SECOND
REPORT FROM THE HEALTH CARE PRACTICE TASKFORCE TO THE STATE ALLIANCE FOR E-HEALTH

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LETTER FROM THE TASKFORCE CO-CHAIRS

Dear Members of the State Alliance,

Since the last meeting of the State Alliance, the Taskforce has continued to examine licensure and issues that create barriers to an interoperable electronic health information exchange (eHIE). In response to our charge to identify and address issues pertaining to the regulatory, legal, and professional standards that have an impact on the practice of medicine, the Taskforce puts forth the following recommendations for your consideration:

Recommendation 1.3:
The State Alliance should recommend that each health care professional board (e.g., nursing, medicine, pharmacy) develop, with its counterparts in other states, a nationwide core set of credentialing requirements that their respective health professionals would have to meet in order to obtain a license. Individual states may include state specific requirements in addition to the core requirements.

Recommendation 1.4:
In order to reduce and/or eliminate the need for repeated primary source verification, the State Alliance for e-Health should recommend the governors require their medical, pharmacy, and nursing regulatory boards utilize a single centrally coordinated credentials verification organization (CVO) for each profession to conduct the primary source one-time only verification of license applicants' static credentials (e.g. professional school graduation) and update and maintain the verification of dynamic credentials (e.g. licensure status). These centrally coordinated CVOs should collect and verify a core set of credentials established by each profession (see recommendation 1.3). They should have a means of identifying practitioners with a high degree of confidence such as requiring the use of the national provider identification number or using such functionality as a master provider index algorithm.

The Federation's Credentials Verification Service (FCVS) and its trusted agent platform, operated by the Federation of State Medical Boards (FSMB), is an example of a service that could assume this role for the boards of medicine. The pharmacy and nursing boards should work with their professional organizations, certification organizations, or other similar organizations with a mission to facilitate public protection to develop and implement centrally coordinated CVOs for their professions.

Recommendation 1.5:
The State Alliance should recommend that all state boards require that applicants for initial professional state licensure must undergo state and federal criminal background checks prior to obtaining a license. These background checks may be conducted periodically thereafter.

Recommendation 1.6:
The State Alliance should recommend that all Health Care Practice Taskforce recommendations, as applicable, be used as a model for other licensed health care professionals, (e.g. physical therapists) contingent upon verification that there are no unique requirements applicable to those professions.

We present the following report for your consideration and look forward to speaking with you at the meeting of the State Alliance on e-Health.

Sincerely,

Dr. Darleen Bartz
and
Thelma McClosky Armstrong

Health Care Practice Taskforce Co-Chairs

REPORT FROM THE HEALTH CARE PRACTICE TASKFORCE TO THE STATE ALLIANCE FOR E-HEALTH

I. Introduction

The following is the second report from the Health Care Practice Taskforce to State Alliance for e-Health. This report is intended to provide a detailed summation of the research and discussions conducted by the Taskforce in the development of its findings and recommendations on streamlining the licensure process for healthcare professionals. The report also highlights the Taskforce's next steps in developing recommendations related to its charge.

The Health Care Practice Taskforce is charged by the State Alliance for e-Health with identifying and addressing issues pertaining to "the regulatory, legal, and professional standards that have an impact on the practice of medicine and create barriers to interoperable, electronic health information exchange (eHIE)."[1] In addition to supporting the State Alliance on these issues, the charge specifically requires that the Practice Taskforce:

> "Develop and advance actionable policy statements, resolutions, and recommendations for referral to the State Alliance to inform their decision-making process in addressing state-level issues related to best practices and the harmonization of regulatory, legal, technical, and professional standards that have an impact on the practice of medicine in interoperable, eHIE."[2]

The practice of medicine[i] in an electronic health information exchange (eHIE) context means using information technology (IT) systems to record and store health data and exchange information electronically. It is widely believed that the use of health IT and eHIE will enhance the efficiency, effectiveness, and quality of the health care delivery system and lead to improvements in health outcomes.

Patients are increasingly receiving cross-state consultation from healthcare providers. As technology and procedures advance, consumers are seeking care and treatment from specialists who are licensed in another state, and do not practice in their state of residence, to provide direct consultation. A more technology savvy healthcare consumer market is also increasing the demand for Internet and e-mail consultative services. The Taskforce recognized that in order to facilitate e-Health in this current context, it would be necessary to develop recommendations that encompass the entire practice of e-health in ways that extend beyond just telemedicine.

The provision of e-Health services encompasses cross-state consultation via e-mail and telephone, as well as the remote delivery of health services. A problem that resonated throughout each taskforce meeting was how the current licensure process is often a barrier to health care professionals who want to obtain multiple licenses. Streamlining the licensure process in ways that would allow healthcare professionals to satisfy the demand for cross-state consultation was identified by the Taskforce as an essential way to facilitate the practice of medicine across state lines.

[i] The use of the word "medicine" in this context does not solely apply to the work of physicians, but also encompasses the practices of other healthcare professionals such as nurses and pharmacists.

