Report to the General Assembly

An Act Expanding Economic Opportunity in Occupations Licensed by The Department of Public Health and Consumer Protection and Requiring a Report from Certain Executive Branch Agencies Regarding Background Checks and the Feasibility of Establishing Preclearance Assessments of Criminal History

Manisha Juthani, Commissioner

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State of Connecticut
Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

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Connecticut Work Group on Interstate Compacts Members 2021-2022

Chris Andresen Section Chief, Practioner Licensing & Investigations Department of Public Health	**Jonny Dach** Policy Advisor and Deputy Chief of Staff Office of the Governor
Meari Avery Advocate and APRN AARP	**Maureen Sullivan Dinnan** Board Delegate and former Executive Director HAVEN
Claire Botnick Covid Recovery Advisor Office of the Governor	**Michael Dugan** **Founder & President** Capitol Consulting
Pat Bouffard RN Member, Chair Board of Examiners of Nursing	**Layne Gaykos** **Executive Director** **Connecticut State Medical Society**
John Brady Executive Vice President American Federation of Teachers	**Claudio Gaultieri** Undersecretary of Health and Human Services Office of Policy and Management
Karen Buckley Vice President, Advocacy Connecticut Hospital Association	**Mike Johnson** Member Connecticut State Medical Society
Barbara Bunk Clinical Psychologist Connecticut Psychology Association	**Marilyn Katz** Member Connecticut State Medical Examining Board
T.J Cantwell Compact Administrator Physical Therapy Compact Commission	**Jill Kennedy** Health Program Associate Healthcare Quality and Safety Branch Department of Public Health
Stephen Carragher Public Health Services Manager Department of Public Health	**Mariella LaRosa** Chief Executive Officer HAVEN
Liz Connelly Lobbyist Capitol Consulting	**Jim Leahy** Lobbyist Liberty Square Group
Brian Cournoyer Director, Government Relations Connecticut Hospital Association	**Nicole Livanos** Associate Director, Legislative Affairs NCSBN

Andy Marcoccia Licensed Clinical Psychologist	**Stephen Magro** Organizer SEIU 1199
Geraldine Marrocco Member Board of Examiners of Nursing	**Jean Rexford** Member CT Medical Examining Board
Stephanie McGuire Chair, Government Relations Committee CT Nurses Association	**Melissa Riley** Director, Office of Government Affairs Hartford HealthCare
Howard Oakes Chair CT Psychology board	**Marcy Russo** Member CT Psychology Association
Janet Orwig Executive Director PSYPACT	**Kim Sandor** Executive Director CT Nurses Association
Michael Parisi Chair Physical Therapy Board	**Anita Schepker** Lobbyist Capitol Consulting
Marcia Proto Executive Director CT League of Nursing	**Vic Vaughn** Member Physical Therapy Association
Jim Puente Director Nurse Licensure Compact	**Vicki Veltri** Executive Director Office of Health Strategy

I. Executive Summary

In accordance with Public Act 21-152 (Appendix A), the Connecticut Department of Health ("DPH") presents analyses and recommendations regarding the entry into Interstate Compacts for certain professions requiring occupational licenses. Today, 25 percent of jobs are in licensed occupations, up from less than 5 percent in 1950.[1] Occupational licensing serves an important role in protecting the health and safety of the people of Connecticut. However, as society becomes increasingly mobile, state-by-state occupational licensing can be burdensome for people who are licensed in their home state, but wish to practice across state lines, move often, or practice telehealth.[2]

Interstate occupational licensing compacts ("Interstate Compacts") offer flexibility and portability for occupational license holders and expand access to care for patients and consumers. In the last several years, most other states have joined Interstate Compacts that allow professions such as physicians, nurses, psychologists, EMTs, physical therapists, and others to work across state lines, provide telehealth, supply aid in emergency situations, and apply more easily for a license in another state or territory.[3] Connecticut is one of only six states that is not party to any Interstate Compacts, placing it out of step with many other states in the Northeast and limiting our ability to attract talent.

The COVID-19 pandemic has illustrated the benefits Interstate Compacts may offer. Executive Orders and Commissioner's Orders allowing healthcare providers licensed in other states to practice in Connecticut during the public health emergency have operated in important respects as a trial period for Interstate Compact membership. Those Orders expanded access to care and relieved the burden on our workers without compromising quality of care. As the country continues to grapple with the COVID-19 pandemic, the mobility of the healthcare workforce is important to the ongoing response. The COVID-19 pandemic has also revealed the limitations of emergency declarations at the federal, state, and local level, which can take time to enact, create a confusing patchwork of orders and directives, become politicized, and may not cover all prospective needs. The ability to mobilize immediately across state lines as we tackle surges of the virus will benefit providers and patients alike and will make Connecticut's healthcare system stronger and more resilient during this challenging time. Even after the pandemic subsides, the rise of remote work will make it increasingly important for Connecticut residents traveling outside the state to be able to access continuous care, especially mental health care, from their Connecticut-based providers.

This report examines whether joining Interstate Compacts will strengthen our healthcare system for patients, providers, and the people of Connecticut. In undertaking this work, DPH

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[1]See Introduction, Occupational Licensure: Interstate Compacts In Action, *available at* https://compacts.csg.org/wp-content/uploads/2020/11/OL_Compacts_InAction_Update_APR_2020-3.pdf citing, U.S. Bureau of Labor Statistics. (2018). For additional data on certificates and licensing, *available a*t http://www.bls.gov/cps/certifications-and-licenses.htm#highlights.

[2] See Policy Perspectives: Options to Enhance Occupational License Portability, *available at* https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper_0.pdf at 1.

[3] See National Center for Interstate Compacts: The Council of State Governments, *available at* http://licensing.csg.org/compacts/

formed working groups (the "Work Groups" or "Work Group") dedicated to five professions considering entering an Interstate Compact and engaged a diverse group of stakeholders in discussions of the benefits and drawbacks of joining Interstate Compacts. Each Work Group met several times, heard presentations from the Interstate Compact commissions, and engaged in discussion and debate of the pros and cons of entry (Appendix B). To assist the Legislature in its consideration of whether to join any Interstate Compacts the Work Groups considered the impact that joining an Interstate Compact would have on the following:

1. Patient Access to Quality of Care and Family Caregiving
2. Economic and Workforce Considerations
3. Fiscal Impact on State
4. Impact on Cost of Care
5. Impact on Clinicians
6. Integrity of Connecticut's Alternative to Discipline Programs

Each of the Work Groups considered the perspectives of members of the profession, patients and clients, labor, professional associations, and hospital systems. A description of each Work Group's process, a summary of the pros and cons identified, and recommendations are described in this report.

Based on the Work Groups' considerations, DPH recommends Connecticut join the physician and psychologist compacts in 2022. While there are compelling reasons to also join the nursing, APRN, and physical therapy compacts, these three require further investigation and discussion.

II. Background

Public Act 21-152, An Act Expanding Economic Opportunity in Occupations Licensed by The Department of Public Health and Consumer Protection and Requiring a Report from Certain Executive Branch Agencies Regarding Background Checks and the Feasibility of Establishing Preclearance Assessments of Criminal History, required that the Commissioner of DPH convene work groups to determine whether Connecticut should join any Interstate Compacts. Such Work Groups were required to consist of:

1. The Commissioner of DPH, the Secretary of the Office of Policy and Management, and the executive director of the Office of Health Strategy, or their designees;

2. The chair of the appropriate board of examiners or advisory board, or his or her designee;

3. A representative of the appropriate state professional association;

4. A representative of the professional assistance program for regulated professions established pursuant to section 19a-12a of the general statutes;

5. Any other members the Commissioner of DPH deemed appropriate.

6. Each Work Group was required to convene not later than sixty days after the effective date of this section.

7. Not later than January 15, 2022, the Commissioner of Public Health was required to submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Such report shall include recommendations that reflect the determinations of the Work Group. The Work Group shall terminate upon the submission of the report.

In light of the ongoing COVID-19 pandemic, the needs of practitioners, patients, and clients, and in the interest of public health, the DPH Commissioner determined that the Work Group should evaluate entry into Interstate Compacts for the following professions: (1) psychologists; (2) physicians; (3) nurses; (4) advanced practice registered nurses ("APRNs"); and (5) physical therapists.

B. What Is An Interstate Compact?

An interstate compact is a "legal, legislatively enacted contract between two or more states that allows states to cooperatively address shared problems, maintain sovereignty over state issues, and respond to national priorities with one voice."[4] The Contracts Clause of the

[4] See National Center for Interstate Compacts: The Council of State Governments, *available at* https://compacts.csg.org/compacts/

Constitution[5] grants states the authority to enter into contracts for a mutual purpose.[6] Compacts are "subject to the principles of contract law . . . have the force and effect of statutory law, and take precedence over conflicting state laws regardless of when those laws are enacted."[7] Interstate compacts have been used since the earliest days of American history to "address matters requiring a long-term, stable solution such as boundary disputes, water rights, and regional transportation systems spanning multiple states."[8] Today, there are more than 200 interstate compacts in effect.[9] Connecticut participates in dozens of interstate compacts that address a wide array of issues from drivers licenses to fighting forest fires. These compacts help states to act when cooperation among states is required.

C. Occupational Licensing Interstate Compacts

Interstate compacts addressing occupational licensing is a more recent development. Interstate Compacts facilitate multistate practice by allowing people to work across state lines in other member states. Interstate Compacts aim to reduce waiting time for licensure approval by other state boards, reduce costly fees paid to other states, and streamline the license application process.[10] Advocates of these compacts maintain that they help to improve health and safety, mobility, regulatory certainty, support telework, and ease the burden on military families.[11] Interstate Compacts may also improve the ability of states to respond to emergency situations such as disasters, disease outbreaks, or acute shortage of practitioners in specific areas.[12] Interstate Compacts may aid states in securing agreement on uniform licensure requirements, creating shared data systems, and enhancing cooperation among state boards.[13]

D. Interstate Compacts: A Nationwide Trend Towards Adoption

In response to an increasingly mobile workforce, the proliferation of telehealth, and an effort to reduce red tape for workers, Interstate Compacts have become increasingly common. Nine professions have Interstate Compacts for occupational licensing, six of which are health professions.[14] The first occupational licensing Interstate Compact, the Nurse Licensure Compact

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[5] "No state shall, without the Consent of Congress . . . enter into any Agreement or Compact with another State, or with a foreign Power[.]" U.S. Constitution, art. I, § 10, cl. 3.
[6] See Multistate Problem Solving with Interstate Compacts, The Council of State Governments, *available at* https://compacts.csg.org/wp-content/uploads/2020/11/Compact-Resource-Guide-1-1.pdf
[7] *Id.*
[8] See Policy Perspectives: Options to Enhance Occupational License Portability, *available at* https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper_0.pdf
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] See Request for Applications to Develop New Interstate Compacts for Occupational Licensure, The National Center for Interstate Compacts, The Council of State Governments, *available at* https://compacts.csg.org/wp-content/uploads/2021/10/Application-for-Interstate-Compact-Development.pdf

("NLC") was implemented in 2000.[15] Today, 44 states have adopted at least one Interstate Compact. In 28 states at least three Interstate Compacts have been adopted. Across the country 182 pieces of compact legislation have been enacted since 2016.[16] In 2021, Ohio entered five Interstate Compacts in a single year when Governor Mike DeWine signed legislation entering the physician, nursing, audiology and speech-language pathology, occupational therapy, and physical therapy Interstate Compacts.[17] Connecticut is one of the few states remaining that has yet to join any Interstate Compacts addressing occupational licensing.

E. Interstate Compacts: Not One Size Fits All

Interstate Compacts typically have two models, the "mutual recognition" model and the "expedited licensure model."[18] The mutual recognition model, which is similar to a driver's license, provides the licensee a privilege to practice in other states that are members of the Interstate Compact. The "expedited licensure model," which is similar to colleges' Common Application or TSA pre-check, provides a procedure for acquiring a license on an expedited basis in states that are also members of the Interstate Compact.[19] Despite those two primary models, each Interstate Compact has its own unique features.

