A Survey of Knowledge and Opinion of the Nurse Licensure Compact among Nurses Licensed in Minnesota

Minnesota Board of Nursing

N C S B N
National Council of State Boards of Nursing

(March 29, 2017)
BACKGROUND

In the late 1990s, the National Council of State Boards of Nursing (NCSBN) developed the Nurse Licensure Compact (NLC), based on the U.S. Driver’s License Compact, to allow for mutual recognition of state licenses and thereby remove a major barrier to nurses practicing across state lines either physically and/or electronically (Hellquist & Spector, 2004). The NLC is an agreement between participating states to mutually recognize each other’s registered nurse (RN) and licensed practical nurse (LPN)/licensed vocational nurse (LVN) licenses. It allows nurses to hold a multistate license and be eligible to practice in the licensing state as well as all other states participating in the NLC, subject to each state’s practice laws and regulations (NCSBN, 2017a). The NLC streamlines nurse mobility and promotes the standardization of nursing practice regulations (Evans, 2015; Litchfield, 2010; Poe, 2008).

Currently, 25 states participate in the NLC. To further increase access to care and increase public protection, NCSBN promoted an enhanced NLC in 2015 (Alexander, 2016; NCSBN, 2015, 2017b). The enhanced NLC necessitates criminal background checks as well as 10 additional uniform licensure requirements. Please see https://www.ncsbn.org/nurse-licensure-compact.htm for more detailed information.

Minnesota is not in the NLC at the time of this study period, however, all four states bordering Minnesota are a part of the Compact (ND, SD, IA and WI; see Figure 1 for all participating states). To address Minnesota nurses’ questions regarding a potential adoption of the NLC, the Minnesota Board of Nursing (MN BON), in collaboration with NCSBN, conducted a web survey of all nurses licensed in Minnesota in February 2017.

Figure 1. Distribution of the NLC States in the United States (March, 2017)

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1 Because advanced practice registered nurses (APRNs) are recognized in a separate Interstate Compact arrangement for the differences in regulations and scope of APRN practice across states, in this document, “nurses” will refer to registered nurses and licensed practical nurses/licensed vocational nurses only.
SURVEY QUESTIONS
1. What do nurses licensed in Minnesota know about the NLC?
2. How do nurses holding an active Compact license (issued by another state) feel about their Compact license?
3. What are the opinions of Minnesota nurses regarding Minnesota joining the NLC?

METHODOLOGY
This was a descriptive online survey of over 120,000 nurses who hold active RN or PN licenses in Minnesota.

Survey Instrument
The survey instrument was developed by the MN BON with input from NCSBN. It comprised 12 questions regarding nurses’ knowledge of and opinions about the NLC, their NLC related work experiences, as well as licensure and practice settings (Appendix A). The survey was designed to be administered via the Qualtrics platform. It was estimated to take less than five minutes to complete.

Study Population
The study subjects are all RNs and PNs who hold an active license in Minnesota and have a valid email addresses registered in the NCSBN Nursys database. According to the Nursys database, at the time this survey was conducted 127,516 nurses held an active RN or PN licenses in Minnesota, 96% of whom registered an email address (N= 122,973). Ninety-eight percent of these email addresses (N=120,640) were valid for the purpose of distributing this survey.

Procedures
An email with the study link was sent to all study subjects on February 21, 2017. Per requests from nurses who did not receive the survey via email invitation, or had trouble completing survey link they originally received, six additional survey links were distributed. One follow-up reminder was sent to non-respondents on February 28. On March 21, 2017 the survey was closed.

Data Analysis
Data was exported from Qualtrics via an Excel file. The file was examined for any errors or inconsistencies and the data was cleaned and coded. Standard descriptive analysis of data was performed using SAS Enterprise Guide 6.1. Additionally, where possible, results from this survey were compared to the Minnesota-specific findings from the 2014 NCSBN National Compact Survey, in which 614 nurses participated.

Confidentiality
The survey did not collect identifiable personal information such as name or social security number of the participants. The email address was the only link to the individual participant. The Western Institutional Review Board granted NCSBN approval of the study (Appendix B).
RESULTS
Over twenty thousand nurses (N=20,834) completed the survey. On the assumption that non-response is random, the maximum margin error for the findings of the survey is less than ±1%.

I. Characteristics of Study Subjects
The majority of the respondents (80%) considered Minnesota their primary residence and were RNs (Table 1). This is the same proportion of RNs as in the entire Minnesota nursing workforce, as reported in the Minnesota annual licensure report in fiscal year 2016 (Minnesota Board of Nursing, 2017). Most respondents (92%) had practiced within the last 24 months and 50% of respondents were direct care nurses. Almost 40% of all respondents reported they provided nursing services across a state border in the last 24 months.