Two barriers around which the Taskforce first developed recommendations were the lack of uniformity in licensure requirements and the methods which state boards accept licensure applications. The Taskforce heard information about the challenges that many states boards were facing in expediting their licensure process. Although most professional state boards have common licensure requirements (such as information on training and certification), health care professionals are often reluctant to apply for a license in another state because of the variance in licensure requirements from state to state and the lengthy timeframes associated with obtaining a license. Expert testimony to the Taskforce indicated that the process for obtaining a licensure can take up to one year. As a result, health care professionals that wish to engage in e-health activities across state lines are often deterred from obtaining multiple state professional licenses.

At the February and April meetings of the Health Care Practice Taskforce, Taskforce members received presentations from a representative of a telehealth network and representatives from state medical boards each indicating the need for a more streamlined licensure process to support e-health activities across state lines. Taskforce members learned that some medical boards are attempting to address these challenges by implementing online licensure applications and common licensure applications. For example, North Carolina implemented an online licensure application and found that it not only reduced the timeframes for obtaining a license, but also reduced administrative errors. Similarly common licensure application forms have led to efficiencies in the licensure process and have been found to reduce the number of incomplete applications received by state medical boards, allow for the collection of uniform information, and add convenience for physicians applying for licensure in multiple states.

Recognizing the efficiency provided by online licensure applications and the promise that it holds for common licensure applications, the Health Care Practice Taskforce proposed two recommendations on streamlining the licensure process to the State Alliance for e-Health.

On August 15th 2007, the State Alliance adopted two recommendations from the Health Care Practice Taskforce:

> **Recommendation 1.1**: The State Alliance for e-Health should recommend that state medical, nursing, and pharmacy boards work to implement online licensure applications.
>
> **Recommendation 1.2:** The State Alliance for e-Health should recommend that all state nursing and pharmacy boards develop common core licensure application forms, and state medical boards adopt the [Federation of State Medical Board's] Common Licensure Application Form (CLAF). Individual states may include state specific requirements.

These recommendations address the two key barriers in streamlining the licensure process:

1) The onerous, paper-based process of submitting a licensure application; and

2) The variation of licensure application *forms* across states.

The adopted recommendations were supported by the *First Report from the Health Care Practice Taskforce to the State Alliance for e-Health*. The report detailed the findings of the Taskforce with respect to the current state of the licensure process and the rationale behind the preceding recommendations. The Health Care Practice Taskforce also noted the vital role that state boards play in the licensure process and stressed the importance of continued state autonomy, but emphasized the need for uniformity of procedures and electronic implementation of those procedures whenever possible.

The deliberations and testimony heard by the Taskforce members on ways to streamline the licensure process led them to the identification of additional barriers. These barriers are:

1) The lack of a uniform set of core credentials needed by the state boards to issue a license to a healthcare professional.

2) The process by which healthcare professionals are credentialed.

3) The variations in requirements for criminal background checks for licensure applicants.

4) A lack of uniformity in the processes that states use to conduct criminal background checks.

The current credential verification method is a very time-consuming, paper-based process for states boards that contributes to the reluctance of healthcare professionals to apply for multiple licenses. As previously stated in the first Taskforce report to the State Alliance, a reduction in the length of time required for obtaining a license would increase the number of healthcare professionals who were willing to apply for multiple licenses and thus facilitate cross-state consultation via electronic means and the remote delivery of healthcare services. The Taskforce believes that state boards can reduce these timeframes by establishing a centrally coordinated credentials verification organization for each profession to conduct the primary source verification of applicants' credentials. In order to facilitate the collection of credentialing data for this system and ensure the portability of these credentials, state boards should collaborate to develop a nationwide core set of credentialing requirements that their respective health professionals would have to meet in order to obtain a license.

Whereas variations in the credentialing process inhibit healthcare professionals' pursuit of multiple licenses, the variations in criminal background check requirements increase the reluctance of state boards to recognize professional licenses issued by other states. Since state licensing boards serve as the front line of protection for the millions of people who receive medical care, it is the duty of the boards to determine if any of the individuals applying for licensure pose as a risk to the public. The variations in states' criminal background check requirements are often cited by the state boards as a primary reason for their reluctance to enter into reciprocal licensing agreements and mutual licensure recognition compacts with other state boards. The Taskforce believes that the implementation of uniform criminal background check requirements would increase the level of trust among state professional boards and facilitate greater licensure portability.

The Taskforce chose to initially focus its recommendations on three particular health care professions: physicians, pharmacists, and nurses. However, the Taskforce believes that its recommendations pertaining to licensure have the potential to positively impact the licensure processes of other health care professionals, in addition to those mentioned in its reports. To that end, the Taskforce believe that the licensure-related recommendations may be utilized by other healthcare professions (e.g., physical therapists, psychologists), contingent upon verification that there are no unique requirements applicable to those professions.