1. Mutual Recognition Model

Applicants who meet certain criteria apply for a single state license and, if approved, are granted a privilege to practice in other states that are members of the Interstate Compact.[20] Typically, this helps applicants avoid additional fees, paperwork, and lengthy waiting time.[21] If a license holder moves to a new state, however, they must apply for a new home state license.[22] They cannot rely on the Interstate Compact license if they permanently relocate.

2. Expedited Licensure Model

The expedited licensure model facilitates multistate practice by expediting the application process in each state in which they intend to practice.[23] The state board from the home state of licensing (home state of residence) determines whether an applicant qualifies for expedited

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[15] NLC: Unlocking Access to Care for 20 Years, *available at* https://www.ncsbn.org/20-NLCAnnualReport.pdf
[16] See Request for Applications to Develop New Interstate Compacts for Occupational Licensure, The National Center for Interstate Compacts, The Council of State Governments, *available at* https://compacts.csg.org/wp-content/uploads/2021/10/Application-for-Interstate-Compact-Development.pdf
[17] Ohio to Expand Interstate Health-Care Access through Nurse Compact, Cleveland Scene, *available at* https://www.clevescene.com/scene-and-heard/archives/2021/08/12/oh-to-expand-interstate-health-care-access-through-nurse-compact
[18] Occupational Licensure: Interstate Compacts in Action: The Council on State Governments, *available at* https://compacts.csg.org/wp-content/uploads/2020/11/OL_Compacts_InAction_Update_APR_2020-3.pdf
[19] *Id.*
[20] Policy Perspectives: Options to Enhance Occupational License Portability, Federal Trade Commission (Sept. 2018), *available at* https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper_0.pdf at 16-17.
[21] *Id.* at 17.
[22] *Id.* at 18.
[23] *Id.* at 19.

treatment.[24] If the state board determines that they are qualified, then the applicant will receive expedited treatment in other states that are members of the Interstate Compact.[25]

F. Occupational Licensing Compacts

Today, there are nine occupational licensing Interstate Compacts. In addition, Interstate Compacts are currently under development for social work, cosmetology and barbering, dentistry and dental hygiene, massage therapy, and K-12 teaching.[26]

1. Psychology Interjurisdictional Compact ("PSYPACT")[27]

The PSYPACT Commission was established in 2019 and has been enacted by 27 states to date.

2. Interstate Medical Licensure Compact ("IMLC")[28]

The IMLC began in 2017. To date, 34 states, the District of Columbia, and the Territory of Guam, have entered the IMLC. During the writing of this report Governor Phil Murphy of New Jersey signed the IMLC into law making New Jersey the 34th state to join the IMLC.

3. Nurse Licensure Compact ("NLC")[29]

The NLC, which was the first Interstate Compact for occupational licensure, was initially implemented in 1999 and was substantially revised in 2015. The NLC has been adopted by 39 states and territories.

4. Advanced Practice Registered Nurse Compact ("APRN Compact")[30]

The APRN Compact was established in 2020. Two states have enacted the APRN Compact but it has not yet taken effect.

5. The Physical Therapy Licensure Compact ("PTLC or Physical Therapy Interstate Compact")[31]

The Physical Therapy Interstate Compact went into effect in April 2017 and has been enacted by 34 states.

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[24] *Id.*
[25] *Id.*
[26] New Compacts Announced, Council on State Governments (March 15, 2021), *available at* https://compacts.csg.org/march-15-2021-new-compacts-announced/
[27] See generally https://psypact.site-ym.com/?
[28] See generally https://www.imlcc.org/
[29] See generally https://www.ncsbn.org/nurse-licensure-compact.htm
[30] See generally https://www.ncsbn.org/aprn-compact.htm
[31] See generally https://ptcompact.org/

6. Audiology and Speech Language Pathology Compact ("ASLP-IC")

As of October 2021, ASLP-IC was enacted in 15 states passing the threshold for activation. The ASLP-IC Commission is scheduled to convene in January 2022 to establish rules and bylaws. The Commission is expected to begin issuing privileges to practice in member states by late 2022 or early 2023.[32]

7. Emergency Medical Services Compact[33]

The EMS compact was enacted in May 2017 and has been adopted by 21 states.

8. Occupational Therapy Compact[34]

The Occupational Therapy Compact has not yet taken effect.

9. Counseling Compact[35]

The Counseling Compact has been adopted by two states and has not yet taken effect.

G. Modifying Interstate Compacts

As discussed above, Interstate Compacts are contracts between states. Every state must adopt model language for the Interstate Compact to be enforceable. Most Interstate Compacts have commissions that have the power to make new rules; however, the process can be burdensome because all member states must agree to any change and in some instances legislative action is required for the change to be implemented.[36] When considering whether to join an Interstate Compact, states should be aware that it can be difficult to make changes to the terms.

H. Military Support for Compacts

The Department of Defense ("DoD") has been active in its support of Interstate Compact legislation across the United States to ease the burden on military spouses who are frequently required to move across state lines. One third of military spouses are in professions that require an occupational license.[37] The process for reapplying for licensure with every move can be costly

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[32] See generally https://aslpcompact.com/
[33] See generally https://www.emscompact.gov/
[34] See generally https://www.aota.org/Advocacy-Policy/State-Policy/Licensure/Interstate-Professional-Licensing-Compact.aspx
[35] See generally https://counselingcompact.org/.
[36] Policy Perspectives: Options to Enhance Occupational License Portability, Federal Trade Commission (Sept. 2018), *available at* https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper_0.pdf at 15.
[37] "About 35 percent of military spouses in the labor force work in professions that require State licenses or certification, and they are ten times more likely to have moved across State lines in the last year than their civilian counterparts. Occupational Licensing: A Framework for Policymakers, The White House (July 2015), *available at* https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf

and burdensome and may contribute to higher rates of unemployment among military spouses and pose challenges to the long-term retention of service members.[38] Christopher Arnold, the northeast regional liaison at the United States Department of Defense-State Liaison Office, testified in support of Interstate Compacts last year.[39] In his testimony Mr. Arnold described occupational licensing as an "enduring problem" for military spouses given the short duration of many military assignments and the time, expense, and effort that goes into the licensing process.[40] The DoD has stated that going forward license reciprocity will be considered when evaluating locations for future military bases or where to expand existing bases.[41]

I. Potential Fiscal Impact on Connecticut

Participation in Interstate Compacts will negatively impact revenues from traditional sources while providing potential new sources of revenues. Certain costs of participation will also be incurred by the state. These revenue and cost impacts are discussed below and in the sections that follow.

For those Interstate Compacts currently under consideration that consist of a mutual recognition model, a loss in licensure fee revenue will result. This is because out-of-state applicants for DPH licensure or recognition of the privilege to practice, who hold a license in their own home state would no longer have to pay a licensure fee to Connecticut. Based on SFY 2020 fees collected by DPH from applicants who reported holding a license in a state that was a member of an Interstate Compact as well as current Connecticut licensees who live in states that are members of Interstate Compacts and hold out-of-state licenses, an estimated annualized revenue loss of approximately $5.64 million would result. HAVEN (described in further detail below) would experience a corresponding revenue loss estimated at $0.18 million as $5 from each license renewal fee is utilized to support its operations.

Details are presented in the following table.

Profession	Initial Applications	Initial Application Revenue	License Renewals	License Renewal Revenue	Total State Revenue	HAVEN Revenue
Registered Nurse	(8,196)	($1,475,280)	(34,942)	($3,668,910)	($5,164,190)	($174,710)
Licensed Practical Nurse	(147)	($22,050)	(474)	($30,810)	($52,860)	($2,370)
Psychologist	(125)	($70,625)	(497)	($278,320)	($348,945)	($2,485)
Physical Therapist	(147)	($41,895)	(480)	($48,000)	($89,895)	($2,400)

[38]Remarks of Christopher R. Arnold, Department of Defense (March 3, 2021), *available at* https://www.cga.ct.gov/2021/PHdata/Tmy/2021HB-06449-R000303-Arnold,%20Christopher,%20Northeast%20Region%20Liaison-Defense-State%20Liaison%20Office-TMY.PDF
[39] *Id.*
[40] *Id.*
[41] *Id.*

APRNs[42]	N/A	N/A	N/A	N/A	N/A	N/A
Totals		($1,609,850)	(36,393)	($4,026,040)	($5,635,890)	($181,965)

Revenue losses could be offset by new sources of revenue particular to specific compacts. For example, under the Interstate Compact for physicians, which requires participants to continue to pay fees to each state in which licensure is sought, Connecticut would experience an estimated revenue increase of approximately $0.5 million from collecting a share of a per physician Compact fee and due to expected growth in the number of licensees (see the section discussing the physician Interstate Compact for additional information).

In no case would joining an Interstate Compact increase the licensing fee for professionals who continue to practice under their traditional Connecticut license.

J. Interstate Compacts and Responding to the COVID-19 Pandemic

Advocates of Interstate Compacts maintain that they facilitate emergency preparedness and disaster relief without requiring government action to address emergency licensure and supervision. According to National Council of State Boards of Nursing, the Interstate Compact for nursing was a critical tool during the COVID-19 pandemic.[43] In response to the COVID-19 pandemic state licensing boards were put under tremendous stress while trying to respond to the rapidly changing emergency. As the virus surged, states needed to rapidly increase the number of healthcare professionals to meet the needs of the healthcare system. Further, states were grappling with complex questions as to how to grant short-term licenses on an expedited basis, maintain high standards of professional practice, and provide oversight as practitioners traveled to meet acute needs across the country. In Connecticut, as in many other states, this was accomplished through a series of emergency orders issued by the Governor and the DPH Commissioner. Those emergency orders, which in some cases lapsed and had to be re-issued for the recent wave, allowed practitioners licensed, certified, or registered in another state to practice in Connecticut. Executive Orders and Public Acts 20-2 and 21-9 also made it easier for people licensed in other states to provide telehealth services to Connecticut patients. Interstate Compacts provide a solution to the problem of complicated emergency orders and expiration dates and allows practitioners to come to Connecticut or for Connecticut's practitioners to practice elsewhere to meet demand during the pandemic and other emergencies.

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[42] APRN Compact is not yet enacted so costs have yet to be determined.

[43] New Jersey, which recently enacted the Compact, accelerated partial implementation in March 2020 to allow nurses with Compact licenses to practice in the state in response to the first wave of the COVID-19 pandemic. *See* Acting AG Announces Full Implementation of Nurse Licensure Compact Allowing Qualifying NJ Nurses to Obtain a Multistate License to Practice in Participating States (Nov. 16, 202), *available at* https://www.njoag.gov/acting-ag-bruck-announces-full-implementation-of-nurse-licensure-compact-allowing-qualifying-nj-nurses-to-obtain-a-multistate-license-to-practice-in-participating-states/. In Pennsylvania, the Pennsylvania Nurses Association reversed its previous opposition to the NLC, citing the fact that COVID-19 "exacerbated" the need to reduce the regulatory burden on nurses. *See* PSNA Responds to Nurse Licensure Compact, Pennsylvania State Nurses Association (July 16, 2020), *available at* https://www.psna.org/psna-responds-to-nurse-licensure-compact/

K. Connecticut's Alternative to Discipline Program

Connecticut is unique in that its alternative to discipline program, the Health Assistance Intervention Education Network ("HAVEN"), is authorized by state law to serve virtually all healthcare professionals licensed or eligible for license in the State of Connecticut. HAVEN is an independent non-profit corporation founded by the Connecticut State Medical Society, Connecticut Nurses Association, Connecticut State Dental Association, Connecticut Veterinary Medicine Association, and Connecticut Academy of Physician Assistants that provides confidential consultation and support to healthcare professionals facing health concerns related to alcoholism, substance abuse, behavioral or mental health issues, and/or physical illness. HAVEN offers a confidential alternative to public disciplinary action for professionals suffering from chemical dependency, emotional or behavioral disorder, or physical or mental illness.[44]

In 2007, Connecticut General Statute Section 19a-12a was passed enabling the establishment of HAVEN. The purpose of this statute was to eliminate the fear and stigma of licensure discipline and, thereby, reduce barriers to care for professionals. Healthcare professionals face physical and mental illnesses at the same rate or higher than the general population; however, healthcare professionals are less likely to seek care and treatment due to fear of licensure discipline and stigma.[45] By encouraging a healthy workforce, the public policy also promotes improving the quality of care across Connecticut. Historically, professionals were not seeking help because they were afraid that it would impact their license and were going "underground" to seek treatment, placing both the professional and patients at risk.