Table 1. Characteristics of Respondents (N=20,834)

<table>
<thead>
<tr>
<th></th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>80% (16,590)</td>
</tr>
<tr>
<td>Out of Minnesota</td>
<td>20% (4,242)</td>
</tr>
<tr>
<td>RN</td>
<td>80% (16,544)</td>
</tr>
<tr>
<td>PN</td>
<td>17% (3,483)</td>
</tr>
<tr>
<td>APRN</td>
<td>8% (1,590)</td>
</tr>
<tr>
<td>Yes</td>
<td>30% (6,352)</td>
</tr>
<tr>
<td>No</td>
<td>70% (14,480)</td>
</tr>
<tr>
<td>Yes</td>
<td>92% (19,072)</td>
</tr>
<tr>
<td>No</td>
<td>7% (1,650)</td>
</tr>
<tr>
<td>Yes</td>
<td>39% (7,980)</td>
</tr>
<tr>
<td>No</td>
<td>61% (12,737)</td>
</tr>
</tbody>
</table>

Primary Practice Settings (N=20,571)

<table>
<thead>
<tr>
<th></th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>38% (7,786)</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>16% (3,236)</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>9% (1,904)</td>
</tr>
<tr>
<td>Home Care/Hospice</td>
<td>7% (1,428)</td>
</tr>
<tr>
<td>Public Health/School Health</td>
<td>5% (1,023)</td>
</tr>
<tr>
<td>Academia</td>
<td>3% (698)</td>
</tr>
<tr>
<td>Other</td>
<td>22% (4,496)</td>
</tr>
</tbody>
</table>

Primary Role (N=20,531)

<table>
<thead>
<tr>
<th></th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Care Nurse</td>
<td>50% (10,269)</td>
</tr>
<tr>
<td>Nurse Administrator/Manager</td>
<td>10% (1,968)</td>
</tr>
<tr>
<td>Case Manager Nurse</td>
<td>8% (1,683)</td>
</tr>
<tr>
<td>Nurse Educator</td>
<td>6% (1,159)</td>
</tr>
<tr>
<td>Telephone Triage Nurse</td>
<td>4% (801)</td>
</tr>
<tr>
<td>Transport Nurse</td>
<td>&lt;1% (47)</td>
</tr>
<tr>
<td>Other</td>
<td>22% (4,604)</td>
</tr>
</tbody>
</table>

*5% of the respondents (n=1,028) reported having multiple licenses, including RN and PN, or RN and APRN licenses.

2 The 95% confidence interval maximum margin of error (MOE) can be calculated with the formula: MOE = (0.98) square root (1/n).
II. Knowledge of the Nurse Licensure Compact

Over 65% of MN nurses surveyed were either “aware” or “fully aware” of NLC (Table 2). This was an increase in awareness from a 2014 NLC survey of MN nurses conducted by NCSBN. The proportion of nurses who reported being “aware” or “fully aware” increased 97%, from 33% to 65% since 2014 (Figure 2).

Table 2. Awareness of the NLC (N=20,832)

<table>
<thead>
<tr>
<th>Awareness Level</th>
<th>n</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Aware</td>
<td>7,348</td>
<td>35.3</td>
</tr>
<tr>
<td>Aware</td>
<td>6,175</td>
<td>29.6</td>
</tr>
<tr>
<td>Not Aware at all</td>
<td>7,309</td>
<td>35.1</td>
</tr>
</tbody>
</table>

Figure 2. MN Nurses’ Awareness of the Nurse Licensure Compact in 2017 and 2014

*The 2014 National NLC Survey did not specify the definition of NLC in the survey.

III. Compact License Usage and Perception of Benefit

Approximately 18% (3,734) of the 20,715 respondents indicated they held a Compact license. Among them, 69% (2,550 out of 3,712) indicated they had practiced under their Compact license in another state/jurisdiction within the past 24 months. Nurses with a Compact license overwhelmingly felt the Compact was of benefit to them (Figure 3). Furthermore, nurses who had practiced under their Compact license within the last 24 months (n=2,550) indicated even stronger support for the Compact: 93% reported it to be beneficial to them.
Figure 3. Perception of Benefit of the NLC by those Holding a Compact License (N=3,686)

IV. Opinions about Minnesota Joining the NLC

Overall, more than 80% of respondents were in favor of Minnesota joining the NLC (Table 3). Compared with the findings from the 2014 NLC survey of MN nurses, the proportion of nurses who expressed their support for joining the NLC almost doubled from 42% to 80% (Figure 4).