II. Findings on Centralized Credentialing Verification Systems

A. The Current State of Credentialing Verification

The Taskforce has identified credentialing verification as an area upon which it should focus based upon previous testimony from experts about (1) state-by-state variations in the credentials required for professionals to obtain a license, (2) the amount of credentialing paperwork involved in processing an initial licensure application, and (3) the length of time necessary to verify basic background information of an applicant.

In order to credential healthcare professionals in the United States, state licensure boards, managed care entities, and many other organizations must verify basic background information of an applicant, including graduation from an accredited professional school, satisfactory completion of post-graduate education, and certification. Although the Taskforce is aware of the considerable variation among healthcare providers, such as hospitals, with respect to the criteria used to privilege healthcare professionals to perform certain procedures, or care for a defined spectrum of patients, the Taskforce decided to focus its attention on the issue of credentialing as it pertains to verification of basic background information for licensure applicants.

The portability of healthcare professional credentials is dependent upon the state boards' assurance that:

- Primary source verification of the credentials has been conducted.
- The verified documents are securely maintained.
- The credentials verification process is consistent across different state jurisdictions.

In order to facilitate the collection of credentialing data for primary source verification and ensure the portability of these credentials, state boards also will need to collaborate to develop a nationwide core set of credentialing requirements that their respective health professionals would have to meet in order to obtain a license.

The Taskforce was very interested in learning about the ways in which the current credentialing process creates barriers to healthcare providers in obtaining cross-state licenses. The Taskforce also wanted to hear expert opinions on states' willingness to adopt a centralized credentialing verification system. To that end, the Taskforce heard testimony from Bruce McIntyre, General Counsel of the Rhode Island Board of Medical Licensure and Discipline, and Kate Nosbisch, the Deputy Executive Director of Practitioner Information in the Virginia Board of Medicine.

i. Problems Associated With the Current System

The current paper-based process by which healthcare professionals' credentials are verified for initial licensure results in delays, errors, and many redundancies.

The length of time between the date on which a signed application for licensure is received by a state board and the date on which a licensure decision is reached is often increased by the inefficient credentials verification process. The Taskforce heard testimony that healthcare professionals who want to shorten the length of time it takes to obtain a license often have to personally contacting and following up with the professional schools, training programs, and appropriate hospitals to motivate these institutions to verify credentials more expeditiously. The

time required to verify the credentials of professionals applying for licenses also remains a critical element in creating differences in the application process between international and domestic medical graduates.

There are also instances in which errors in processing requests for credentialing may occur. "These errors occur most frequently for [applicants] with similar names or changes in marital status. Even one [discrepancy] in confirmation of an applicant's history will stop the process. In states where the Credentials Committee meets infrequently, this may represent a significant delay." [3]

ii. States' Willingness to Collaborate on Credentialing

The Taskforce discussed options for the future of licensure, mainly related to online credentialing, and reviewed past and current federal activities designed to improve the portability of credentialing. The Taskforce heard that due to advances in technology the willingness of states to collaborate on credentialing systems has increased. There have been previous attempts to create a centralized credentials verification organization that were met with resistance from the states.

In the 1990s, the American Medical Association (AMA) decided to phase out its National Credentialing Verification System based on its determination that the resources needed to maintain the system meant developing a larger subscription base or increasing current members' fees met subscriber needs, none of which the AMA could sustain. The reasons offered by the other states for not using the AMA's service fell into three broad categories: cost, perceived system limitations, and statutory or regulatory constraints.[4]

With recent technological advancements of credentialing verification systems have reduced limitations in data collection methods and the costs associated with implementation of centralized credentials verification organizations, states are more willing to collaborate on credentialing issues. The Taskforce heard testimony that state boards are increasingly recognizing that a centralized credentialing verification organization is a valuable tool in achieving uniformity in the licensure process without compromising the boards' control over the details of the credentialing process and requirements to obtain a license.

B. The Federation Credentials Verification Service

An example of a centralized credentials verification system currently being used by several states is the Federation Credentials Verification Service (FCVS). FCVS was established by the Federation of State Medical Boards (FSMB) in 1996 to provide a centralized, uniform process for state medical boards to collect a verified primary source record of a physician's medical education, postgraduate training, examination history, board action history, board certification and identity. This repository of information allows a physician to establish a confidential, lifetime professional portfolio can be forwarded to other medical boards. [5]

Kate Nosbisch reviewed the key advancements in credentialing portability and testified that FCVS is beneficial because it reduces the workload for the credentialing staff and decreases duplication in the verification process. At least twelve states require FCVS, an additional 35 states accept FCVS, and 3 states do not accept FCVS. Arkansas already has its own credentials verification system and feels that adopting FCVS would be redundant and would take valuable

funds away from its state board. Other states have also identified several challenges in implementing FCVS.