Connecticut General Statute Section 19a-12a(b) states in relevant part:

> The program shall (a) be an alternative, voluntary and confidential opportunity for the rehabilitation of health care professionals, and (b) include mandatory, periodic evaluation of each participant's ability to practice with skill and safety and without posing a threat to the health and safety of any person or patient in the health care setting.

The Connecticut General Statutes define when a professional who is referred to HAVEN must be disclosed to the DPH: (1) felony charges are pending or there is a history of felony conviction; (2) history of licensure discipline; (3) patient harm; or (4) non-compliance with the terms and conditions for participation in HAVEN.[46] Under such circumstances, DPH determines eligibility for participation.

Professionals who participate in HAVEN are assured that if they comply with the conditions of the program, the participant will not suffer licensure discipline, lose privileges to practice, or be disclosed to any regulating body. Unlike many other states that have separate programs for different professional disciplines run by or under contract with a state board or commission, Connecticut has a single assistance program that is separate and distinct from DPH,

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[44] Conn. Gen. Stat. Sec. 19a-12a(a)(5) and Conn. Gen. Stat. Sec. 19a-12a(b)

[45] See, Smiley, et.al., Outcome of Substance Use Disorder Monitoring Programs for Nurses, Journal of Nursing Regulation, Vol III/Issue 2 (July 2020) at 28; see also, American Society of Addiction Medicine, Physician Health Programs and Addiction Among Physicians, Chapter 49 (2014).

[46] Conn. Gen. Stat. Sec. 19a-12a(d-f)

the boards, or commissions. Creating a single assistance program enhanced the likelihood that all professionals licensed and practicing in Connecticut have access to the same assistance and are handled with the same protocols, dignity, and respect regardless of profession. While many other states limit the scope of their programs to substance use disorders, the Connecticut General Assembly approved the program "to provide education, prevention, intervention, referral assistance, rehabilitation or support services to health care professionals who have a chemical dependency, emotional or behavioral disorder or physical or mental illness."[47]

Creating a program separate and distinct from DPH was considered essential for professionals to be willing to refer colleagues to the program and for professionals to accept assistance. To obtain meaningful help, a professional must feel safe to make full disclosures of personal and sensitive information. The statute expressly states that the program shall be "an alternative, voluntary and confidential opportunity for the rehabilitation of health care professionals."[48] The statute further set forth protections for "all information given or received in connection with any intervention, rehabilitation, referral assistance or support services provided by the assistance program and for the proceedings of a medical review committee.[49]

Advocates for HAVEN are concerned that entering certain Interstate Compacts may have the unintended impact of eroding participant confidentiality, a cornerstone of the program, because some of the Interstate Compacts require disclosure of participation in an alternative to discipline program to the Interstate Compact commissions. Further, some Interstate Compacts treat participation in an alternative to discipline program as an encumbrance on the license. As a result, participation in HAVEN's program may be perceived punitively and disqualify a professional from participating in the Interstate Compact, which could have the effect of stigmatizing seeking support for treatment. This issue is discussed in greater depth in the subsections below addressing each Interstate Compact.

L. Labor Unions Perspective on Interstate Compacts

Each Work Group included representatives from the American Federation of Teachers ("AFT"), the second largest union of Registered Nurses in the country, and SEIU 1199. Both represent nurses across the State. Physical therapists, physicians, and psychologists are not typically members of unions. Labor unions are opposed to joining the nurse and APRN Compacts. They cite several reasons for opposing those Interstate Compacts.

1. Impact on Collective Bargaining Power

Labor unions have expressed concern that Interstate Compacts will be used as a tool to undermine collective bargaining and strike power. Interstate Compacts allow employees to move between member states for temporary work, thereby giving employers access to a short-term

[47] Conn. Gen. Stat. Sec. 19a-12a(a)(5)
[48] Conn. Gen. Stat. Sec. 19a-12a(b)
[49] See Conn. Gen. Stat. Sec. 19a-12a(h)(1) and (2). The importance of confidentiality was also addressed for the Oversight Committee which the legislature created to ensure the assistance program was complying with the statutory directives. See Conn. Gen. Stat. Sec. 19a-12b(f).

labor supply to pull from in the event of a strike. Although there are no known examples of this to date, labor unions are concerned that if Interstate Compacts become more widely adopted this issue could arise.

2. Loss of State Sovereignty

Connecticut has autonomy over the regulation of occupational licenses within the State. Joining an Interstate Compact would erode that sovereignty because some control is delegated to the Interstate Compact commission who (in some cases) hold the power to adopt rules and bylaws.

3. Threat to Public Safety

State boards are responsible for protecting the health and safety of Connecticut residents by regulating the practice of nursing, psychology, physical therapy, and medicine. Labor unions have expressed concern that under an Interstate Compact it can become more difficult to track practitioners coming into the state to practice and can hinder the Board's ability to protect the public.

4. Scope of Practice

Licensing by the State of Connecticut ensures that all practitioners are practicing within the Connecticut Scope of Practice. Professionals holding a license under an Interstate Compact may not adhere to the Connecticut Scope of Practice.

5. Discipline

If an out-of-state healthcare practitioner were to violate Connecticut's laws governing practice, the practitioner would be disciplined by their home state. If the home state failed to discipline the professional, that may be able to continue to practice in Connecticut.

6. Loss of State Revenue

If Connecticut joins any Interstate Compacts, practitioners who live out of state but hold Connecticut licenses would no longer be required to obtain a Connecticut license, which would result in a loss of revenue.

7. Impact on Alternative to Discipline Programs

If Connecticut joins an Interstate Compact it may have the effect of undermining the work of Connecticut's alternative to discipline program, HAVEN, which is unique in that it incentivizes Connecticut professionals to seek treatment and support for substance use disorders and mental health treatment and affords a high level of confidentiality, typically without involving the state board.

The AFT and SEIU maintain that there are no major issues or concerns with the current process for obtaining licenses in Connecticut and would like more time to study whether to join any Interstate Compacts.

M. FBI Background Check

The nursing, APRN, physician, psychologist, and physical therapist Interstate Compacts require an FBI background check for participation. The requirement for FBI background checks does not apply retroactively but does apply going forward to new licensees. The psychology Interstate Compact requires that Connecticut implement FBI background checks for psychologists within 10 years.

N. Facilitating Telehealth

The pandemic will have many lasting effects on the healthcare system in the United States, but the rapid adoption and acceptance of telehealth may be one of the most enduring. The expansion of telehealth services has allowed providers to deliver care in innovative ways. During the pandemic many restrictions on practicing via telehealth across state lines were waived by emergency order.[50] In the absence of these emergency orders providers will be limited in their ability to provide telehealth to patients across state lines unless they hold a license to practice in the state where the patient is located. Going forward this will limit providers' ability to provide high-quality, cost-effective care, and meet patient needs. The CSCU student who lands an exciting summer job in Atlanta and wants to maintain weekly appointments with his psychologist, or the Connecticut resident who sees a specialist before work in Manhattan and wants to follow-up with her by phone, should not have their care options unduly constrained by state licensing systems. Interstate Compacts are an effective way to facilitate telehealth by reducing the barriers to practicing, such as cumbersome application and renewal processes and fees.

Whether or not Connecticut joins any Interstate Compacts, telehealth is here to stay. Despite its promises, telehealth is not suitable in every situation. Ensuring telehealth is offered in appropriate contexts and facilitates the provision of high-quality care requires significant oversight by DPH and ongoing action of the Connecticut General Assembly. Telehealth is currently governed by both traditional patient protections and Public Act 21-9, which expires in 2023. Any extension of Public Act 21-9 in the 2023 session will provide a good opportunity to ensure telehealth lives up to its promise.

O. Making Connecticut an Attractive Place to Live and Work

Connecticut is an amazing place to live, work, and raise a family. However, people who are considering moving to Connecticut may choose to move elsewhere if they will be forced to navigate a burdensome licensure application process in other states and maintain those licenses

[50] Gerald E. Harmon, Expansion of Telehealth Services Must Be Sustained, American Medical Association (July 14, 2021), *available at* https://www.ama-assn.org/about/leadership/expansion-telehealth-services-must-be-sustained

over time. The fact that Connecticut has not joined any Interstate Compacts or taken action to address this burden limits Connecticut's ability to compete and grow. Scholars at the Federal Reserve Bank of Minneapolis found licensed workers are up to 36% less likely to move to a new state than comparable unlicensed workers.[51] According to a report by the Obama Administration "licensing constitutes a significant barrier to relocation" and recommended states "form interstate compacts that make it easier for licensed workers to practice and relocate across State lines."[52]

III. Analysis of Each Compact Under Consideration

A. Psychology Compact[53]

The Psychology Interstate Compact ("PSYPACT") was developed to address barriers to temporary practice across state lines and to support the expansion of telepsychology.[54] PSYPACT went into effect on April 23, 2019. Today, there are 27 member states. PSYPACT follows the mutual recognition model, granting a privilege to practice via telehealth and/or permission to practice temporarily in another PSYPACT state. Psychologists who apply to PSYPACT for a temporary privilege are granted permission to conduct temporary in-person, face-to-face practice in remote states. This privilege is limited to 30 days within a calendar year and is primarily used for emergency situations. PSYPACT is governed by a commission made up of a representative from each member state. PSYPACT is a statutory agreement between two or more states. Each state is a signatory to an identical contract to which there can be no substantive modifications.

1. Benefits of PSYPACT

Proponents of PSYPACT identify the following benefits: (1) increases access to care; (2) facilitates continuity of care; (3) improves ease of knowledge of legal requirements; (4) promotes cooperation across PSYPACT states in areas of licensure and regulation; (5) improves consumer protection across state lines by establishing a disciplinary process that gives states enhanced authority; (6) improves the ability to address the mental health care crisis (including COVID-related mental health issues and the opioid epidemic); (7) facilitates telehealth which has proven to be effective and provides several advantages of traditional treatment methods; (8) confers the authority to practice in all PSYPACT states; and (9) eliminates regulatory delay to commence telepsychology and/or temporary practice into another PSYPACT state.

[51] Janna E. Johnson & Morris Kleiner, Is Occupational Licensing a Barrier to Interstate Migration? (Nov. 6, 2017), *available at* https://research.minneapolisfed.org/johnson-kleiner-occupational-licensing-barrier-interstate-migration
[52] https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf
[53] See generally PSYPACT About Us, *available at* https://psypact.site-ym.com/page/About
[54] See PSYPACT Fact Sheet (May 2021), *available at* https://cdn.ymaws.com/psypact.site-ym.com/resource/resmgr/legislative_resources/psypact_fact_sheet_may_2021.pdf

2. Requirements of PSYPACT

To qualify for PSYPACT a psychologist must: (1) hold a graduate degree in psychology from an institution that meets PSPYACT requirements; (2) possess a current, full and unrestricted license to practice psychology in a home state that is part of PSYPACT; (3) have no history of adverse action that violates the rules of the Commission; (4) have no criminal record history reported on an identity history summary that violates the Rules of the Commission; (5) possess an active E. Passport (for telepsychology, requirements described below) or an active Interjurisdictional Practice Certificate ("IPC") (for temporary in-person practice); (6) provide attestations to qualifications and other requirements; (7) and meet other criteria as defined by the Rules of the Commission.

In order qualify for a PSYPACT privilege to practice telepsychology, a psychologist must meet the following criteria: (1) hold a graduate degree in psychology from an APA accredited program; (2) hold a current full and unrestricted license in a compact state; (3) Hold a current active E Passport; (4) meet educational standards; (5) doctoral degree from an APA/CPA or Joint Designated Program; (6) Possess a current, full, and unrestricted license to practice psychology in home state; (7) Home state must be Compact member; (8) passing score on the EPPP; (9) no history of adverse action; (10) provide attestations of intended practice and work experience; (11) provide a release of information to allow for primary source verification; and (12) be held to guidelines for the practice of telepsychology.