Table 3. Nurses’ Opinion about Joining the NLC (N=20,647)

<table>
<thead>
<tr>
<th>In Favor of Joining NLC</th>
<th>N</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>16,585</td>
<td>80.3</td>
</tr>
<tr>
<td>No</td>
<td>960</td>
<td>4.7</td>
</tr>
<tr>
<td>No Opinion</td>
<td>3,102</td>
<td>15.0</td>
</tr>
</tbody>
</table>

Figure 4. Nurses’ Opinions about Minnesota Joining the NLC in 2014 and 2017
We examined opinions about joining the NLC among nurses in different employment setting and with different primary roles (Table 4). The majority of the respondents in all roles were in favor of Minnesota joining the NLC, ranging from 77% of direct care nurses to 88% of nurse educators and administrators/managers. Overwhelming support was also indicated from nurses in various employment settings, from 78% among hospital nurses to 91% support among nurses in academia.

Table 4. Respondents’ Opinions about Minnesota Joining NLC by Primary Employment Settings and Nursing Roles

<table>
<thead>
<tr>
<th>Employment Setting</th>
<th>In Favor of Joining NLC</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No Opinion (%)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td></td>
<td>78% (6,039)</td>
<td>7% (544)</td>
<td>15% (1,203)</td>
<td>7,786</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td></td>
<td>82% (2,657)</td>
<td>2% (78)</td>
<td>15% (501)</td>
<td>3,236</td>
</tr>
<tr>
<td>Long Term Care</td>
<td></td>
<td>83% (1,569)</td>
<td>3% (52)</td>
<td>15% (280)</td>
<td>1,901</td>
</tr>
<tr>
<td>Home Care/Hospice</td>
<td></td>
<td>83% (1,181)</td>
<td>3% (37)</td>
<td>15% (208)</td>
<td>1,426</td>
</tr>
<tr>
<td>Public Health/School Health</td>
<td></td>
<td>80% (821)</td>
<td>4% (41)</td>
<td>15% (161)</td>
<td>1,023</td>
</tr>
<tr>
<td>Academia</td>
<td></td>
<td>91% (638)</td>
<td>2% (17)</td>
<td>6% (43)</td>
<td>698</td>
</tr>
<tr>
<td>Direct Care Nurse</td>
<td></td>
<td>77% (7,907)</td>
<td>6% (608)</td>
<td>17% (1,752)</td>
<td>10,267</td>
</tr>
<tr>
<td>Nurse Administrator/Manager</td>
<td></td>
<td>88% (1,738)</td>
<td>2% (41)</td>
<td>10% (189)</td>
<td>1,968</td>
</tr>
<tr>
<td>Case Manager Nurse</td>
<td></td>
<td>85% (1,436)</td>
<td>3% (42)</td>
<td>12% (204)</td>
<td>1,682</td>
</tr>
<tr>
<td>Nurse Educator</td>
<td></td>
<td>88% (1,024)</td>
<td>4% (44)</td>
<td>8% (91)</td>
<td>1,159</td>
</tr>
<tr>
<td>Telephone Triage Nurse</td>
<td></td>
<td>84% (673)</td>
<td>3% (22)</td>
<td>13% (106)</td>
<td>801</td>
</tr>
<tr>
<td>Transport Nurse</td>
<td></td>
<td>81% (38)</td>
<td>4% (2)</td>
<td>15% (7)</td>
<td>47</td>
</tr>
</tbody>
</table>

The difference in support between hospital nurses and nurses in academia may be a factor of differing levels of awareness of the NLC: 33% of hospital nurses reported they were not at all aware of the NLC, while only 14% of the nurses in academia were not aware of the NLC. When examined separately, there is a statistically significant positive relationship between a nurses’ level of awareness of the NLC and their support for Minnesota joining the NLC ($\chi^2=1,956.4$, df =4, P<.001) (Figure 5).

Figure 5. Association between Respondents’ Awareness of NLC and Their Support for NLC
Further analysis of support for the NLC among sub-groups of respondents indicated a high level of support among all categories (Table 5). The highest level of support (over 90%) was indicated in nurses with primary residency outside of MN, those holding a license outside of MN and those holding a Compact license, and nurses who had recently practiced under their Compact license.