The identified challenges facing FCVS include verification delays caused by incomplete and inaccurate information submitted by applicants and discrepancies in the provided information. FCVS applications may only be 5-10% complete and accurate due to oversights and errors made by both applicants and licensure boards. A possible explanation for this phenomenon is that the application asks for a large amount of information. In order to alleviate some of these challenges, FSMB aims to integrate FCVS with the Common Licensure Application (CLAF) to encourage states to adopt a centrally coordinated credentials verification organization (CVO). A centrally coordinated credentials verification organization would be the entity charged with collecting and verifying the information contained within the system database.

The Federation of State Medical Boards, in collaboration with the National Board of Medical Examiners Center for Innovation, established a multi-state pilot project to facilitate its implementation of the FCVS. The architecture of this project utilizes a secure agent platform system (called the Trusted Agent Platform) that can be queried by the state boards to verify the credentials of licensure applicants. Queries made to the Trusted Agent Platform result in real-time verification of licensing examination scores and any other data that is placed into the system. The objective of this project is to provide an infrastructure to support real-time data sharing across state lines, as well as across organizations, and to reduce redundancy and expense in the credentialing process. States such as Kentucky, New Hampshire, and Ohio are scheduled to begin implementation of this project by scanning applicants credentialing documents in November. The Taskforce anticipates that the results generated by the implementation of this project will further support its recommendations on a centralized credentialing verification organization.

Although the focus of the testimony heard by the Taskforce pertained to physician credentialing, the Taskforce believes that the information presented could potentially relate to other healthcare professionals, such as nurses and pharmacists, who have similar requirements for credentialing.

The Health Care Practice Taskforce proposes the following recommendations to State Alliance:

Recommendation 1.3: The State Alliance for e-Health should recommend that each health care professional board (e.g., nursing, medicine, pharmacy) develop, with its counterparts in other states, a nationwide core set of credentialing requirements that their respective health professionals would have to meet in order to obtain a license. Individual states may include state specific requirements in addition to the core requirements.

Recommendation 1.4: In order to reduce and/or eliminate the need for repeated primary source verification, the State Alliance for e-Health should recommend the governors require their medical, pharmacy, and nursing regulatory boards utilize a single centrally coordinated credentials verification organization (CVO) for each profession to conduct the primary source one-time only verification of license applicants' static credentials (e.g. professional school graduation) and update and maintain the verification of dynamic credentials (e.g. licensure status). These centrally coordinated CVOs should collect and verify a core set of credentials established by each profession (see recommendation 1.3). They should have a means of identifying practitioners with a high degree of confidence such as requiring the use of the national provider identification number or using such functionality as a master provider index algorithm.

The Federation's Credentials Verification Service (FCVS) and its trusted agent platform, operated by the Federation of State Medical Boards (FSMB), is an example of a service that could assume this role for the boards of medicine. The pharmacy and nursing boards should work with their professional organizations, certification organizations, or other similar organizations with a mission to facilitate public protection to develop and implement centrally coordinated CVOs for their professions.

A. Considerations for Implementation

To coordinate the collection and verification of licensure requirements, the Taskforce believes that the establishment of a centrally coordinated credentials verification organization is essential. A centralized credentialing system will result in time savings to boards in the verification of credentials for initial licensure of health care professionals. The system recommended by the Taskforce will not only serve as a means to increase efficiency of the initial licensure process for new applicants, but will also serve to facilitate the licensure of healthcare professionals for the purposes of natural disasters, state emergencies, and other necessities. Centrally coordinated verification organizations (CVOs) also have the potential to be accessed by employing health care facilities to aid in the privileging process. However, before such an organization can be established, the various state boards will have to agree upon a nationwide core set of credentialing requirements.

The Taskforce strongly believes in the need for state boards to retain local control over the licensure process, therefore the Taskforce chose to use the word "nationwide" as opposed to "national" to avoid the implication of federal intervention or control. Related to this need for local control, the Taskforce also chose to us the term "centrally coordinated" as opposed to "single" or "national." This means the use of state-based centralized verification services that are coordinated by nationally by a central verification organization developed by each health care profession, as opposed to using a single repository. It is possible that states may individually maintain central repositories within their states that can be coordinated centrally by the professional board associations such as the Federation of State Medical Boards, The National Council of State Nursing Boards, and the National Association of Boards of Pharmacy. Additionally, the Taskforce also believes that there should be local responsibility to update credentials and local accountability for information that can be centrally accessed via master provider index.

III. Recommendation on Criminal Background Checks

In keeping with the historical and Constitutional role of the states in regulating activities affecting the health, safety and welfare of their citizens, the state licensing boards serve as the front line of protection for the millions of people who receive medical care. In addition to determining whether or not a physician, nurse, or pharmacist meets the minimum necessary qualifications to practice in the given profession, it is also the duty of the boards to determine which individuals who are applying for licensure pose a risk to the public.