In order qualify for a PSYPACT privilege for temporary practice, a psychologist must meet the following criteria: (1) hold a graduate degree in psychology from an APA accredited program; (2) hold a current full and unrestricted license in a compact state; (3) have no history of adverse action; (4) Hold current active IPC; (5) meet educational standards-doctoral degree from APA/CPA or Joint Designated Program; (6) hold a current, full, and unrestricted license to practice psychology in a home state; (7) home state must be member of Compact; (8) have no history of adverse action; (9) provide attestations of intended practice and work experience and provide a release of information to allow for primary source verification; and (10) be held to guidelines for the practice of telepsychology.

A psychologist who does not meet the requirements to practice under the authority of PSYPACT can apply to receive a license directly from the state board.

3. Scope of Practice

Psychologists practicing outside of their home state under PSYPACT must adhere to the scope of practice of the remote state in which the client is located.[55]

[55] Occupational Licensure: Interstate Compacts In Action, *available at* https://compacts.csg.org/wp-content/uploads/2020/11/OL_Compacts_InAction_Update_APR_2020-3.pdf

4. Discipline

Each PSYPACT member state must have a mechanism in place for investigating complaints (typically through the State licensing board) and is required to notify the Commission of any adverse action. Within 10 years the State must be able to administer an FBI background check at the time of initial licensure in the State. If a psychologist is subject to discipline, the psychologist's home state has the power to impose adverse action against the license.[56] If adverse action is taken by the home state, the licensee's privilege to practice in remote states is nullified.[57] Remote states have the authority to take adverse action against a psychologist's temporary authorization to practice and telepsychology privileges within that state.[58] Remote states are to investigate and take appropriate action with respect to any misconduct as it would if such conduct had occurred by a licensee within the home state.[59] All disciplinary orders are to be reported to the Commission. Per PSYPACT, the National Practioner Databank, recorded 341 disciplinary actions taken by all psychology licensing boards combined in the United States.

5. Patient Access to Quality of Care and Family Caregiving

Connecticut, like the rest of the United States, is in the midst of a mental health care crisis. Access to mental health care services is a major challenge for many people in need of mental healthcare treatment. According to the Centers for Disease Control and Prevention approximately 25% of adults in the United States have a mental illness and nearly 50% of adults will develop at least one mental illness in their lifetime.[60]

Joining PSYPACT will expand access to practitioners by reducing barriers to telehealth. Participating in PSYPACT will improve access to care for people living in rural areas of the state where the psychologist shortage is most acute. There is evidence that telehealth has particular benefits for the practice of psychology as it can make mental healthcare available to people who have traditionally been cut off from accessing in-person services because they require specialty care, such as people with physical disabilities, children, people on the autism spectrum, people seeking treatment for substance use disorders, people whose native language is not English, and others. Telehealth psychology has also aided in reducing the stigma of accessing mental health care because it affords greater privacy and convenience.

It can be challenging for a patient to locate a psychologist that meets their needs. Once the psychologist/patient relationship is established, patients often wish to continue that care even when they relocate. Telehealth aids in continuity of care. This was highlighted during the pandemic when colleges closed abruptly, people moved to be closer to family, and people temporarily relocated. Under the current licensing scheme, psychologists were unable to continue delivering mental health treatment unless they held a license in the state where the patient had relocated. PSYPACT allows treatment to continue regardless of whether someone is

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[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] See About Mental Health, The Centers for Disease Control and Prevention, *available at* https://www.cdc.gov/mentalhealth/learn/index.htm

making a temporary or permanent move. For example, when a Connecticut college student returns home to another state for winter break, they could continue with their mental health care without interruption and when they graduate and move to another state for a job they can continue treatment with their Connecticut-based provider.

Granting temporary permission to practice in person in another state will also improve the quality of care because it will allow for practitioners to operate outside of the state in an emergency. Further, it will allow out of state practitioners to come to Connecticut's aid in times of crisis.

6. Economic and Workforce Considerations

The facilitation of telehealth will expand access to care and, in turn, will lift current restrictions on practice that are limiting psychologists in the state from expanding their practice.

7. Fiscal Impact on State

Upon joining PSYPACT, states are charged an assessment of $10 per PSYPACT license, per fiscal year. The assessment is capped at $6,000 annually. Licensure revenues are estimated to fall by approximately $0.35 million. This number assumes all out-of-state license holders switch to PSYPACT, so it is likely an overestimate. However, the state may charge a compact privilege fee to psychologists who chose to practice in other states through PSYPACT, which could mitigate the licensure fee revenue loss.

8. Impact on Cost of Care

The expansion of telehealth is likely to reduce the cost of care over time.

9. Clinician Impact

Clinicians will benefit from the joining PSYPACT because it will allow them to continue to treat patients if they move or temporarily relocate. Joining PSYPACT will reduce time spent applying and maintaining licenses across the country, cut down on time waiting for license applications to be approved, and reduce unnecessary paperwork and costly application fees. Joining PSYPACT also lends greater certainty to practitioners because they will know the legal requirements, scope of practice, and temporary practice limits that they must comply with.

10. Integrity of the Alternative Programs[61]

HAVEN has submitted the following comments regarding the impact that entering PSYPACT will have on its program. HAVEN supports recommending that Connecticut enter PSYPACT with reservations, described below.

[61] HAVEN has authored the sections addressing integrity of alternative programs for each profession. HAVEN also plans to submit a letter detailing their concerns. HAVEN will also provide testimony to the legislature.

Joining PSYPACT will create two tracks of participation in HAVEN for psychologists: (1) those known to DPH; and (2) those unknown to DPH. Although PSYPACT does not exclude program participants who present to HAVEN voluntarily and without DPH or Board involvement, a psychologist of whom DPH is aware of the participation is disqualified from holding compact privileges. If a disciplinary referral is made by DPH or the Board, then participation is treated as an encumbrance on the license, which results in the immediate suspension of PSYPACT privileges. A psychologist can regain PSYPACT privileges when the non-disciplinary encumbrance is removed.[62]

PSYPACT has confirmed that initial application forms and renewal forms do not request information on participation in alternative programs unless participation is known to DPH or the Board. The perception of a threat of disclosure places a high expectation of strict compliance for a psychologist voluntarily referred to HAVEN who has compact privileges. Currently, HAVEN reports virtually all noncompliance to DPH and DPH exercises its discretion to determine ongoing eligibility for participation in HAVEN. HAVEN works with relapsing or exacerbating conditions. The relapsing or exacerbating component of the health condition is what makes the condition potentially impairing. A relapse or exacerbation does not mean discipline is warranted. Under PSYPACT, any noncompliance regardless of the nature or severity, could result in loss of practice opportunities and the ability to participate in PSYPACT. This will have a chilling impact on the willingness of the community to make referrals to HAVEN and for a psychologist to work with HAVEN. HAVEN recommends that DPH navigate new protocols for reporting technical noncompliance, including but not limited to low creatinine urines, reluctant participation, and documentation delays. HAVEN does not want to undermine the trust that has been built with the DPH since the creation of the program. Compacts, including PSYPACT, change the confidentiality afforded by HAVEN for the professionals covered by the Compact. Changes in confidentiality conflict with the state law that enabled HAVEN's establishment. When a compact conflicts with state law, the compact overrides the state law. Confidential access to health services and accountability will no longer be consistent among professions.

Information on participation in an alternative program is shared in a coordinated data system when the psychologists was referred by DPH or if DPH is aware.[63] This further undermines the expectation of privacy set forth in current state law. If Connecticut joins PSYPACT, HAVEN will also be required to report to DPH when the conditions for participation are successfully completed. PSYPACT Rule 9.5 requires a compact state to report to the ASPPB PSY/PRO software system "non-confidential information related to alternative program participation information."[64] Some states make public referrals to the alternative programs. In Connecticut, there is no "non-confidential information" related to participation. The mere fact of participation is confidential under Conn. Gen. Stat. Sec. 19a-12a. HAVEN recommends working with DPH and the PSYPACT Commission to clarify what constitutes non-confidential

[62] See PSYPACT Rule 7.6.
[63] See, section 7.7 Report information to the Coordinated Database.
[64] See also, Rule 9.8.

information and whether PSYPACT considers the confidentiality attributed to participants to be overridden if Connecticut joins the Compact.

PSYPACT counsel has confirmed that a member state "has subpoena authority to obtain information about a psychologist who is licensed in another compact state who is or has participated in an alternative to discipline program in that state, including the mental health records of the psychologist to the extent such records are considered or prepared as part of the alternative program. There is no limit to what may be subpoenaed regarding the alternative program and the psychologist's participation in the program." PSYPACT counsel has confirmed that the recipient of the subpoena may challenge it under state law. HAVEN recommends seeking clarification on whether the ability of PSYPACT to issue the subpoena overrides the confidentiality afforded HAVEN records under existing state law as well as notice and the opportunity for a hearing.

DPH has estimated the licensure fee loss to HAVEN to be approximately $2,485. There will be additional fiscal impact due to the administrative demands arising out of two tracks of participation for psychologists who are in the Compact as well as record keeping and production concerns. In the first year of compact membership, there will also be a fiscal impact to account for needed resources to develop revised parameters with DPH on reporting noncompliance and the determination of whether these parameters will be limited to psychologists or apply to all professions.

11. Key Concerns

As telehealth practice expands new issues regarding payment and reimbursement will be raised. The Work Group discussed that if someone isn't licensed in Connecticut and holds the PSYPACT privilege they may be barred from receiving Medicaid reimbursement. The Work Group agreed that there should be further exploration of this issue and there may need to be accompanying legislation proposed to clarify the Medicaid guidelines.

The Work Group also discussed concerns about maintaining a high quality of care when delivering services via telehealth. Telepsychology is an emerging modality, and it is important to Connecticut's psychologists to maintain high quality services while incorporating new technology into service provision. Telehealth is currently governed by both traditional patient protections and Public Act 21-9, which expires in 2023. Any extension of Public Act 21-9 in the 2023 session will provide a good opportunity to review the standards and best practices of telehealth to safeguard the delivery of high-quality telepsychology.

12. Recommendation

The Work Group identified several benefits of joining PSYPACT Compact, including streamlining process for psychologists providing telehealth, expanding Connecticut's ability to respond to overwhelming demand for mental health services and supports, and improving the State's preparedness for emergencies and other acute staffing needs. The Work Group recognized the potential impact on HAVEN and recommends that DPH, PSYPACT, and HAVEN continue to collaborate to cooperatively address HAVEN's concerns to preserve the

integrity of the program. The consensus of the Work Group was that the legislature should enact legislation enabling Connecticut to join PSYPACT at this time.

B. Physician Compact

The Interstate Medical Licensure Compact ("IMLC") provides an expedited process for physicians to obtain a full, unrestricted license from states that are members of the Interstate Compact. The IMLC was formed in 2017 and now operates in 34 states. The IMLC is a statutory agreement between two or more states. Each state is a signatory to the same contract. There can be no substantive modification to the contract.

The IMLC operates like the college Common Application or TSA pre-check and is based on the expedited licensure model. A qualifying physician is issued a letter of qualification by the IMLC and then is granted permission to obtain multiple licenses using a single online application. Typically, expedited licenses are issued within 7 to 10 calendar days. The single application process eliminates the need to reproduce paperwork and background documents for each state licensing board.

The IMLC is "created" by each member board state when legislation is passed, making it a discretionary state function. Once the legislation is passed, each state will select two commissioners. The IMLC Commission has rulemaking authority. There are five standing committees (Budget, Communications, Personnel, Rules and Administrative Procedures, and Technology).

1. Benefits of the IMLC

Proponents of the IMLC identify the following benefits: (1) expanding opportunities for improving post-treatment care; (2) allowing doctors from other states to jointly continue care after a patient returns home to Connecticut; (3) continuing to work with patients who travel from another IMLC member state to receive care in Connecticut and then return home; (4) improving ability to respond to ongoing pandemic; (5) continuing to expand as surrounding states adopt (example: New Jersey Governor Phil Murphy signed enabling legislation this month, and New York Governor Kathy Hochul committed to introducing enabling legislation in her State of the State); (6) facilitating sharing of information between states; (7) improving access to physicians and specialists for older adults; and (8) expanding the pool of physicians to work in rural and underserved areas.