### Table 5. Support for Joining the Compact among Sub-Groups of Respondents

<table>
<thead>
<tr>
<th>Sub-Group</th>
<th>In Favor of Joining NLC</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>No Opinion</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>88% (11,748)</td>
<td>5% (659)</td>
<td>8% (1,016)</td>
<td>13,423</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>67% (4,837)</td>
<td>4% (301)</td>
<td>29% (2,085)</td>
<td>7,223</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>77% (12,721)</td>
<td>5% (892)</td>
<td>17% (2,837)</td>
<td>16,450</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>92% (3,864)</td>
<td>2% (68)</td>
<td>6% (265)</td>
<td>4,197</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81% (15,308)</td>
<td>5% (869)</td>
<td>15% (2,824)</td>
<td>19,001</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>78% (1,276)</td>
<td>6% (91)</td>
<td>17% (278)</td>
<td>1,645</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>88% (6,974)</td>
<td>3% (210)</td>
<td>10% (765)</td>
<td>7,949</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>76% (9,607)</td>
<td>6% (749)</td>
<td>18% (2,337)</td>
<td>12,693</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>92% (5,821)</td>
<td>2% (125)</td>
<td>6% (350)</td>
<td>6,296</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>75% (10,764)</td>
<td>6% (835)</td>
<td>19% (2,752)</td>
<td>14,351</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>94% (3,499)</td>
<td>1% (54)</td>
<td>4% (157)</td>
<td>3,710</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>77% (13,082)</td>
<td>5% (905)</td>
<td>17% (2,943)</td>
<td>16,930</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>97% (2,465)</td>
<td>2% (57)</td>
<td>1% (28)</td>
<td>2,550</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>89% (1,032)</td>
<td>2% (27)</td>
<td>9% (102)</td>
<td>1,161</td>
<td></td>
</tr>
</tbody>
</table>

Comments regarding the Benefits and Challenges of Joining the NLC

The survey asked respondents to provide a rationale for their opposition to Minnesota joining the NLC. A text box was provided for these respondents’ comments. Additionally, respondents sent comments both in opposition to and support for the NLC via email. A summary of comments, from both those in favor and those with concerns is provided below; additional and more detailed comments can be found in Appendix C.

#### Concerns about Minnesota Joining the NLC
- Licensure requirements, work ethics and standards vary across states
- Difficulty tracking nursing practice across state lines
- Increase in license fees,
- Would decrease the power of the union.
- Decrease in benefits and salaries by allowing non-Minnesota nurses to practice in Minnesota.
- No need for a Compact license due to retirement, or having no intention or requirement to practice outside of Minnesota, or do not know enough about the NLC.
Benefits of Minnesota Joining the NLC (These comments were voluntarily offered by respondents)

- Streamlines mobility and reduce barriers to cross-border practice
- Increases access to standardized patient care and safety
- Promotes a cost-effective licensure process
- Facilitates the care of patients who seek treatment in MN but reside across the border

Discussion

We surveyed all nurses with a Minnesota license and over twenty-thousand nurses responded. The vast majority (80%) were in favor of Minnesota joining the NLC, almost double the proportion from a similar survey only three years prior. Less than five percent of respondents were not in favor. Awareness of the NLC also increased substantially from the earlier survey period—from 33% in 2014 to 65% in 2017. There was a strong positive association between knowledge of the NLC and support for the NLC, indicating the more nurses know about the NLC, the more they are in favor of Minnesota joining it.

Nurses in Minnesota are already obtaining and using multistate licenses. Just under 20% hold a Compact license from another state and most report practicing under that license in the last two years. Support from nurses currently using a Compact license was also high (over 90%), indicating that nurses with multistate practice privileges overwhelmingly find it beneficial.

Almost 40% of respondents reported they had provided nursing services to and/or communicated with patients or clients located in a state other than Minnesota. This is more than the number of nurses with a compact license, suggesting that many MN nurses already practice across state borders and would benefit from a multistate license. Over 90% of these nurses indicated they were in favor of MN joining the NLC.

Concerns about MN joining the NLC included fears of higher licensure fees, decreasing pay and benefits for MN nurses, and decreasing standards of patient care licensure requirements. After 18 years of the NLC in the US, there is still no evidence to support those concerns. NCSBN has received letters of support for the NLC from 27 healthcare associations (NCSBN, 2015). Recently, the Minnesota Association of Occupational Health Nurses (MAOHN) announced their continued support for the NLC in both email and phone contacts with NCSBN.

This study relied upon voluntary self-reported data. Due to the study design, nurses who did not have a valid email account nor internet access (approximately 5% of the MN nursing population) were excluded from participation. While certain sample characteristics indicate respondents to this survey were very similar to the overall MN nursing workforce, we did not gather sufficient demographic information, such as gender, age or length of license, to make a detailed comparison.