The Health Care Practice Taskforce recognizes that the lack of uniform requirements for criminal background checks among healthcare professions has been cited by various experts as a reason for why many state boards are reluctant to recognize a license issued by another state, and as reason for why many states are reluctant to enter into an interstate compact that would allow for mutual recognition of licenses issued by another state.[6]

The Health Care Practice Taskforce finds it critical that all state nursing, pharmacy, and physician licensure boards require both state and federal criminal background checks as part of their evaluation process, but ultimately the individual state boards will need to determine whether applicants may be eligible for a permit to practice pending receipt of the criminal background check results. The Taskforce recognizes that a state board will need to make a number of policy decisions prior to seeking statutory authority for implementing a criminal background program. If a state board does not currently have statutory authority to conduct a criminal background check, a comprehensive communication strategy will be necessary to obtain legislative support and inform policy makers of the necessity of these background checks. The Taskforce sees the recommendations process of the State Alliance as an opportunity to communicate with such key stakeholders.

The Taskforce found that even among the state boards that do require criminal background checks there is a wide degree of variation in these requirements. Some boards require state background checks, but not federal. Some boards require the use biometrics (such as fingerprint submission), while others do not. This lack of uniformity in criminal background check (CBC) procedure for all health professions was identified by the Taskforce as a major impediment to streamlining the licensure process. The Taskforce heard in expert testimony that states boards were often reluctant to enter into licensure compacts and reciprocity arrangements with states that forego criminal background checks or that have requirements for applicants to be of "good moral character" but do not include an extensive review of criminal background as part of this requirement.[7]

At the Health Care Practice Taskforce meeting held on August 30th of this year it was suggested by the members that, prior to finalizing their recommendation on this topic, additional research related to the development of a consistent interpretation of criminal background checks to be utilized by all state boards would need to be conducted. The Taskforce members felt that in order to adopt a recommendation they needed clearly identified information about what state boards consider when rendering a healthcare professional unfit to be granted a license. Following this request for additional information, the National Governors Association Center for Best Practices conducted a review of the current state of criminal background checks for licensed practical nurses and registered nurses (LVNs and RNs), pharmacists, and physicians (MDs and DOs).

A. The Current State of Criminal Background Checks

i. Nurses

A total of 31 states have federal criminal background check requirements for Registered Nurse (RN) and Licensed Practical/Vocational Nurse (LPN/LVN) applicants. States that have conditional criminal background check requirements require that applicants for nurse licensure self disclose criminal convictions, and in states such as Alabama criminal background checks are conducted only for licensees under investigation. Seven states have conditional CBCs that are required only when an applicant reports a criminal history in response to an application question. As of the date of this report, four states are awaiting implementation of criminal background check legislation passed in 2006, or early 2007, and two states (Kansas and South Carolina) introduced legislation in 2007.

The National Council of State Boards of Nursing (NCSBN) recommends state and federal criminal background checks be completed for all applicants for nursing licensure. NCSBN further recommends that conviction of certain offenses result in a permanent bar or time-limited bar to licensure, while other criminal behavior should be evaluated on a case-by-case basis.[8]

NCSBN also suggested that state boards develop a plan for the evaluation of the process and the outcomes of these criminal background checks. In its report, NCSBN identified several pertinent issues that state boards will have to consider in implementing a criminal background check process for it applicants, such as:

- Increased staff workload.
- The security of stored CBC information.
- The revision of application forms.
- The revision of database systems.
- The impact on other board operations (e.g., lengthening time required for making licensure decisions).
- Planning for the financial aspect of requiring CBC
    - Including operational cost for state boards and costs to applicants associated with obtaining their fingerprints and obtaining the criminal background check.

ii. Pharmacists

Similar to state nursing and medical boards, there is a wide degree of variation between state pharmacy boards with respect to criminal background check requirements. The majority of state boards of pharmacy focus their background checks on the candidates' criminal convictions and drug history.[9]

The National Association of Boards of Pharmacy (NABP) does not currently track the criminal background check policies of state boards of pharmacy. For purposes of this report, information on pharmacy boards' criminal background check requirements was based upon a survey conducted by the American Association of Colleges of Pharmacy (AACP), a national organization representing the interests of pharmacy education and educators. Ten state boards of pharmacy reported to AACP in September 2006 that they require candidates to complete a criminal background check as part of the licensure application process: Arkansas, California, Mississippi, Missouri, New Jersey, Oregon, Texas, Utah, Washington, and Wyoming. Thirty-six states do not currently require a criminal background check and 4 states did not respond to the survey. Several of the states that do not currently have a criminal background check policy in place indicated they may require criminal background checks in the future.[10]

> "Selected state boards may require pharmacists to undergo criminal background check once licensure is granted. Seven states (Nevada, Oklahoma, South Carolina, West Virginia, Wisconsin, Wyoming, and Texas) require a criminal background check during the renewal process or if an offense is noted. Four states (Colorado, Michigan, North Dakota, and Oregon) request background checks of licensed pharmacists on a random basis or at the request of the employer."[11]

State boards of pharmacy review and evaluate criminal records and self-reported offenses differently. Some states review offenses on a case-by-case basis. Other state boards have published explicit criteria regarding who is eligible to practice pharmacy. In Arkansas, a licensure applicant who has a criminal conviction may seek to have the conviction waived and

application approved at which time the state board may consider relevant data such as references, age at the time of the offense, etc.[12]