2. Requirements for Compact License

To be eligible for an IMLC license a physician must hold a full, unrestricted license in an IMLC member state and must either (1) hold a principal residence is in the state of principal license; (2) practice medicine at least 25% in the state of principal license; (3) employer is in the state of principal license; or (4) physician uses the state of principal license as the state of residence for U.S. federal income tax purposes.

Once you establish eligibility, then the IMLC reviews the nine common standards: (1) medical school accreditation; (2) no more than three attempts at USMLE or COMPLEX-USA steps; (3) Graduate Medical Education accreditation by ACGME or AOA; (4) ABMS or AOA-BOS including time-unlimited certificates; (5) no prior convictions or criminal activity; (6) no

history of licensure actions; (7) clean DEA history; (8) no active investigation; and (9) must pass FBI criminal background check.

3. Scope of Practice

The IMLC authorize licensees to practice medicine in the issuing state consistent with the Medical Practice Act and all applicable laws and regulations of the state in which the patient is located.[65]

4. Discipline

The medical boards of each state retain authority over the practice of medicine in each state, including the authority to impose an adverse action against a license to practice medicine in that state for violations of the Medical Practice Act.[66] Any physician disciplined by a member state may be subject to discipline by other member boards in which the physician holds a license.[67] If a license is encumbered in the home state, then all licenses in IMLC member states will be placed on the same status.[68] If a physician's license is encumbered in any other member state, then all licenses will automatically be suspended.[69]

5. Patient Access to Quality of Care and Family Caregiving

The Work Group discussed the impact of the IMLC on patient access to quality care and caregiving. The key benefits that were identified were expanded access to physicians via telehealth, which improves access for people living in remote areas, older adults, and people with disabilities. Expanded access to telehealth can help to preserve continuity of care, so that physicians may continue to provide care if the patient moves or relocates temporarily to a state that is also a member of the IMLC. The Work Group also discussed the benefits to quality of care by expanding opportunities for improving post-treatment care. Entering the IMLC would allow doctors from other states to jointly continue care after a patient returns home to Connecticut and would allow Connecticut-based physicians to continue working with patients who travel from another IMLC member state to Connecticut to receive care.

6. Economic and Workforce Considerations

Healthcare systems have reported cost savings after joining the IMLC as a result of reducing administrative costs related to maintaining applications for out of state licenses for their physicians.

Some members of the Work Group expressed a concern that joining the IMLC will result in out-of-state physicians expanding their practice in Connecticut and will have the effect of

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[65] Occupational Licensure: Interstate Compacts In Action, *available at* https://compacts.csg.org/wp-content/uploads/2020/11/OL_Compacts_InAction_Update_APR_2020-3.pdf
[66] *Id.*
[67] *Id.*
[68] *Id.*
[69] *Id.*

shrinking Connecticut physician's patient base. This has not been the case in other states according to the IMLC after studying this issue.

The IMLC has reviewed physician application data and has found that applications come from three populations: (1) physicians seeking to obtain one to three additional licenses from surrounding states to expand their practice; (2) physicians taking advantage of locum tenens opportunities; and (3) physicians expanding the licenses held to meet the needs of telemedicine patients. Member states have reported to the IMLC that joining the Interstate Compact has not had a negative impact on currently licensed physicians, rather the addition of new physicians has been instrumental in covering physician shortages, especially in rural and underserved areas.

7. Fiscal Impact on State

All states that have adopted the Compact have reported a positive fiscal impact to the IMLC. The IMLC requires participants to continue to pay fees to each state in which licensure is sought. Based on a review of states with similar physician populations,[70] the IMLC estimates that Connecticut would experience a revenue increase of approximately $0.425 million from collecting a share of a per physician IMCL fee and due to expected growth in the number of licensees. The IMLC fee is $700 at the time of initial application. Of that fee $300 is paid to the state of principal license to cover the administrative costs of reviewing applicant eligibility. $400 of the fee is paid to the IMLC to cover its administrative costs. There is an additional $100 fee to add licenses in additional states, if requested after the initial application. There is a fee of $25 paid to the IMCL for renewal of each license. These fees are revisited by the Commission of the IMLC on an annual basis.

Connecticut is expected to receive (1) $300 for each application received as the State of Principal License (for physicians currently licensed in Connecticut wishing to use the process to obtain licenses in other states; physicians licensed in Connecticut who do not choose to invoke the compact will not see additional requirements or fees); (2) $565 for each license issued using the IMLC process; and (3) $575 for each license renewed that was issued using the IMLC process

The Federation of State Medical Boards has a 501(c)(3) that provides grants to support IMCL implementation, including costs associated with any technical upgrades that may be required.

8. Impact on Cost of Care

Increasing access to telehealth may have the effect of reducing healthcare costs for patients as well as for providers.

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[70] The 3 states used are (based on the FSMB Census of Licensed Physicians in the US, 2018 report): Colorado (25,070 physicians); Kentucky (19,528 physicians); Louisiana (17,538 physicians); and Connecticut (20,146 physicians). See Federation of State Medical Boards FSMB 2018 Physician Census, Journal of Medical Regulation, Volume 105, No 2, page 20, *available at* https://www.fsmb.org/siteassets/advocacy/publications/2018census.pdf].

9. Clinician Impact

Joining the IMLC will have the effect of streamlining the process for applying for and maintaining multiple state licenses which can be a cumbersome and costly process. The IMLC reduces the burden on physicians who hold licenses in multiple states. Joining the IMCL will also allow physicians to treat patients when they leave Connecticut for another state in which the physician holds a license. Physicians will have greater flexibility to treat their increasingly mobile patient base while complying with the law.

10. Integrity of Alternative Program

HAVEN has submitted the following comments regarding the impact of entering the IMLC on HAVEN. HAVEN supports recommending that Connecticut enter the IMLC with reservations, described below.

The IMLC does not directly or indirectly exclude professionals who are participating in HAVEN from holding IMLC licenses. However, a physician may be disqualified from holding an IMLC license if he or she is under active investigation. This means a physician is barred from applying to the IMCL or from renewing licenses in other states until the physician has made a full commitment to participate in HAVEN, which does not appear unreasonable.

During the Work Group's discussion, the IMLC represented that initial application forms and renewal forms do not request information on participation in alternative programs and this should be confirmed. Information on participation in HAVEN is not shared in a coordinated data system. Member boards may report any non-public complaint, disciplinary, or investigatory information to the IMLC Commission, which oversees a coordinated information system.[71] If DPH has knowledge of a physician's participation in HAVEN, DPH has the discretion to make or withhold a disclosure. HAVEN has requested confirmation from DPH that DPH will comply with current state law, as it is not in conflict with the IMLC.

HAVEN recommends further discussion between the IMLC, DPH, and HAVEN regarding whether HAVEN records would be required to be produced to other members of compact states on request or subpoena. Currently, if a physician is noncompliant with the conditions for participating in HAVEN, HAVEN records are transferred to DPH in accordance with state law. DPH has developed a process for review of such records when it has determined that disciplinary action is warranted. In such instances, HAVEN relies on DPH. The issue is more troublesome when the request is for records or information regarding a physician who has been compliant with HAVEN and no records have been provided to DPH. It would appear Mental Health and Substance Use records may not be produced if such a disclosure violates a federal law. However, most of the HAVEN file is not considered medical or mental health records as HAVEN does not provide care and treatment. Therapists and practice liaisons who provide quarterly reports to HAVEN may be reluctant to work with HAVEN participants if their reports are vulnerable to disclosure. IMLC Rule 6.2 provides for producing records "confidential and filed under seal." However, records so produced may be redisclosed as part of any public

[71] See Section 8.d. and Rule 6.2 to 6.4.

disciplinary action. Unless the alternative program records are relevant to the grounds for discipline and are the records of the physician subject to discipline, there should be no fear of public disclosure. HAVEN recommends that there be further exploration of this issue.

The IMLC gives any member state the authority to issue a subpoena in any other member state. A subpoena issued by a member Board is enforceable in any other member state whether or not the subpoena concerns a Compact physician or applicant. It would appear that a physician may choose not to join the Interstate Compact and his or her information including participation in HAVEN may still be subject to subpoena. HAVEN recommends that the legislature clarify that the parameters for confidentiality set forth in Conn. Gen. Stat. Sec. 19a-12a(h)(1) and (2) still apply and that a subpoena issued by the compact does not meet the requirements for "unless disclosure is otherwise required by law." The physician and HAVEN should be provided notice and the opportunity for a hearing. No physician or professional should be afraid that his or her personal information will be vulnerable to disclosure.

As a physician must obtain a license in each member state where he or she intends to practice, the IMLC would not appear to cause any financial loss to HAVEN.

11. Key Concerns

Some members of the Work Group were concerned that joining the IMLC may make it easier for large telemedicine companies to expand their presence in Connecticut. The COVID-19 pandemic has rapidly advanced the use of telemedicine and demonstrated its positive uses; however, physicians want to ensure that telemedicine is a part of a continuity of care plan between a patient and his or her established physicians. Some members of the Work Group expressed concern that because telemedicine providers often do not have access to a patient's documented medical history or records, telemedicine can result in the delivery of fragmented medical care.

The Work Group also expressed concern that joining the IMLC would have the effect of aiding in the expansion of telemedicine-only primary care practices, which could negatively impact the quality of care. The Work Group recommends that a comprehensive state-wide review of telemedicine and its impact on patient care be initiated so that telemedicine standards may be addressed in a comprehensive way. The anticipated review of Public Act 21-9 prior to its 2023 expiration should provide a good forum for those discussions.

12. Recommendation

The Work Group identified several benefits to joining the IMLC, including streamlining the process for Connecticut physicians seeking licenses in other states and for out-of-state physicians looking to care for Connecticut residents, improving Connecticut's preparedness for pandemics, emergencies, and other acute staffing needs, and facilitating telehealth. The Work Group recognizes that potential impacts on HAVEN and recommends further discussion between DPH, HAVEN, and IMLC to protect the confidentiality of participants in HAVEN's programs. The consensus among the Work Group was that the state legislature should enact legislation enabling Connecticut to join the IMLC at this time.

C. The Nurse Licensure Compact

The Nurse Licensure Compact ("NLC")[72] allows registered nurses ("RNs"), licensed practical nurses ("LPNs"), and licensed practical vocational nurses ("LVNs") to work in other states that are members of the Interstate Compact. A nurse is issued a multistate license in their home state (primary state of residence) and is authorized to practice in all NLC states in person or via telehealth. The authority to practice in other NLC states is known as a "privilege to practice." Each NLC state is authorized to act against a privilege to practice when necessary to protect the public. When providing care in another state, a nurse is subject to each state's practice laws.[73]

The National Council of State Boards of Nursing ("NCSBN")[74] describe the following benefits of entering the NLC:[75] (1) expands access to care; (2) enables telehealth practice (including triage, call centers, case managers); (3) facilitates disaster relief; (4) provides support for nurse spouses in military families; (5) facilitates online nursing education; (6) cost effective for nurses and employers; (7) addresses access for rural populations and areas of healthcare shortages; (8) facilitates transport nursing; (9) enables facility staffing (i.e., travel nursing); (10) enhances mobility for nurses residing near borders and practicing in adjacent states; (11) provides administrative efficiency; and (12) offers flexible licensure (i.e., nurses may still obtain a single-state license, if ineligible for a multi-state license).