Conclusion

Over 20,000 Minnesota nurses responded to the survey and the vast majority were in favor of Minnesota joining the NLC. Many nurses in MN already practice with a Compact license and across state borders. Those most experienced with the Compact (those with one already) are strongly in favor of MN joining the Compact. Awareness of the NLC was also found to be strongly related to
support for the NLC. Effective educational outreach will be critical to fully inform nurses, other health care providers and leaders, legislators and the public about the NLC.

References


Appendix A: Survey Instrument

Introduction:
The Nurse Licensure Compact (NLC) allows mutual recognition of a nursing license between states. A nurse who holds a multistate license issued by a state in the NLC can practice in any other NLC state without obtaining another license.

The NLC is a solution to increase access to care and the mobility of nursing services. It facilitates cross-border practice both physically, and electronically, via telehealth and online nursing education. Adoption of the NLC by a state would ultimately serve to improve patient care and safety.

The NLC has been in effect since 1999 and includes 25 states. All states bordering MN (ND, SD, IA, and WI) are in the NLC; Minnesota is not currently a state in the NLC.

The NLC must be enacted by the legislature in a state and it does not supersede existing state labor laws. A nurse must meet uniform licensure requirements to be eligible for a multistate license and adhere to the Nurse Practice Act in the state where the patient is.

The Minnesota Board of Nursing is frequently asked, “Will Minnesota join the NLC?” To better understand your feelings about joining the NLC, please answer the following questions.

Q1. Prior to receiving this survey, were you aware of the Nurse Licensure Compact?
   - Yes, fully aware
   - Somewhat aware
   - Not at all aware

Q2. Is Minnesota your state of primary residence?
   - Yes
   - No

Q3. Other than Minnesota, do you hold an active nursing license in any other state?
   - Yes
   - No

Q4. In the past 24 months, have you been employed in a position that required a nursing license?
   - Yes
   - No
Q5. In the past 24 months, have you provided nursing services and/or communicated with a patient or client who was located in a state other than Minnesota?
- Yes
- No

Q6. Do you currently hold an active multistate license issued by a state in the NLC?
- Yes
- No —> Skip to Question 9

Q7. Have you practiced in another state/jurisdiction under your multistate license in the past 24 months?
- Yes
- No

Q8. Has the Nurse Licensure Compact been beneficial to you?
- Yes
- No

Q9. Would you be in favor of Minnesota joining the Nurse Licensure Compact?
- Yes
- No (please provide reason) ____________________
- No opinion
Q10. What type of license do you currently hold? (Select all that apply.)

- LPN/VN
- RN
- APRN

Q11. What is your primary practice setting?

- Hospital
- Long Term Care
- Ambulatory Care
- Home Care/Hospice
- Public Health/School Health
- Academia
- Other ____________________

Q12. What is your primary role?

- Telephone Triage Nurse
- Transport Nurse
- Case Manager Nurse
- Nurse Administrator/Manager
- Nurse Educator
- Direct Care Nurse
- Other ____________________
Appendix B: Western IRB Approval Letter

THE FOLLOWING WERE APPROVED

INVESTIGATOR: Elizabeth Zhong, PhD
111 E. Wacker Drive, Suite 2900
Chicago, IL 60601, United States

BOARD ACTION DATE: 01/19/2017

STUDY APPROVAL EXPIRES: 01/19/2018

STUDY NUM: 1171616
WIRB PRO NUM: 20170044
ONLINE TRACKING: 11-1876023
INVEST NUM: 285551
WO NUM: 1-9867-61-1
CONTINUING REVIEW: Annually
SITE STATUS REPORTING: Annually

SPONSOR: National Council of State Boards of Nursing

PROTOCOL NUM: None

AMD. PRO. NUM: None

TITLE:
Web Survey of Knowledge and Opinion of the Nurse Licensure Compact among Nurses Licensed in Minnesota

APPROVAL INCLUDES:
Investigator
Protocol
Consent Information Sheet [S0]
Financial Disclosure Form [01-69-2017] Zhong

WIRB APPROVAL IS GRANTED SUBJECT TO:
The Board found that this research meets the requirements for a waiver of documentation of consent under 45 CFR 46.111(9)(2).

The Board requires that all subjects must be able to consent for themselves to be enrolled in this study. This means that you cannot enroll incapable subjects who require enrollment by consent of a legally authorized representative.

WIRB HAS APPROVED THE FOLLOWING LOCATIONS TO BE USED IN THE RESEARCH:
National Council of State Boards of Nursing, 111 E. Wacker Dr, Suite 2906, Chicago, Illinois 60601

If the PI has an obligation to use another IRB for any site listed above and has not submitted a written statement from the other IRB acknowledging WIRB's review of this research, please contact WIRB's Client Services department.