There have been some efforts taken toward standardizing background check information among pharmacists. NABP developed Model State Pharmacy Act Model Rules that specify requirements for initial licensure of pharmacist. Article III of the Model Rules requires the applicant to "be of good moral character," and they allow the board to refuse to issue, revoke, or suspend the license of someone guilty of a felony. However, the Model Rules do not address the use of a criminal background checks.

iii. Physicians

Requirements for criminal background checks for physicians (MDs and DOs) also vary from state to state. In Washington State, efforts to implement criminal background checks for physicians failed to pass in the state legislature in 2007.[13] Twenty-nine states give their licensure board authority to run a criminal background check as a condition of licensure, although these states do vary with respect to whether this background check is federal, state, or both. In states that do require federal background checks only 24 of those states grant their state board access the National Crime Information Center (NCIC) FBI database, with Maine requiring that this check be run through the Office of the State Attorney General.

States also vary in their use of biometrics data in criminal background checks. Currently, only 23 states require the submission of fingerprint data for applicants seeking physician licensure, although some states such as Virginia require only a thumbprint and other state, such as Oklahoma require fingerprints for MDs and not for DOs. If a state board does wish to implement the use of biometrics into its CBC procedure, it would be necessary for the board to determine what state agency has access to and maintains fingerprint data that will serve as the conduit for transmitting fingerprints to the FBI and criminal record histories to the Board.

iv. Recommendation

Recognizing the vital role that uniformity in CBC requirements will play in streamlining the licensure process for healthcare professionals seeking to practice in multiple states, the Health Care Practice Taskforce advances the following recommendation to the State Alliance**:**

> **Recommendation 1.5**: The State Alliance should recommend that all state boards require that applicants for initial professional state licensure must undergo state and federal criminal background checks prior to obtaining a license. These background checks may be conducted periodically thereafter.

IV. Other healthcare professional organizations

Recognizing the potential for its research, discussions and recommendations to impact healthcare professions other than those specifically addressed in its reports, the Taskforce developed a recommendation on advancing the concept that all recommendations it proposes to the State Alliance be applied to other licensed health care professionals. The Taskforce understands the unique conditions and challenges facing various licensed health care professionals, therefore its recommendations should only be extended to other professionals where applicable.

Recommendation 1.6: The State Alliance should recommend that all Health Care Practice Taskforce recommendations, as applicable, be used as a model for other licensed healthcare professionals, (e.g. physical therapists) contingent upon verification that there are no unique requirements applicable to those professions.

IV. Discussion on Licensure Models and Next Steps

The Health Care Practice Taskforce has explored various licensure models in great detail over the past eight months. To further its understanding of the various methods that may be used to facilitate the licensure of healthcare professionals that wish to practice across state lines, the Taskforce arranged for the Center for Telehealth and e-Health Law (CTeL) to draft a detailed report on the current state of licensure in the United States and to review the benefits and drawbacks of various licensure models. The findings of CTeL were incorporated into this section of the report and used to provide a framework for the Taskforce's discussion and future recommendation development.

Limited License or Special Purpose License

In addition to state-by-state variations in requirements to obtain a healthcare professional license, there are also variations with respect to the types of licenses required to practice medicine. Some states explicitly address telemedicine in their state licensing laws and define the practice of telemedicine. However, other states use language such as "by any means or instrumentality" and do not specifically address healthcare practice by an electronic means.[14] Additionally, 17 states do not directly or indirectly address telemedicine in their state licensing statues or regulations.[15] According to the Office for the Advancement of Telehealth, for states that do not directly or indirectly address telemedicine in their licensing laws, it is generally assumed that any act of diagnosing or recommending treatment is the practice of medicine whether it is accomplished in the physical presence of the patient of through electronic media. Therefore, in the absence of special telemedicine licensure requirement, all state boards would likely require a physician to obtain a full license to practice medicine before allowing the physician to provide telemedicine services to a patient located in their state.[16] Due to time-consuming process of applying for a license to practice in each state in which the telemedicine practice would reach, this lack of consistency in defining the practice of medicine presents a significant barrier to any multi-state telemedicine program.[17]

In 2000, The Federation of State Medical Boards (FSMB) established a committee to evaluate the issues involving telemedicine the committee recommended that state medical boards offer a process for physicians who meet certain qualifications to have an expedited endorsement process to get a special purpose license solely to practice across state lines. The FSMB developed a model legislative act for states to adopt in order to implement the recommendations of this Committee. The model act establishes an abbreviated licensure process for physicians not physically practicing within a state's jurisdiction, but providing services to patients within that jurisdiction. So far, a total of 9 states have adopted plans similar to the FSMB model.[18]

According to the Center for Telehealth and e-Health Law, while the concept of a granting special purpose licenses to physicians has the advantages of reducing administrative complexities of multiple licensure applications by allowing an expedited endorsement process the model act has

had limited success in its adoption by different states, thus it has not had a great impact on physicians' ability to obtain licenses.