1. Requirements To Hold License

To hold a multistate license a nurse must: (1) have graduated or be eligible to graduate from a board-approved RN or LPN/VN prelicensure education program; (2) have passed an English proficiency exam (if English is not the applicant's native language or if prelicensure education program was not taught in English); (3) have successfully passed an NCLEX-RN® or NCLEXPN® Examination or recognized predecessor; (4) be eligible for or hold an active, unencumbered license; (5) have submitted biometric data for criminal history record checks; (6) have not been convicted or found guilty, or entered an agreed disposition, of a felony offense; (7) have not been convicted or found guilty, or entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing; (8) not be enrolled in an alternative program; (9) be subject to self-disclosure requirements regarding current participation in an alternative program; and (10) have a valid U.S. Social Security number.[76]

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[72] The NLC does not include APRNs. The APRN Compact is not yet enacted.
[73] Nurse Licensure Compact, NLC Model Legislation, Article III(e), *available at* https://www.ncsbn.org/NLC_Final_050415.pdf.
[74] Founded in 1978, NCSBN is an independent, 501(c)(3) not-for-profit organization with 59 U.S. members including the nursing regulatory bodies in all 50 states. See NCSBN's website, *available at* https://www.ncsbn.org/index.htm
[75] NLC, Updated One Pager ("Updated One Pager"), available at https://nursecompact.com/Updated_onepaged_NLC.pdf
[76] Nurse Licensure Compact, NLC Model Legislation, Article III(c), *available at* https://www.ncsbn.org/NLC_Final_050415.pdf

2. Scope of Practice

Licensees must comply with the scope of practice defined by the state in which the patient is located at the time service is provided.[77]

3. Discipline

The home state has the power to impose discipline against a nurse's license, which can result in the license being considered "encumbered."[78] If a practioner's home state license is encumbered, the practioner's privilege to practice in remote states is removed until the home state license is fully restored.[79] A remote state may act against a nurse's privilege to practice within that state.[80] Any adverse action is reported to both the licensure information system and the licensee's home state, where the adverse action will be handled.[81]

4. Patient Access to Quality of Care and Family Caregiving

Becoming a member of the NLC may increase access to quality care by increasing access to practitioners in hard-to-reach places (i.e., rural parts of the state or in facilities facing a COVID surge that need to rely on out of state nurses to provide telehealth support to reduce burden on staff). The COVID-19 pandemic has greatly advanced the use of telehealth. Nurses are required to be licensed in the state where the patient is receiving care. This can be burdensome for nurses practicing telehealth and can pose significant barriers to providing care for patients who are on traveling, temporarily relocating, or receiving specialized treatment in another state. Once a state becomes a member of the NLC, nurses holding an Interstate Compact license may practice nursing via telehealth in any of the 39 states and territories that are members of the Interstate Compact.

5. Economic and Workforce Considerations

There is an acute shortage of nursing educators in Connecticut. The shortage is hindering the State's ability to recruit and train enough new nurses to meet demand for nurses. Connecticut needs to rapidly expand teaching capacity so that, in turn, more students can be trained to join the profession. Nurse educators are bound by the same licensure requirements and must hold a license in the state in which they are teaching. Under the NLC, however, if a nurse educator is licensed in a NLC state and the students are also in NLC states, the faculty member will not need additional licenses. Joining the Interstate Compact for nurses will expand the pool from which to draw faculty to teach and train the next generation of Connecticut's nurses.

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[77] Occupational Licensure: Interstate Compacts In Action, *available at* https://compacts.csg.org/wp-content/uploads/2020/11/OL_Compacts_InAction_Update_APR_2020-3.pdf
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] *Id.*

6. Fiscal Impact on State

The current annual fee for a state to be a member of the Interstate Compact is $6,000. In addition, DPH estimates that joining the Compact could result in an annual licensure revenue loss of approximately $5 million. If Connecticut joined the Compact, DPH would continue to receive licensure fees from nurses licensed in Connecticut but would lose revenue collected from nurses residing in other Compact states who currently pay for licensure in Connecticut. However, it could offset those losses by charging Connecticut-based nurses a fee for a compact license that costs the Connecticut nurse less than the renewal fees he or she currently pays to other compact states.

7. Impact on Cost of Care

Increasing access to telehealth may have the effect of reducing healthcare costs for patients as well as for providers.

8. Clinician Perspectives and Impact

Joining the NLC will reduce barriers to and the time it takes to obtain and maintain multiple state licenses. In a survey conducted by the Minnesota Board of Nursing in 2017, 80% of respondents were in favor of joining the Compact (and fewer than 5% were not in favor of joining).[82] In addition, they found respondents with a Compact license overwhelmingly felt the Compact was of benefit to them. In 2020, the Pennsylvania State Nurses Association reversed its opposition to the NLC citing a survey of 15 state affiliates of the American Nurses Association on their nurses' experiences with the NLC, which were "overwhelmingly positive."[83] Although survey data is not widely available, surveys of nurses in Oregon, Alaska, and Guam all reported overwhelming support for joining the NLC.[84]

9. Integrity of the Alternative Programs

HAVEN has submitted the following comments regarding the impact of entering the NLC and the APRN Compact on HAVEN. HAVEN opposes entering the NLC and APRN Interstate Compact at this time.

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[82] 2017 Survey of Minnesota Nurses, *available at* https://mn.gov/boards/assets/Nurse_Licensure_Compact_Survey_Results_2017_tcm21-311674.pdf

[83] PSNA Responds to Nurse Licensure Compact, *available at* https://www.psna.org/psna-responds-to-nurse-licensure-compact/

[84] Guam survey results, *available at* https://bloximages.newyork1.vip.townnews.com/postguam.com/content/tncms/assets/v3/editorial/4/96/496a2686-6606-11eb-ad6f-cb3001f631a7/601a73e290cb0.pdf.pdf; Alaska survey results, *available at* https://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/BoardofNursing/NurseLicensureCompact.aspx; Oregon survey results *available at* http://epubs.democratprinting.com/publication/?i=329420&article_id=2557549&view=articleBrowser 96.8% of nurses said they would not be opposed to Oregon joining the NLC (note: working on getting active link for this poll).

A nurse is ineligible to participate in the NLC if they are currently enrolled in HAVEN.[85] The NLC does not differentiate between referrals to HAVEN, which are mandated by DPH or the Board, from voluntary participation. HAVEN is concerned that being barred from holding an NLC license while participating in its program will have the effect of stigmatizing seeking mental or physical health treatment or will have a chilling effect on referrals to HAVEN for early intervention. THE NLC and the APRN Interstate Compacts are in direct conflict with the confidentiality afforded to nurses and APRNs by Connecticut General Statute Section 19a-12a. PRNs and RNs must self-disclose participation in an alternative program.[86] The NLC requires in that in order for a multistate licensee to retain their multistate license, they must be "not currently enrolled in an alternative program."[87] This creates the duty to report to the licensing board any participation in HAVEN, resulting in the deactivating the multistate license for the duration of the nurse's participation in the alternative program.'[88]

Many nurses present to HAVEN without regulatory involvement. HAVEN supports nurses suffering from all health conditions including depression, anxiety, difficult to manage diabetes, chronic neurologic conditions, and substance use. A nurse is less likely to voluntarily present to HAVEN if he or she will be identified to DPH or will be required to self-disclose. Employers will also be less likely to make a referral if they know they will be subjecting the nurse to disclosure to the regulating agency. Employers will typically refer to HAVEN when the employer does not feel the health condition rises to the level of needing DPH oversight and discipline. Mandating self-disclosure of participation in HAVEN stigmatizes participation in HAVEN and reenforces fear of seeking help and shame.

HAVEN is especially concerned that each Interstate Compact treats participation in HAVEN differently. In particular, HAVEN takes issues with the fact that doctors and nurses are treated differently, which undermines the NLC's position that withholding Interstate Compact privileges to nurses is in furtherance of public safety. Instead, it appears discriminatory and punitive. There is no reason that the nurses and APRNs cannot benefit from the consistency developed among physician health programs and standards, which HAVEN meets or exceeds. Through the NLC and ARPN Compact commissions, participating states have the opportunity to inform the bylaws. HAVEN recommends that Connecticut require a commitment to facilitating consistency and excellence among alternative programs within the Compact for nurses to promote mental health and self-care. If nurses or employers are discouraged from reaching out to HAVEN because the nurse will lose compact privileges, our state and the citizens of our state lose, and patient safety will be at increased risk.

Information on participation in an alternative program is shared in a coordinated data system.[89] Currently, participation in HAVEN is not shared in a coordinated licensure information

[85] See, eNLC III.c. 9 and APRN LC Art. III.11.
[86] APRNLC Art III.12.
[87] Art.III (c)(9)
[88] Art.V(c)
[89] Article IV of the eNLC states that upon application for a multistate license, the licensing board in the issuing party state shall ascertain through the coordinated licensure information system …. whether the applicant is currently participating in an alternative program.

system. By state law, HAVEN is mandated to report to DPH only those nurses referred who have a history of licensure discipline, felony charges, allegation of patient harm, or noncompliance.

As noted above, the NLC application process overrides and violates Conn. Gen. Stat. Sec. 19a-12a. Article VI of the NLC further mandates that all party states participate in a coordinated licensure information system and requires that "all licensing boards shall promptly report to the coordinated licensure information system …nurse participation in alternative programs known to the licensing board regardless of whether such participation is deemed nonpublic or confidential under state law.[90]

An NLC member state that is a member of the Interstate Compacts may designate information not to be shared with non-member states or disclosed to other entities or individuals without the express permission of the contributing state. Under the compact, the nurse has no expectation of privacy from the Board and from other member states who access this coordinated system. Reverting to a single state license does not lessen the sense of loss and violation. Further the loss is not attributed to a finding of unfitness, but rather the loss is attributed to participation in a program that is supposed to help the nurse and that has approved return to practice when the nurse is fit to practice.

A review of 38-member state jurisdictions shows that 29 of those states have alternative programs that are run by the Board of Nursing, DPH, or by an entity under contract with the Board of Nursing or DPH. Five states have no alternative program, and four states were unclear status. At least four states seemed to have developed two track systems for regulatory mandated referrals and voluntary referrals in possible violation of the terms of the NLC. Unlike Connecticut, a state whose program is run by the Board of Nursing or by contract with the Board has never offered a nurse an expectation of privacy and joining the compact does not risk loss of referrals as a nurse in that state had no expectation not to be known to the Board. The prior physician program in Connecticut operated under contract with the DPH and proved to be unsuccessful. It failed because physician and physician employers/partnerships did not refer to the program due to the perception of regulatory control and lack of anonymity or confidentiality.

The NLC and APRN compacts undermine the mental health initiative and promotion of professional wellness in Connecticut. While the NLC and the APRN Compacts will not request records, HAVEN records remain unacceptably vulnerable to other member states. This vulnerability may impact the willingness of therapists, practice liaisons, and volunteers to work with HAVEN.

DPH estimates the fiscal loss to HAVEN for the NLC to be approximately $175,000. Licensed practical nurse fiscal loss is estimated to be an additional $2,400. HAVEN cannot function with this substantial loss which would undercut staffing and leadership. In addition to the licensure revenue loss, HAVEN would also be anticipated to suffer a loss from a decrease in referrals due to the loss of confidentiality. HAVEN may anticipate only maintaining referrals that

[90] Article VI(a) and (c).

are considered mandated or through DPH. HAVEN estimates that the overall loss would be closer to $200,000 to $250,000. This is approximately 25% of the HAVEN budget.

10. Key Concerns

There are many issues facing nurses in Connecticut today. After almost two years on the front lines of the pandemic, nurses have been working under extremely difficult circumstances, putting their own health at risk as they care for patients. Nursing shortages have put tremendous pressure on the nursing workforce and nurses are retiring and leaving the profession in unprecedented numbers, exacerbating the issue. Some members of the Work Group expressed skepticism that joining the Interstate Compact would have the effect of alleviating the burden on nurses or whether it would meaningfully improve the conditions for nurses today. They cited the fact that at this time no bordering states are members of the NLC, limiting Connecticut's ability to draw nurses from our neighbors to meet acute staffing needs. Some members of the Work Group were skeptical that licensing was a bar to relocating and maintain that the process for applying for a Connecticut license is relatively simple. Further, some members of the Work Group expressed concern that participation in the NLC would exacerbate Connecticut's nursing shortage because it will allow Connecticut nurses to leave the state to practice in other states.

In addition, some members of the Work Group expressed concern that joining the NLC would aid the proliferation of telehealth at the expense of quality of care. The Work Group is also concerned that the confidentiality of participants in HAVEN would be jeopardized by participating in the NLC, which would have the effect of lessening protections for nurses seeking treatment for substance use disorders or mental health treatment.

Joining the NLC would result in a loss of revenue to the State. The Work Group was concerned those losses would not be sustainable long term.

11. Recommendations

Although the Work Group identified several benefits of joining the NLC, including streamlining the process for nurses holding licenses in multiple states, improving the State's preparedness for pandemics, emergencies, and other acute staffing needs, and facilitating telehealth, the consensus among the group was that the Legislature should continue to study the impact of joining the NLC and not enact legislation enabling Connecticut to join the 39 other jurisdictions at this time.