ALL WIRB APPROVED INVESTIGATORS MUST COMPLY WITH THE FOLLOWING:

1. Conduct the research in accordance with the protocol, applicable laws and regulations, and the principles of research ethics as set forth in the Belmont Report.

2. Although a participant is not obliged to give his or her reasons for withdrawing prematurely from the clinical trial, the investigator should make a reasonable effort to ascertain the reason, while fully respecting the participant's rights.

3. Unless consent has been waived, conduct the informed consent process without coercion or undue influence, and provide the potential subject sufficient opportunity to consider whether or not to participate. Due to the unique circumstances of research conducted at international sites outside the United States and Canada, when there is a local IRB and WIRB approved

IF YOU HAVE ANY QUESTIONS, CONTACT WIRB AT 1.800.562.4789

This is to certify that the information contained herein is true and correct as reflected in the records of the Western Institutional Review Board (WIRB), OHF/PEA parent organization number 10R3 600442. IRB registration number R800009653. WE CERTIFY THAT WIRB IS IN FULL COMPLIANCE WITH GOOD CLINICAL PRACTICES AS DEFINED UNDER THE U.S. FOOD AND DRUG ADMINISTRATION (FDA) REGULATIONS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) REGULATIONS, AND THE INTERNATIONAL CONFERENCE ON HARMONISATION (ICH) GUIDELINES.

Board Action: 01/16/2017, Study: 1171616
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Appendix B: Western IRB Approval Letter (Cont’d)

materials are reviewed by the local IRB and translated into the local language, the following requirements regarding consent forms bearing the WIRB approval stamp and regarding certification of translations are not applicable:

a. Use only the most current consent form bearing the WIRB “APPROVED” stamp.
b. Provide non-English speaking subjects with a certified translation of the approved consent form in the subject’s first language. The translation must be approved by WIRB unless other arrangements have been made and approved by WIRB.
c. Obtain pre-approval from WIRB for use of recruitment materials and other materials provided to subjects.

4. Enrollment of limited readers and non-readers: unless consent has been waived or the protocol excludes enrollment of limited readers or non-readers, involve an impartial witness in the consent process when enrolling limited or non-readers and document the participation of the impartial witness using the designated signature lines on the WIRB-approved consent form. In the absence of designated signature lines, download the WIRB standard impartial witness form from www.wrb.com.

5. Enrollment of pregnant partners: that do not have the capacity to consent for themselves and require consent be provided by a legally authorized representative; unless the protocol excludes the enrollment of pregnant partners that do not have capacity to consent for themselves, obtain consent from the pregnant partners legally authorized representative and document consent using the pregnant partner legally authorized representative signature lines on the WIRB-approved consent form. In the absence of designated signature lines, download the WIRB standard legally authorized pregnant partner form from www.wrb.com.

6. Obtain pre-approval from WIRB for changes in research.

7. Obtain pre-approval from WIRB for planned deviations and changes in research activity as follows:
   • If the research is federally funded, conducted under an FWA, or is a clinical investigation of a drug or biologic; then all planned protocol deviations must be submitted to WIRB for review and approval prior to implementation except where necessary to eliminate apparent immediate hazards to the human subjects [(DHHS 45 CFR § 46.103(b)(4); (FDA 21 CFR § 56.108(e)(4); ICH 3.3.7)].
   • However, if the research is a clinical investigation of a device and the research is not federally funded and not conducted under an FWA, then only planned protocol deviations that may adversely affect the rights, safety, welfare or subjects or the integrity of the research data should be submitted to WIRB for review and approval prior to implementation except where necessary to eliminate apparent immediate hazards to the human subjects [(DHHS 45 CFR § 46.103(b)(4); (FDA 21 CFR § 56.108(e)(4); ICH 3.3.7)].

The reason for these different requirements regarding planned protocol deviations is that the Office for Human Research Protections (OHRP) and the Food and Drug Administration (FDA) drug and biologic divisions have adopted the regulatory interpretation that every planned protocol deviation is a change in research that needs prior IRB review and approval before implementation; however, the FDA device division operates under a distinct regulation (See 21 CFR 812.150(e)).

Deviations necessary to eliminate apparent immediate hazards to the human subjects should be reported within 10 days.