The Taskforce has a stated goal of delivering recommendations to the State Alliance which will have the greatest discernable impact on the ability for all healthcare professionals to obtain licenses. Therefore, in its desire not to limit the impact of its recommendations, the Taskforce will likely not develop a recommendation on a special purpose telemedicine license.

Mutual Recognition and State Compacts

Another licensure approach examined by the Taskforce was the possibility of states to enter into a compact to grant licenses to healthcare professionals within the states that have signed onto the compact. This approach is generally considered to be a mutual recognition model that is then implemented by an interstate compact. An interstate compact is an agreement between two or more states that is entered into for the purpose of addressing a problem that crosses state lines. Modification of the compact is only possible with the unanimous consent of all party states. Once enacted, the compact takes precedence over prior statutory provisions.[19]

Under a mutual recognition model, practice across state lines is allowed, whether physical or electronic, unless the healthcare professional is under disciplinary action or a monitoring agreement that restricts practice across state lines. In order to implement a mutual recognition model, each state must adopt and implement the interstate compact. The mutual recognition model benefits the state because it reduces the administrative burden on both healthcare professionals and the state board.

There are some universal concerns and challenges in implementing interstate compacts that apply to the various health care professions. These concerns include the potential of a loss of revenue to states and questions about the compact's disciplinary process. The Taskforce is greatly concerned about the potential loss of funding to al state boards. As previously highlighted in its first report to the State Alliance, the boards' capacity to be effective is often hampered by lack of resources and state funding. Many boards raise money through licensure and registration fees. In many states large proportions of these funds go into general state revenues rather than the boards' own budgets. The Taskforce also believes that, in implementing an interstate compact, there will be a need for disciplinary monitoring to be conducted via an electronic or online system.

Although the National Council of State Boards of Nursing (NCSBN) has a mutual recognition compact,[20] the Taskforce recognizes that nurses are typically hospital employees and thus different than doctors; therefore, a compact model based on NCSBN's compact may not be not amenable to the medical licensing processes.

Expedited Licensure by Endorsement

Licensure by endorsement is a process by which state boards can grant licenses to health professionals in other states that have equivalent standards. Healthcare professionals must apply for a license by endorsement from each state in which they seek to practice. States may require additional qualifications or documentation before endorsing a license issued by another state. Endorsement allows states to retain their traditional power to set and enforce standards that best meet the needs of the local population. However, complying with diverse state requirements and standards can be a time consuming and expensive for a multi-state practitioner.
Licenses granted by endorsement may be based upon:

1) documentation of successful completion of an approved examination previously administered by another agency;

2) acceptance of core documents which have been authenticated by an approved process; and

3) completion of additional requirements which assess the applicant's fitness to practice in the new jurisdiction.

If the Taskforce discusses whether or not state boards should implement a system of licensure by endorsement, the following considerations may also apply:

- The ultimate responsibility for assessing applicants' fitness to practice is retained by each licensing jurisdiction.

- Healthcare professionals remain subject to the authority of each and every jurisdiction wherein they hold a license.

Licensure Models Next Steps

Based upon testimony heard at several of the Taskforce's meetings and information presented in CTeL's report, the Taskforce will discuss licensure models and develop recommendations at its upcoming October 2007. The Taskforce recognizes that the implementation of various licensure models is a very complex and contentious issue and therefore feels that this topic warrants continued in-depth discussion.

VI. Taskforce Next Steps

In response to its charge by the State Alliance, the Taskforce plans to continue its examination of the regulatory, legal and professional standards impacting the practice of medicine and other healthcare practices, as well as issues that create barriers to eHIE. The Taskforce is expected to receive expert testimony and delivery of its work product from the National Association of Attorneys General at its next meeting.

The following two issues will be examined in depth at the Taskforce's upcoming meeting on October 24-25, 2007:

A. The Exchange of State Lab Results

Although the Taskforce had initially planned to develop recommendations on the exchange of state laboratory information in time for this second report to the State Alliance, the in depth exploration and discussion of issues surrounding licensure and the limited timeframes in which to conduct these discussions, precluded the formation of substantive recommendations at this time. The Taskforce has already heard testimony regarding this issue and has reviewed substantive research on state-by-state variations with respect to patient access to clinical lab data. The Taskforce has also examined issues regarding provider access to lab data and how eHIEs can be used to exchange laboratory results.

At its next meeting in October, the Taskforce will identify and discuss issues with respect to the exchange of state laboratory results and develop recommendations around these issues. The

Taskforce will examine patient access to information, the variation in state laws pertaining to the statutory definition of an "authorized person" to receive lab results, state law conflicts in relation to the Clinical Laboratory Improvement Amendments (CLIA), as well as issues and other third party matters such as provider access to lab data and how eHIEs can be used to exchange laboratory results.