D. APRN Compact

The APRN Interstate Compact was adopted as model law on August 20, 2020, and has now been enacted by two states, Delaware, and North Dakota. The APRN Compact has not yet taken effect. It will officially be implemented when seven states join. Like the NLC, the goal of the APRN Compact is to promote mobility of APRNs, facilitate the utilization of telehealth, increase access to care, and address the burden on APRNs holding licenses in multiple states. The APRN Interstate Compact takes a mutual recognition approach, where APRNs apply in their home state for a multistate license. A resident of an APRN Interstate Compact member state is issued a multistate license that is valid for practice (in person, electronic, or telephonic) in all states that are members of the Interstate Compact.

1. Requirements for APRN Compact

For an APRN to be eligible for a multistate license they must be a legal resident of a state that is a member of the Interstate Compact, meet the home state's licensure requirements, and meet the uniform licensure requirements for a multistate license, which include (1) graduation from an accredited graduate-level education program or an international APRN education program and have passed an English proficiency examination, (2) successfully passed a national certification examination; (3) hold an active, unencumbered license as a RN and an active, unencumbered authorization to practice as an APRN, (4) passed an NCLEX-RN® examination or recognized predecessor examination, (5) practiced for at least 2,080 hours as an APRN in a role and population focus congruent with the applicant's education and training, (6) submitted to state and federal fingerprint-based criminal background checks, (7) has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state, federal or foreign criminal law, and have no misdemeanor convictions related to the practice of nursing (determined on a case-by-case basis by the APRN Interstate Compact Commission); (8) is not currently enrolled in an alternative program, and self-disclose participation in an alternative program; and (9) have a valid United States Social Security number.[91]

2. Scope of Practice

Licensees must comply with the scope of practice defined by the state in which the client is located at the time service is provided.[92] Multistate licensees are authorized to practice independent of a supervisory or collaborative practice agreement with a health care provider.

3. Discipline

The APRNs home state has the sole authority to impose discipline against an individual's license.[93] If an individual's home state license is encumbered, the privilege to practice in remote

[91] APRN Model Rules, Art. III(b), *available at* https://www.ncsbn.org/FINAL_APRNCompact_8.12.20.pdf.
[92] Occupational Licensure: Interstate Compacts in Action, *available at* https://compacts.csg.org/wp-content/uploads/2020/11/OL_Compacts_InAction_Update_APR_2020-3.pdf
[93] Occupational Licensure: Interstate Compacts in Action, *available at* https://compacts.csg.org/wp-content/uploads/2020/11/OL_Compacts_InAction_Update_APR_2020-3.pdf

states is revoked until the home state license is fully restored.[94] A remote state may take action against a practioner's multistate licensure privilege in the state.[95] Any adverse action is reported to both the home state and the licensure information system.[96] The adverse action will be handled as if it had occurred in the home state. An APRN license can only be revoked by the original licensing state.[97]

4. Patient Access to Quality of Care and Family Caregiving

Connecticut faces many challenges to providing quality care to the aging, the chronically ill, the un-or under insured, across the healthcare system. A shortage of providers exacerbates an already challenging landscape for healthcare delivery across the state. One avenue for meeting the needs of the people of Connecticut is to expand access to APRNs. Increasing access to APRNs will help to improve access to quality providers and reduce costs. The APRN Compact, which reduces barriers to accessing APRN, is one way of increasing access to APRNs.

Some studies have found that APRNs deliver high quality primary care services, with "similar or better patient health outcomes, higher levels of patient satisfaction, and better quality of life" at a lower cost than physicians.[98] And "[r]elative to primary care physicians, APRNs are more likely to practice in underserved areas and care for large numbers of minority patients, Medicaid beneficiaries, and uninsured patients."[99] Increasing access to APRNs will improve access to quality care in Connecticut.

Joining the APRN Interstate Compact will increase access to APRNs, which can help to facilitate access to lifesaving services during natural disasters, weather emergencies, or a public health crisis. As the COVID-19 pandemic has illustrated, there is a need for state-based APRN license portability during a health care crisis to help states secure surge capacity when local needs exceed local health care supply.

Expanding access to APRNs will improve quality of care for older adults. Health care provider shortages have a negative impact on the care of older adults. Older adults sometimes lack the ability or resources to get to their appointments because of mobility issues, long travel distances to a provider, and wait times for appointments. Expanding APRN's ability to see patients via telehealth will help to connect older adults to quality care.

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[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] *Id.*
[98] Laurant M, van der Biezen M, Wijers N, Watananirun K, Kontopantelis E, van Vught, Cochrane Library, Nurses as Substitute for Doctors in Primary Care, *available at* https://primaerversorgung.org/wp-content/uploads/2020/01/2018_Cochrane_Nurses-as-substitutes-for-doctors-in-primary-care.pdf
[99] Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses (March 2014), *available at* https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf

The APRN Compact establishes uniform standards across the states and makes it easier for state boards to exchange information with other members of the Interstate Compact when issues arise. This will help to improve oversight, coordination, and strengthen public safety.

5. Economic and Workforce Considerations

In Connecticut APRNs are required to practice for three years in a collaborative agreement with a physician. Several of the leading APRN advocacy groups have taken the position that Connecticut's APRNs should be permitted to practice independently on the basis that a trained APRN can independently provide core primary care services as safely and effectively as physicians. Under the APRN Interstate Compact, there is no requirement that the APRN enter into a collaborative agreement with a physician. According to NCSBN, 90% of APRNs would qualify for an Interstate Compact license on day one in Connecticut. Entering the APRN Interstate Compact would have the effect of reducing barriers to accessing APRNs because they will hold full practice authority.

6. Fiscal Impact on State

The Fiscal impact on the State is expected to be minimal. The APRN Compact has not yet been enacted and so there is no estimation of the lost revenue as of the writing of this report.

7. Impact on Cost of Care[100]

Full independent practice authority is likely to deliver cost savings to patients because they will have greater access to providers. When comparing the cost of primary care when delivered by nurses and physician assistants to care provided by physicians, studies have shown that when nurses and physicians assistants assumed roles previously occupied by physicians, "substitution of visits to physicians by visits to nurse and physicians achieved savings in the first year of implementation."[101] A study of 26 capitated care practices of a group model managed care organization found that total labor costs were lowest in practices where nurses and physician assistants were used to a greater extent.[102] Using Massachusetts-specific MEPS data, a recent RAND study estimated nurses and physician assistant visits are 35 percent less expensive than physician visits. The study estimated that if scope of practice laws were expanded, Massachusetts could save between $4.2 and $8.4 billion over the course of the next ten years.[103]

8. Clinician Impact

Joining the APRN Compact will expand access to work opportunities in telehealth, facilitate cross-border practice, and make APRNs more competitive candidates for jobs.

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[100] For addition discussion of APRN cost savings please see, https://campaignforaction.org/wp-content/uploads/2016/11/Freemarketcasefullpractice.pdf

[101] Cost of Care Provided by Advanced Practice Registered Nurses (APRNs), Campaign for Action, available at https://campaignforaction.org/resource/cost-care-provided-aprns/ (citing Naylor and Kurtzman 2010).

[102] *Id.* (citing Roblin et al., 2005)

[103] *Id.* (citing Eibner et al., 2009).

9. Integrity of the Alternative Programs

HAVEN has addressed its concerns regarding entering the APRN Interstate Compact and the NLC together in the section above. HAVEN opposes entering the APRN Interstate Compact for the reasons described above.

10. Key Concerns

The primary concern regarding the APRN Interstate Compact is related to the 2,080 practice hours required for eligibility. The American Association of Nurse Practitioners ("AANP"), the National Association of Pediatric Nurse Practitioners ("NAPNAP"), and the Nurse Practitioner Roundtable, which includes AANP, NAPNAP, the National Organization of Nurse Practitioner Faculties, Gerontological Advanced Practice Nurses Association, and the National Association of Nurse Practitioners in Women's Health, all oppose the practice hour requirement. These organizations maintain that APRNs are prepared for practice at graduation and the practice hour requirement conflicted with the APRN Consensus Model. They view any restrictions on practice to be unnecessarily restrictive.

Some APRN organizations also oppose the Interstate Compact on the basis that the APRN Compact does not grant multistate licensees the ability to prescribe controlled substances in any Interstate Compacts state without obtaining DEA authorization in that state to do so. The current scheme has resulted in a patchwork process for practitioners, requiring ARPNs to obtain controlled substance authority in the state where their patient is located. The APRN Interstate Compact does not address controlled substance prescribing for multistate licensees because no Interstate Compact can supersede DEA authority over controlled substances. Although the APRN Interstate Compact does not create a solution to the current DEA patchwork process, it does reduce the burden of carrying occupational licenses in each state where the practitioner prescribes.

Some APRN organizations have expressed concern regarding the membership of the APRN Compact Commission, which is the governing body of the APRN Interstate Compact. The APRN Compact Commission membership is made up of one voting member from each party state. Like the NLC, the IMLC, PSYPACT, and the physical therapy compact the commissioners are not required to be members of the profession. They must, however, be a regulator of that profession in the state they are representing. Some members of the Work Group have expressed concern that there is not an advisory committee on the commission made up of APRNs. NCSBN has stated that it believes an APRN advisory commission could be beneficial. The formation of such an advisory commission, however, can only occur once the APRN Compact takes effect and the APRN Interstate Compact Commission exercises their authority to create the committee. To address the concerns regarding the Commission structure and APRN advisory committee, NCSBN recommended the addition of enabling language to APRN Compact legislation introduced in Connecticut that would require the Connecticut commission

representative to recommend (once the commission is formed) that an APRN advisory committee be formed.[104]

The American Medical Association opposes the APRN Compact because the APRN Compact allows multistate licensees to practice independent of a supervisory or collaborative practice agreement. The Connecticut State Medical Society also expressed concern about the APRN Compact on the basis that it supersedes existing legislation in Connecticut requiring that APRNs practice in collaborative agreements with physicians for the first 2000 hours, three years of practice, and when prescribing. If Connecticut were to join the Interstate Compact, then APRNs would have full practice authority in all APRN Compact member states so long as they have practiced for 2,080 hours.

11. Recommendation

The Work Group identified several benefits to joining the APRN Compact, including streamlining the process for APRNs holding licenses in multiple states, improving the State's preparedness for pandemics, emergencies, and other acute staffing needs, and facilitating telehealth. However, given that the APRN Compact is not yet operational, the consensus of the Work Group was to focus our immediate attention on advocating for potential improvements and revisions that better reflect Connecticut's current practice environment and policies.

The Workgroup also identified short-term opportunities to reduce barriers to APRN practice in Connecticut. In the absence of joining the APRN Interstate Compact, an experienced APRN from a different state will not be able to come to work in Connecticut without entering a collaborative agreement with a Connecticut physician. The result of this restriction is that seasoned APRNs meeting the requirements for independent practice cannot transfer their expertise to practice in Connecticut and are required to enter into a collaborative agreement with a physician, essentially treating them as a new graduate regardless of their level of experience. This requirement is a barrier to experienced APRNs relocating to Connecticut to practice. The Work Group recommends a change to Connecticut General Statute Sec. 20-87 allowing Connecticut to recognize the training and experience of APRNs working in other states as sufficient to meet the requirements of Connecticut's collaborative agreement. By changing the statute, Connecticut would increase access to experienced APRN primary care providers from other states, which would increase access to care.

[104] The Delaware APRN Compact companion legislation included amending the duties of the Delaware Board of Nursing's APRN Committee to include the review of emerging practices and advising the Board of Nursing on APRN licensure, the APRN Compact, and practice standards, including prescribing trends, and provide recommendations to the Board of Nursing regarding APRN practice. If Connecticut chooses to move forward with the APRN Interstate Compact, then similar companion legislation could be considered.

D. Physical Therapy Compact

The Physical Therapy Compact, which began in 2017, currently operates in 25 states. Compact legislation has been enacted in a total of 33 states and D.C. Nine additional states are in the process of implementing the Physical Therapy Compact.[105] The Compact allows physical therapists with a valid license from a member state to apply for the privilege to practice in other states that are members of the Interstate Compact. The Compact does not issue a multistate license but instead issues a privilege to practice in remote states, provided the applicant maintains active status and residence in the home state.

