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Cross-Border Labour Mobility in the Windsor-Detroit Region: The Case of Nurses

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The objective of this research article is to address the issues Canadian nurses encounter when commuting across the border to work in the United States. While there are challenges, this study also demonstrates that this is an area where cross-border labour mobility has been more easily attainable under the specific NAFTA requirements, most notably in obtaining the applicable TN visa to work in the United States. This article explores the following: 1) trends in nursing demand in Windsor-Essex and Detroit Metropolitan Area; 2) professionals under NAFTA: TN visas; 3) impediments to crossing the border; 4) accreditation requirements to work in the United States; 5) 2014 changes to nurse accreditation in Ontario; 6) differences in compensation and other financial considerations; 7) differences in opportunities for advancement, work structure and environment; and 8) conclusions.

Keywords: Canada-U.S., cross-border, labour mobility, North American Free Trade Agreement (NAFTA), nurse professionals, TN visa

Introduction

Cross-border labour has been a trend since the 1980s for many healthcare professionals who commute daily across the international border to work, notably in the Windsor (Ontario)/Detroit (Michigan) region. This is the direct result of

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the nature of the trade relationship between Canada and the United States stemming from the North American Free Trade Agreement (NAFTA). Realizing differences in nursing structure and culture, Ontario nurses have sought opportunities for employment across the border under the facilitation mechanism in NAFTA for specific types of professionals using the Treaty NAFTA (TN) visa. Nonetheless, this situation is not without challenges to these individuals, the healthcare industry and governments from both countries. Nurses must clear hurdles in obtaining licensing to work in the United States, and they find uncertainties in physically crossing the border to get to their workplaces; as well, they are faced with a licensing change where they can no longer retain their professional license in Ontario if they have worked outside the province for three years or more. Despite these challenges, many health care professionals, specifically nurses, still commute across the border each day to be able to work in their profession. This case study displays a success in the functionality of a system that facilitates this cross-border commuter movement.

Objective and Methodology

The objective of this article is to address the issues Canadian nurses encounter when commuting across the border to work in the United States. While there are challenges, this study also demonstrates that this is an area where cross-border labour mobility has been more easily attainable under the specific NAFTA requirements, most notably in obtaining the applicable TN visa to work in the United States. This research article explores the following: 1) trends in nursing demand in Windsor-Essex and Detroit Metropolitan; 2) professionals under NAFTA: TN visas; 3) impediments to crossing the border; 4) licensing requirements to work in the United States; 5) 2014 licensing changes for Ontario nurses; 6) differences in compensation and other financial considerations; 7) differences in opportunities for advancement, work structure and environment; and 8) conclusions.

The current literature on cross-border nurses from the Windsor Region working in the United States has not been authoritatively explored from a regional economic perspective, nor has it been developed as a case study to illustrate this unique group of professionals that work across the border. Additionally, there has not been a study conducted that incorporates interviews with nurses themselves in which they discuss what they experience on the ground on a daily basis. This research study uses quantitative and qualitative approaches, with the inclusion of interviews to triangulate the findings collected from secondary and primary sources during the research and writing phase. This study acknowledges that perceptions of the researcher can be biased, and using this collaborative methodology helps to balance the discussion.

Interviews consisted of a semi-structured set of questions which were asked of the participants and allowed for them to offer additional information as it related to their position of work. This approach resulted in elaboration and verification of some of the key findings and offered viewpoints that would not have been attainable by only seeking primary and secondary sources, whether they were qualitative, quantitative or both.

Trends in Nursing Demand in Windsor-Essex and Detroit Metropolitan Area

Since the early 1980s, the U.S. health care industry, specifically in the Detroit area, has demonstrated a professional nurse deficiency. Mary J. Voutt-Goos, the director of patient safety initiatives and clinical care design at Henry Ford Health System in Detroit, started her career as a registered nurse in 1986. At that time, due to the nursing shortage, the Detroit area hospitals sought nurses from across the border in the Windsor region (Voutt-Goos, phone interview, 2014). In earlier census years, including 1996 and 2001, Statistics Canada did not survey the breakdown of health occupation workers working outside Canada from the Windsor Census Metropolitan Area (CMA). They did so only at provincial and national levels. The 2006 census data (table 1) show 2,005 health care and social assistance workers who worked outside of Canada but lived in the Windsor CMA (Statistics Canada, 2006). This number of workers may seem marginal; however, Windsor-Detroit is the only border crossing in North America where such an anomaly exists. While cross-border labour mobility between Canada and the United States does occur in other areas and amongst different sectors, this is a unique situation in Windsor-Detroit, specifically for health care and social assistance workers from Canada. This mobility is enabled by Detroit, Michigan being substantially the most populated U.S. region immediately adjacent to the Canadian border and furthered because of their extensive health care network. This network includes thousands more nursing positions than any other U.S. city on the country's northern border, robust medical research activity and the largest single-campus medical school in the United States (Wayne State University).