8. Report the following information items to the IRB within 5 days:
   a. New or increased risk
   b. Protocol deviation that harmed a subject or placed subject at risk of harm
   c. Protocol deviation made without prior IRB approval to eliminate an immediate hazard to a subject
   d. Audit, inspection, or inquiry by a federal agency
   e. Written reports of federal agencies (e.g. FDA Form 483)
   f. Allegation of Noncompliance or Finding of Noncompliance
   g. Breach of confidentiality
   h. Unresolved subject complaint
   i. Suspension or premature termination by the sponsor, investigator, or institution
   j. Incarceration of a subject in a research study not approved to involve prisoners
   k. Adverse events or IND safety reports that require a change to the protocol or consent
   l. State medical board action
   m. Unanticipated adverse device effect
   n. Information where the sponsor requires prompt reporting to the IRB

Information not listed above does not require prompt reporting to WIRB.

Please go to www.wrb.com for complete definitions and forms for reporting.

9. Provide reports to WIRB concerning the progress of the research, when requested.

Board Action: 01/18/2017, Study: 1171610  
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Appendix C: Selected Comments from Respondents

NCSBN received hundreds of emails and phone calls from Minnesota nurses with additional comments to the survey. The following is a brief list of some comments. To protect the confidentiality of the respondents, sensitive data such as the name of the employing facilities are not included here.

In Favor of Minnesota Joining the NLC

- The policy for the government is if you hold a clear and valid license in any state you can work for them. This makes it very convenient to move and continue to practice nursing in any state as long as you continue to work for the military/VHA. I would hope that not only Minnesota, but all other states would consider the NLC for this reason, if not others. In our very mobile society, this only makes sense to me.

- I currently hold [licenses in] Florida, Arizona, Arkansas and New York, in addition to MN. Because MN is not a compact state, when I applied to Arizona, I am only eligible to work in Arizona - the compact agreements between Arizona, California, and New Mexico are not honored. The same is true for Arkansas. I have to license in every compact state individually, and cannot work in any other compact state. It's time Minnesota "got on the bandwagon".....it's difficult and expensive having to apply everywhere I go. (Honestly, I believe there should be a National Nursing License that covers nurses in ALL states.) Thank you for pursuing compact licensure in Minnesota....

- We were always fortunate to be able to accept any state RN license in both areas as it made recruitment a bit easier. I think mobility for nurses would make it a little easier to at least retain our professional staff. Our profession is still majority female and when couples move for work/promotion reasons it's still usually the guys making the move. How wonderful for our nurses, and our health care systems, if they could more readily search and find employment in their new communities.

- My original state of licensure is Virginia. I keep that license active. Virginia is a Compact State, but because I now live in Minnesota I cannot utilize the Compact State on my Virginia license. I have wanted to do some Per Diem work in Wisconsin which is a Compact State, but I cannot because I
cannot utilize the Compact of my Virginia License. If I want to do that, I have to apply for a Wisconsin license.

-When I first came back to Minnesota I asked my local legislator where Minnesota was with becoming a Compact State. He informed me there is a draft but it has not come up for a vote yet. I am hopeful this survey means Minnesota is now going to become a Compact State. I think it is long overdue. I would support a national nursing license. This would allow for nurses to be more easily mobilized to areas that are in crisis.

-I have been tracking this issue for years as a past telephonic nurse. The enhancements mitigate most of the previous concerns voiced by non-participating states. I hope to see some momentum and hope the Minnesota RN perceptions surrounding the compact engage Minnesota's participation by bringing it forward to our legislature.

-I was initially licensed in Colorado which was a compact state and that program is amazing. I simply can't believe states including Minnesota haven't jumped at this opportunity sooner. As a pediatric home care nurse supervisor, I often work with other states who require our nurses to be licensed in their state when they are traveling with one of our home care patients. A few years back, one of our patients took a trip from Minnesota to California by train and we had to get the nurses licensed in every state between Minnesota and California so they could travel with her. I really hope this becomes a reality—often times I think nurses outside of the hospital setting aren't thought about when it comes to policy changes.

-As a clinical informatics analyst, I travel to different healthcare organizations throughout the country, designing content for electronic medical records. I use my nursing skills and experience to do this. Not having a license in the states that I travel to do this work, puts me at a disadvantage. For instance, I have been asked multiple times to help with transferring patient data from an existing electronic medical record, to one that is going to be activated. I can't. I'm not licensed in any state except Minnesota. I'm qualified, but not licensed. As nursing roles become more diverse, and move away from the bedside, it's important to have a license to practice wherever our jobs take us.

-I don't travel outside of my home state of WI, but in my job we handle calls from all over the US, so I answered yes to that. Since Obamacare regulations, we now have to be licensed in every state the person calls in from. So I require multiple licenses. Each state has its own requirements and it gets ridiculous. The public isn't any safer now that I have 10 licenses and the NLC state for 25 more. It gets crazy trying to gain them all and renew them all.