12. Requirements for the Physical Therapy Compact

To obtain a privilege to practice the physical therapist must meet the following requirements: (1) Primary residence state is a compact member that is actively issuing privileges; (2) must be licensed in their home state;(3) must not have any encumbrances on their license; (4) no disciplinary action within the last two years; and (5) must meet jurisprudence requirement of the remote state.[106] Newly licensed physical therapists must pass an FBI background check going forward, however, if the physical therapist is already licensed in a state that does not require an FBI background check (like Connecticut), the requirement does not apply retroactively.

13. Scope of Practice

The Physical Therapy Interstate Compact allows the physical therapist to practice physical therapy in a remote state under the scope of practice of the state where the patient/client is located. It does not change the scope of practice of a member state.[107]

14. Discipline

A remote state may take adverse action against a physical therapist's privilege to practice within that state. If any compact privilege or license is disciplined, then the individual is not eligible for Interstate Compact privileges in any state until at least two years from the date of the action.[108] The home state can choose to take disciplinary action if an the state where the physical therapist had the privilege to practice disciplinary action was taken.[109] If an individual has an encumbrance placed on any compact privilege or license, then they will not be eligible for compact privileges until the encumbrance is lifted. If an individual's license is revoked, the physical therapist will not be eligible for compact privileges until the license is restored. An

[105] PT Compact Map, *available at* https://ptcompact.org/ptc-states.
[106]PT Compact Model Rules, Art.III(A), *available at* https://ptcompact.org/Portals/0/Images/PT_Compact_Language_Final%20with%20Cover%20Page1_11_2021.pdf
[107] Occupational Licensure: Interstate Compacts In Action, *available at* https://compacts.csg.org/wp-content/uploads/2020/11/OL_Compacts_InAction_Update_APR_2020-3.pdf
[108] *Id.*
[109] *Id.*

encumbrance or disciplinary action does not impact a physical therapist's ability to apply for a regular license directly with a state licensing board.[110]

15. Patient Access to Quality of Care and Family Caregiving

Joining the Physical Therapy Compact could improve access to care. During the COVID-19 pandemic, physical therapists have greatly increased the use of telehealth in physical therapy which has highlighted the value of emerging technology as a complement to hands-on care. The pandemic has also highlighted the limitations of the current licensing scheme, which restricts the ability to care for patients remotely. Joining the Physical Therapy Compact would help to enhance the continuity of care so that patients are able to continue treatment when they are traveling or are unable to attend an in-person appointment. Enhancing continuity of care will improve patient outcomes and avoid problems that could further tax the healthcare system.

The Physical Therapy Compact would also provide flexibility for providers. It would allow providers the ability to expand capacity in times of extraordinary demand, like the pandemic, or to fill short term staffing shortages, such as maternity or medical leave, which would increase patient access to quality care.

The Physical Therapy Compact's online application and verification process allows qualified physical therapists to be approved to practice and work within a matter of minutes instead of days, weeks, or even months. The Physical Therapy Compact also improves public protections by instituting a universal record across states for physical therapists and mandatory disciplinary reporting requirements to a central database. Joining the Physical Therapy Compact will help to Connecticut recruit and retain physical therapists because they will know that they will have greater mobility to practice in other states.

16. Economic and Workforce Considerations

Physical therapists often rely on traveling physical therapists to meet demand. Traveling physical therapists would greatly benefit from Connecticut joining the Interstate Compact because it would reduce the time and resources spent on applying to multiple states for licensure, which can be a time consuming and costly process. Many states need physical therapists to practice in rural or underserved areas. Physical therapists based in Connecticut face challenges filling these needs because of an in-state shortage of practitioners and the difficulty of obtaining licenses for out-of-state providers quickly to address immediate needs, which can be financially burdensome for the provider and reduces access for those patients in need.

Joining the Physical Therapy Interstate Compact will also have the effect of improving training opportunities. The mobility of the Interstate Compact allows physical therapists to travel to train in different settings and work with different populations. Increased access to training will help Connecticut's physical therapy workforce to practice skills and remain current on the latest trends and innovations in the field.

[110] *Id.*

17. Fiscal Impact on State

The Physical Therapy Compact charges the physical therapist a $45 fee for each compact privilege issued, however, additional fees assessed on physical therapists applying for a compact privilege are determined by each state. The Physical Therapy Compact Commission has invested in infrastructure to support an online system that confirms an individual's eligibility to get compact privileges and the collection of fees (both the standard $45 Commission fee and whatever the state sets its fee as) so that there is one online payment that is collected by the Physical Therapy Compact Commission and then the state portion is remitted back to the state board in the form of a check monthly. This removes the burden from the state of collecting compact privilege fees. The yearly revenue loss associated with Connecticut licensure fees is expected to be approximately $0.89 million which can be offset by the additional fee (to be determined by the State) collected when a physical therapist applies to the Interstate Compact.

18. Impact on Cost of Care

Increasing access to telehealth may have the effect of reducing healthcare costs for patients as well as for providers.

19. Clinician Impact

By expanding access to telehealth, physical therapists would have new opportunities to grow their patient base. Telehealth offers practitioners the ability to work from home and work on more flexible schedules. It will offer recent graduates the opportunity to travel to train in different settings and work with different populations.

20. Integrity of the Alternative Programs

HAVEN has submitted the following comments regarding the impact that entering PSYPACT will have on its program. HAVEN does not support entering the Physical Therapy Interstate Compact at this time.

The Physical Therapy Interstate Compact excludes participation in an alternative program on the basis that participation in HAVEN is considered an "encumbrance" which renders the physical therapist ineligible for compact privileges. If a physical therapist enters HAVEN while holding an Interstate Compact license, they "immediately lose any and all compact privileges.[111] Effective October 24, 2021, Physical Therapy Compact Commission Rule 3.11 mandates: "A compact privilege holder must report to the Commission any required enrollment into an alternative program, in any jurisdiction, within thirty (30) days. Notification of enrollment in an alternative program will automatically place an encumbrance on the individual."[112] HAVEN recommends further review of whether the Physical Therapy Interstate Compact Commission allows for any distinction between mandated and voluntary referrals and whether the Physical Therapy Compact Commission allows discretion for a professional who seeks health support and assistance before there is any impact on his or her practice. HAVEN also seeks further

[111] See Physical Therapy Compact Rule 3.3.
[112] See Physical Therapy Compact Rule 3.11

determination of whether the Physical Therapy Compact Commission rules allow discretion to recognize the professional's compliance, cooperation, and commitment to fitness or wellness within the accountability of the assistance program.

All member states share data in the Physical Therapy Interstate Compact's online processing system each week. Within two business days of the effective date to impose a non-disciplinary encumbrance on license or compact privilege, the Board will report such decision to the Commission through the interface described in Rule 6.3.[113] When a physical therapist discloses participation in HAVEN, the encumbrance is posted on this interjurisdictional processing system and is available to the member states. The public has access to information limited to verification of the compact privilege.[114]

When HAVEN was created, the legislature made clear that participation in HAVEN was not an encumbrance on one's license or ability to practice. The purpose was to encourage early voluntary participation and to remove the fear of loss of practice or blemish to the reputation. When a professional loses compact privileges, even if the specific reason is not shared, the professional feels tarnished and shamed. The incentive to seek support and assistance is diminished.

In addition, a member state shall notify the Commission that investigatory information is available to party states when a member state has determined probable cause exists that the allegation against the licenses may constitute a violation of that member state's statute or regulations. The actual investigative information can be shared directly with the party state and not through the Commission.[115] If a state does not have an alternative program, then a health condition may be grounds for disciplinary action. Eighteen of the thirty-four member states do not have alternative programs for physical therapists. The failure of any member state of this Compact to have an alternative program supporting wellness for its professionals in 2022 should be cause for concern to Connecticut joining a compact.

DPH estimates the loss of licensure revenue to HAVEN to be $2,400. HAVEN anticipates further loss of revenue resulting from the need to develop two tracks of physical therapist participation and a decline in physical therapy referrals due to the loss of confidentiality and practice opportunities. Although the number of physical therapists participating in HAVEN is approximately one to three per year, HAVEN seeks the same standards of confidentiality and rigorous compliance for all professional disciplines. Establishing different levels of confidentiality undermines the reputation of HAVEN and enhances the likelihood that all professionals, not just physical therapists, will be more reluctant to reach out for support.

21. Key Concerns

The Work Group primarily focused on the benefits of joining the Physical Therapy Interstate Compact, citing the ability to provide telehealth and the ability to meet need during a

[113] See Rule 6.3.
[114] Rule 6.8.
[115] See Rule 6.7

shortage of practitioners on a short-term basis by bringing in practitioners from out of state. The Work Group discussed the impact on participation in HAVEN and determined that protecting the confidentiality of people participating in alternative to discipline was of paramount importance but must be balanced against meeting the needs of patients. Each year between one and three physical therapists participate in HAVEN. Under the Compact rules the Physical Therapy Interstate Compact treats participation in alternative to discipline programs as an encumbrance and would prohibit a physical therapist from participating in the Interstate Compact. However, physical therapists participating in HAVEN would still be able to practice in Connecticut under their Connecticut license and apply to other state licensing boards via the regular process, essentially maintaining the status quo. The Work Group determined that expanding access to quality care for patients should be carefully weighed against protecting access to alternative to discipline programs.

22. Recommendation

Although the Work Group identified several benefits of joining the Physical Therapy Interstate Compact, including streamlining the process for holding licenses in multiple states, improving the State's preparedness for pandemics, emergencies, and other acute staffing needs, and facilitating telehealth, the Work Group also recognized the importance of preserving the ability of physical therapists to participate in HAVEN. As such, the Work Group recommends continued study and discussion of the issue of whether to enter the Physical Therapy Interstate Compact.

IV. APPENDIX A

Statutory Reference:

Sec. 2. (Effective July 1, 2021) (a) The Commissioner of Public Health shall convene working groups to determine whether Connecticut should join any interstate licensure compacts.

(b) Such working groups shall consist of (1) the Commissioner of Public Health, the Secretary of the Office of Policy and Management, and the executive director of the Office of Health Strategy, or their designees; (2) the chair of the appropriate board of examiners or advisory board, or his or her designee; (3) a representative of the appropriate state professional association; (4) a representative of the professional assistance program for regulated professions established pursuant to section 19a-12a of the general statutes; and (5) any other members the Commissioner of Public Health deems appropriate. Each working group shall convene not later than sixty days after the effective date of this section.

(c) Not later than January 15, 2022, the Commissioner of Public Health shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Such report shall include recommendations that reflect the determinations pursuant to subsection (a) of this section. The working groups shall terminate upon the submission of the report. Sec. 3. (Effective July 1, 2021) Not later than January 15, 2022, the Commissioner of Public Health shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of Substitute House Bill No. 6449 Public Act No. 21-152 4 of 9 matters relating to public health. Such report shall be developed in consultation with such boards or commissions as the commissioner deems appropriate and shall recommend whether it would be in the best interest of the state (1) for any examination administered by the state pursuant to chapter 368v, 370, 372, 373, chapters 375 to 388a, inclusive, chapter 393a, 395, chapters 397a to 399, inclusive, chapter 400a, 400c or 474 of the general statutes to be administered by a national organization acceptable to the Department of Public Health, and (2) to reduce any experience and training requirements while increasing any such examination’s ability to test applicants’ knowledge or skills. Sec. 4.

V. APPENDIX B

October 18, 2021 Plenary Interstate Compacts Workgroup Meeting

November 2, 2021 APRN Compact Meeting # 1

November 8, 2021 NLC Compact Meeting # 1

November 9, 2021 IMLC Compact Meeting #1

Wednesday 10, 2021 Physical Therapy Compact Meeting #1

November 16, 2021 PSYPACT Compact Meeting #1

December 1, 2021 IMLC Compact Meeting #2

December 2, 2021 NLC Compact Meeting #2

December 3, 2021 APRN Compact Meeting #2

December 10, 2021 PSYPACT Compact Meeting #2

December 15, 2021 IMLC Compact Meeting #3

December 16, 2021 NLC Compact Meeting #3

December 17, 2021 APRN Compact Meeting #3

December 17, 2021 PT Compact Meeting #2