Potential recommendations that the Health Care Practice Taskforce may consider during this meeting include:

1) A recommendation that states modify existing clinical laboratory regulations to permit patient access to clinical laboratory results and permit transmission of such results to the patient via an electronic medium such as a secured electronic patient record system**;** and

2) A recommendation that states enter a compact, or agree to a common set of rules, regarding who may order laboratory and diagnostic tests as well as receive the results of such tests.

Pursuant to the development of these recommendations, the Taskforce heard testimony from Ken Whittemore Senior Vice President, Clinical Practice Integration for SureScripts, outlining the process and methods that SureScripts used to facilitate the passage of legislation permitting e-prescribing in all 50 states. The Taskforce may consider recommending that the State Alliance employ similar methods when advocating for any future recommendations that require a substantial shift in statutory regulations.

B. Liability

At previous meetings, the Taskforce heard testimony that providers are reluctant to engage in electronic health information exchange because of the unknown liabilities associated with health IT and the electronic storage and exchange of health information. However, the Taskforce has also been made aware that there is a lack of case law concerning medical malpractice and health IT and electronic health information exchange. In two cases described to the Taskforce, *Breeden v. Anesthesia West* and *Oklahoma Case Johnson v. Hillcrest Health Center*, the courts ruled that providers had an obligation to treat the electronic health record the same as a paper record when utilizing information that resides within the record.[21]

As stated in its first report to the State Alliance, the Health Care Practice Taskforce was due to receive a report from the National Association of Attorneys General (NAAG) identifying and analyzing situations where electronic transfer of personal health information, faulty technology, or misuse and failure to use health information technology could change the dynamics of risk to individuals, health care providers, and other actors in the health care arena. At the time of the release of this report to the State Alliance, this work product was not available to the Taskforce.

The Taskforce will receive NAAG's work product and hear further testimony on liability issues at its October meeting. The Taskforce looks forward to putting forth comprehensive recommendations on this issue at the State Alliance's next meeting.

ENDNOTES

[1] Health Care Practice Taskforce official charge.
[2] Health Care Practice Taskforce official charge.
[3] James W. Cole, "A centralized verification system - Physician Credentialing". Physician Executive. Sept-Oct 1998. Available at http://findarticles.com/p/articles/mi_m0843/is_5_24/ai_102286853, accessed on September 14, 2007.
[4] Council on Graduate Medical Licensure WorkGroup, "Summary of Report to Congress: Process by which International Medical Graduates are Licensed to Practice in the United States," available at http://www.cogme.gov/rptcongress.htm, accessed on September 10, 2007.
[5] Federation of State Medical Boards' Frequently Asked Questions, available at http://www.fsmb.org/usmle_faq.html, accessed on September 17, 2007.
[6] *See generally*, National Council of State Boards of Nursing Delegate Assembly, "Using Criminal Background Checks to Inform Licensure Decision Making." Available at http://www.nursing.emory.edu/pulse/faculty_tools/compliance_docs/fc_criminal_background_checks.pdf, accessed on September 4, 2007.
[7] Ark. Code Ann. § 17-95-409.
[8] National Council of State Boards of Nursing Delegate Assembly.
[9] American Association of Colleges of Pharmacy, "Report of the AACP Criminal Background Check Advisory Panel," November 2006.
[10] Ibid.
[11] ibid.
[12] Arkansas State Board of Pharmacy Regulations: Regulation 11 (2004). Available at http://www.arkansas.gov/asbp/lawbook.html, accessed on September 7, 2007.
[13] 2007 HB 1100 (SB 5424) - Requiring that health care providers obtain a state background check through the state patrol prior to the issuance of any license. The background check may be fingerprint-based. In certain situations, an applicant for initial licensure must obtain an electronic fingerprint-based national background check through the state patrol and FBI. And **2007 HB 1103 –** Requiring each applicant for an initial license to obtain a state background check prior to the issuance of any license. The Department of Health may require an applicant to undergo an electronic fingerprint-based national background check.
[14] See, e.g., Wis. Stat. § 448.01(9)(a).
[15] Center for Telehealth and e-Health Law, "Analysis of Licensure Laws, Rules and Procedures as They Relate to e-Health and Telehealth," August, 2007.
[16] Office for the Advancement of Telehealth, U.S. Dep't of health and Human Services, 107th Cong., 2001 Telemedicine Report to Congress 21-25 (2001).
[17] Thomas Wm. Mayo and Tara E. Kepler, *Telemedicine: Survey and Analysis of Federal and State Laws*, American Health Lawyers Association 2007: 9.
[18] Center for Telehealth and e-Health Law, "Analysis of Licensure Laws, Rules and Procedures as They Relate to e-Health and Telehealth," August, 2007.
[19] Ibid.
[20] National Council of State Boards of Nursing, available at https://www.ncsbn.org/126.htm, accessed on August 7, 2007.
[21] *See*, 656 N.W.2d 913 (Neb. 2003) and 2003 OK 16 70 P.3d 811.