-For a number of years, I was licensed in both Wisconsin and Minnesota, with Minnesota as my state of residence. Every two years I had to pay a fee to both states to maintain my licensure and if this new situation is passed, I would presume that would stop the separate update fee for the secondary state or states. I hope that is the case as it does become expensive. I still maintain my Minnesota license and have worked as an RN for 33 years now. I will retire sometime this year and maybe just be on-call for the one case I have had for over 3 years now. I hope Minnesota does adopt this new idea as it would make things so much easier for those of us who find we can work in more than one state.
Not In Favor of Minnesota Joining NLC

-My first thought was that the standards of care across states is not the same. I do believe that MN standards of care are higher than our surrounding states. Does this make a difference? I think it does. Secondarily, I believe nurses are treated differently across different care settings even here in MN....hospitals versus clinics versus nursing homes versus the Veteran's hospitals. Which makes me question salaries versus benefits. I do wonder if these are the same across states which I am sure they are not. All of the above, is not to say that the idea of NLC is right or wrong. My thoughts are just that....food for thought.

-1. Joining the compact could increase the fees for current MN licensed nurses, as MBON would lose the revenue they currently receive from licensing nurses from other states. 2. Joining would eliminate the MBON's ability to know whether nurses from other compact states are practicing in MN. 3. Nurses from compact states would not be required to abide by MN's CEU standards in the same way that MN licensed nurses are. 4. The MBON would be unable to take disciplinary action against a compact nurse, irrespective of the impact on patient safety, as the disciplinary action can only be taken by the nurse’s home state. 5. If MN were to become a compact state, the MN legislature and the MBON would lose their ability to regulate changes for nurses practicing in MN under the compact because only the national compact administrators are able to approve changes.

-National licensure is too broad, and the changes needed would be difficult and costly and a multistate compact puts a great deal of responsibility on the individual nurse to know each state's NPA. If a nurse is accused of any negligent act, it is unclear which state has the jurisdiction to prosecute and the nurse may be tried in two states, requiring two attorneys, which could be quite costly. The lack of clarity of standards and regulations with a multistate compact makes me believe the best practice at the present time is state regulated licensure.

-Decreases the advantage of nurses in state legislation surrounding nursing care practice and ethics. Decreases union power and state economic since the salaries will be spent in different state rather than locally.

-Puts patients at risk due to differing qualifications and levels of competency in other states. Also puts union nurses at risk as it would facilitate filling nurse positions with out of state nurses during a strike thereby favoring the health care organization whom most the nurses are striking against.

-Our fees would increase. It would take our Union paying jobs away and decrease the higher level of care we give our patients. The Minnesota Board of Nursing would lose their ability to regulate and change for Nurses practicing in Minnesota. It would take away the BON ability to discipline, the compact has no one actually following and would allow nurses without licenses to get into the state and practice before anyone found out where they were. I will do everything in my power to stop this, I will be back at the Capital and fight this all the way. Preserve the Minnesota Registered Nurses' dignity and respect they have earned and leave the compact out.

-The NLC is one of the most reprehensible care models that nurses face in their practice here in MN. As a nurse who just lost work time during a strike due in no small part to strike breakers, I am totally against the NLC. In addition, we heard continually while we were out that the care provided was quite substandard! I can't think of one nurse that I know who thinks this is a good idea unless
they are managers. Regardless of the results of this survey, I will fight against this at the MN legislature! Any bedside nurse or direct care nurse who is for this is sadly misinformed.

-Entering the compact will negatively impact the quality of nurses employed in the state of MN. I take a great deal of pride in the high standards required for nurses here in MN. Our Nurse Practice Act, our high standards are best for the patients in MN. Our BON provides guidance and oversight over the honorable profession: nursing. Our citizens may not know that but our high standards ensure their safety and that is something that I take very seriously. In addition to the BON, the MNA is a strong partner both as a professional association and as a labor union that fights for continued high industry standards. Compact states begins the slippery slope to RTW and I am totally against that. As an active citizen I am always fighting against the compact and RTW at our state legislature and will continue to do so. I need to know that anytime I am at work the nurse working next to me is practicing at the same high standards that I am expected to meet. NLC MUST NOT HAPPEN IN OUR STATE.!!!

-I feel it could put our MN patients at risk (due to the lack of continuing ed requirements in other states) and be used as a union-busting mechanism! I am FIRMLY opposed!

-Right now I do not have enough information to make an educated answer on this question. I would need to do more research regarding the Pros and Cons.