already short of health care providers.
- Oversight, Dispute Resolution and Enforcement: The state must follow all Compact laws and ru.es. The Commission could come after the state for funds and obligates incurred for not following the rules or paying assessments. Any lawsuit would occur in District of Columbia or wherever the Commission locates its office. Additional unknown costs.
- Effective Date, Withdrawal and Amendment: The Compact goes into effect after 7 states enter. TO get out of the Compact, it must repeal the statute, but actual legal withdrawal does not occur until 6 months after the repeal. New Mexico would have to continue to comply with the Compact for 6 months. Any changes must by passes by the legislatures of all the party states. IF

any part of the compact is considered unconstitutional, the rest of the Compact remains intact in that state. WE attempted to do this with the RN Compact and we were faced with a threat of lawsuit by the NCSBON.

- There are 43 pages of interstate or intertribal compacts. The RN compact is the only one addressing health care providers. The last thing we want is for Federal government to control our scope of practice. We do not know the cost. The concepts above can be reevaluated after the Compact has been enforced in the 7 states to join. The rules can be analyzed and there will be less unknowns.