By 2011 the Government of Canada had moved from the mandatory census to the voluntary National Household Survey (NHS). In this year Statistics Canada noted that there were 1,560 health occupation workers from the Windsor CMA working outside of Canada (table 2) (Statistics Canada, 2011).

Table 1 2006 Census, Health Occupation Workers Working outside Canada from the Windsor CMA

2006 Census	
Health care and social assistance	2,005

Source: Statistics Canada (2006)

The year 2011 shows a decline of 455 from the 2006 Census; however, it must be noted that the new survey method is not as accurate as the former mandatory census. Also, as noticed from the breakdown in tables 1 and 2, the classifications have been changed from being broader in 2006 to more specific in 2011. The other unknown factor is that neither the census nor the household survey detail exactly where outside the Windsor CMA the commuters work, though the state of Michigan is the most logical deduction based on geographic proximity. Therefore, the numbers provided by Statistics Canada are an estimate based on the questions they posed in their surveys.

Table 2 2011 Total Health Occupation Workers Living in the Windsor CMA and Working outside of Canada

2011 National Household Survey	Total
Total – Health occupation workers	138,080
Ambulatory health services	275
Hospitals	1,270
Nursing and residential	15
Total health occupation workers living in the Windsor CMA and working outside Canada	1,560 (1.13% of total health occupation workers)

Source: Statistics Canada (2011)

Similarly, numbers obtained from the College of Nurses of Ontario (CNO) show a decline since 2011 in the number of Canadian nurses working in Michigan but do not provide data on specific locations. Table 3 illustrates the reduction in numbers. Note that this data is actually specific to nurses (as opposed to including all health occupation workers as the census/survey did), but they are also self-reported and include only the information for nurses that completed the survey. This makes the data potentially less accurate than mandatory reporting.

Table 3 Canadian Nurses Employed in Michigan, U.S.

	2011	2012	2013	2014
Canadian nurses employed in Michigan	1095	1024	988	610

Source: College of Nurses of Ontario (2014)

While specific numbers are not easily obtained due to changes in census/survey formats, as well as the limits of data provided by the CNO, one can still interpret that there has been a decline in the number of Canadian nurses working in the Detroit Metropolitan Area.

One potential reason for decreasing numbers of commuters in nursing is due to increasing border security since the terrorist events of September 11, 2001. In recent years, Henry Ford Health System has been subject to a significant decline in the number of nurse professionals from Ontario, numbering only 489 employees of their current total of 23,888, which accounts for all individuals working in the Henry Ford Health System, not only nurses. However, while not as large as before, it is still a significant number of professionals who regularly cross the Windsor-Detroit border in order to provide a service to Americans in a specific geographic location. As of late there has been a move in patient care to ambulatory and out-patient settings from in-patient hospitalizations, as well as increases in home care delivery. Therefore, while the number of nurses from Ontario working at in-patient hospital settings has declined, more may be moving into these other health care settings (Voutt-Goos, phone interview, 2014). However, Dr. Freeman¹ commented that “the CNO survey data reflects a similar decline which may also be false, as many nurses who work in Detroit give up their registered nurse (RN) Ontario license and therefore would not participate in the CNO survey. This would result in those nurses not being reflected in the CNO statistical data” (Freeman, personal interview, 2013).

By comparison, Wilma Willson, coordinator of clinical placement and patient care services at the Detroit Medical Center, noted that there has also been a decline in Ontario nurse employees. Currently there are 429 Canadian health care workers employed at the Detroit Medical Center, which employs several thousands of individuals in the Detroit Metropolitan Area (Willson, phone interview, 2012). While their numbers have declined over the years, there has also been a move to ambulatory care and other health care settings as in the case of Henry Ford Health System. However, according to Mark Campbell, a certified registered nurse anesthetist at the Detroit Medical Center, “while there has been a decline in Canadian nurses employed at the Detroit Medical Center, it still is one of the largest employers in Metro Detroit.

Many nurse professionals still seek full-time employment across the border at the Detroit Medical Center because it offers a flexible work environment, excellent training opportunities and variable scheduling hours” (M. Campbell, personal interview, 2014). Notably, many U.S. nursing professionals have moved to the suburbs, contributing to the shortage of nurses in the Metro Detroit Area and resulting in Ontario nurses seeking full-time work across the border (M. Campbell, personal interview, 2014). This is also re-iterated by Ms. Candice Girard, a full-time staff nurse at the Detroit Medical Center, who commented that “state-side, there are more opportunities for nurses in areas, including flight nurse training and pilot transport, mid-wife training and practice with anesthesia” (Girard, phone interview, 2014). These are only a few reasons that nurses have been attracted to health provider occupations in the United States.

Professionals under NAFTA: TN Visas

Nurses fall into the professional category in NAFTA, which affords them the ability to apply for the Treaty NAFTA (TN) visa. In order to apply to work in the United States and obtain a TN visa they must pass the American National Council Licensure Examination (NCLEX).² Even if this examination is passed, there still remains a significant amount of paperwork and bureaucracy when obtaining the appropriate visa (Freeman, personal interview, 2013). Once the individual has been approved they are then eligible to apply for a TN visa, which is renewable every three years. In April 2010, this was extended from the previous annual renewal requirement. This category of visa allows professionals to apply for a temporary permit so they can work in the United States. These visas are only available to Canadian and Mexican citizens as per the stipulations in NAFTA. In order to qualify for the TN visa the following criteria must be provided to United States Customs and Border Protection (CBP): “the profession is recognized under NAFTA Appendix 1603.D.1; and the alien possesses the specific criteria for that profession; and the prospective position requires someone in that professional capacity; and the alien is going to work for a US employer” (Embassy of the United States: Ottawa, Canada, 2014). Once the required documentation is provided, in order to qualify for admission to a U.S. port of entry the applicant must provide the following: “request ‘TN’ status, bring the original documentation and provide a copy of the applicant’s college (university) degree and employment records which establish qualification for the prospective job, provide a letter from the perspective US-based employer offering him/her a job in the US, and pay a fee of US \$50” (Embassy of the United States: Ottawa, Canada, 2014). Dr. Freeman commented that “this can be a very stressful and gruelling process,

especially with all of the paperwork and documentation required to be submitted to CBP. However, while initially it was more difficult for individuals such as nurses, over the years the health system responded to the problems experienced at the border by standardizing the process and ensuring the employee had all the right documentation upon entry” (Freeman, personal interview, 2013). Nonetheless, nurses who have worked at the Henry Ford Health System, including Mary J. Voutt-Goos and Mary Parent, the onsite administrator at Windsor Regional Hospital, noted that this institution specifically has always been very good at providing all the necessary paperwork and documentation required for prospective employees who are less familiar with the process (Voutt-Goos, phone interview, 2014; Parent, phone interview, 2014).

The Commission on Graduates of Foreign Nursing Schools (CGFNS) International notes that “Section 343 of the Illegal Immigration Reform and Immigrant Responsibility Act (the IIRIRA) of 1996 requires specific health care professionals to complete a screening program before they can receive either a permanent or temporary occupational visa, including Trade NAFTA status” (CGFNS International, 2014). This is enabled through a *VisaScreen*® which is completed by CGFNS International. The *VisaScreen*®: Visa Credentials Assessment Service “requires specific health care professionals to complete a screening program before they can receive either a permanent or temporary occupational visa, including Trade NAFTA status.” Along with payment of fees associated with this process one must meet the following criteria:

- An assessment of an applicant’s education to ensure that it is comparable to that of a U.S. graduate in the same profession;
- A verification that all professional health care licenses that an applicant ever held are valid and without restrictions;
- An English language proficiency examination;
- For registered nurses only, a verification that the nurse has passed either the CGFNS Qualifying Exam®, NCLEX-RN® or for select years and provinces its predecessor, the State Board Test Pool Examination (SBTPE).

Applicants who successfully complete *VisaScreen*® receive an official ICHP Certificate for the *VisaScreen*®: Visa Credentials Assessment Service, which satisfies the United States federal screening requirements (CGFNS International, 2014).

Claudia Campbell, a contingent staff nurse at the Detroit Medical Center (DMC), noted that these fees are covered by the hospital administration. In 2003 the fee for her initial *VisaScreen*®, which is valid for five years and subject to renewal, was \$325.00 USD. The hospital administration also covers the renewal fee, which was \$200.00

USD in 2008 and in 2013 had increased to \$275.00 USD (C. Campbell, personal interview, 2014).

In terms of other logistical issues and challenges for nurses attempting to cross the border, the wording of the visa can also be problematic if the specific type of job is not clearly identified. If the categories for job-specific roles are not clearly identified under the professional categories outlined for TN visas, an individual can be refused the visa if the appropriate paperwork and documentation are not provided at the border crossing. Dr. Freeman stated that “many jobs that RNs assume now in healthcare, such as project management, specify a graduate degree in a health care field, but may not indicate the individual must be a registered nurse. A Canadian nurse working under a TN visa runs the risk of being refused these promotions if the RN requirement is not specified in the job posting” (Freeman, personal interview, 2013). Similarly, Mary Parent commented that “in order to obtain a TN visa as a RN, you have to be able to demonstrate that you have a Bachelor’s Degree and licence to practise in the state where they are employed to the CBP officer at the U.S. port of entry. If an individual is unable to demonstrate this requirement then they could be denied the TN visa” (Parent, phone interview, 2014). Furthermore, as noted by Mary Parent, if a nurse is no longer employed and working in the United States then they are required by law to immediately give up their TN visa the next time they enter or exit the United States. This must be done in person at the border (Parent, phone interview, 2014). Therefore, while there are greater opportunities for career movement, including greater opportunities for specialization, there are specific details required to be outlined on legal documents that nurses must consider when working across the border.

Impediments to Crossing the Border

Challenges persist for workers physically crossing the border. Mary J. Voutt-Goos noted that “one of the major structural challenges with NEXUS³ for nurses crossing into the United States though either the Detroit-Windsor Tunnel or the Ambassador Bridge is that if either is backed-up then you have to follow along with all the other individuals until you get to the NEXUS queue” (Voutt-Goos, phone interview, 2014).⁴ This point is furthered by Julie Hunter, registered nurse and outreach coordinator at Henry Ford Hospital, who notes she generally takes the Detroit-Windsor Tunnel in the morning since there is generally less back-up, whereas in the evenings she tends to take the Ambassador Bridge home due to more lanes being open during rush hour. In both cases, however, there are no guarantees and often there are unexpected delays (Hunter, phone Interview, 2014). Additionally, the wait times at the border tend to be

longer during holidays. Mary Parent commented that “Ontario has ten statutory holidays,⁵ and Michigan has eight.⁶ Therefore, there is more traffic going from Ontario into Michigan on those days and commuters who work shifts, like nurses, need to be mindful of this regardless if they have NEXUS, due to tunnel and bridge delays” (Parent, phone interview, 2014). Jason Kiernan, a lecturer in the Faculty of Nursing at the University of Windsor, iterates this by noting that “on weekends especially, border traffic tends to be more scrutinized by CBP and CBSA officials due to many travelling to and from the United States for leisure and consumer purposes. Therefore, commuters need to be mindful of this and allot appropriate travel time to work” (Kiernan, personal interview, 2014). While NEXUS has helped to make border crossing more efficient and reduce wait times, individuals can still be selected for secondary inspection, including random compliance examinations (COMPLEX) conducted by CBP officers. CBP states that “COMPLEX examinations involve random selection of vehicles and/or air passengers that ordinarily would not be selected for an intensive examination. By combining the results of these examinations with the results of targeted examinations, CBP is able to estimate the total number of violations being committed by the international travelling public” (CBP, 2014a). In order to ensure law-abiding travellers are not delayed, these techniques assist CBP in developing more efficient enforcement mechanisms for compliance.

Overall border wait times have declined over the past decade; however, there are still procedures that must take place, and this ensures that there will always be some delay in processing people and their goods, no matter how minimal. The Wilson Center⁷ has undertaken a study on labour mobility challenges for Canada and the United States. According to Shotwell, Yewdell and Cryne, “the organizations surveyed identified inconsistency in decisions as the most frequent cause of border processing delays: 82 percent of respondents cited inconsistent decision making by inspectors. Moreover, respondents rated differences in rules between Canada and the United States as the most significant challenge when transferring labour across the border. As part of this problem, 46 percent also noted that a lack of clear guidance on entry requirements contributed to delays.... Delays at the border remove certainty from business planning, creating significant challenges for businesses especially as frequency of short-term international assignments increases” (Shotwell, Yewdell and Cryne, 2013: 7). A commuting worker arriving at the border can plan as best they can to minimize the time required to clear customs, but factors beyond their control mean there is always a degree of uncertainty to the process. Dr. Freeman commented that issues remain for nurses in terms of labour mobility under NAFTA. She notes that no one ever truly knows what will happen when they arrive at the border crossing, nor

can they anticipate the temperament of the CBP officer (Freeman, personal interview, 2013). Examples related to these factors follow in the remainder of this section.

Dr. Freeman cites the example of issues with respect to homemade lunches (Freeman, personal interview, 2013). Everything related to food and prepared food must be declared upon entry into the United States, including plants, animals and other related products. There are strict rules with regard to items which are prohibited from entry including: dried or canned meat, imported fish, meat products and prepared meat products from other countries. Jason Kiernan commented that “there are differences in regulations between Canada and the U.S. Fruits and vegetables are regularly confiscated going into the U.S. The onus is on the commuter to know which of those items are unacceptable to bring across” (Kiernan, personal interview, 2014). However, there are also exceptions to this once items are declared (CBP, 2014b). Taking a lunch is a normal thing to do if working in Canada; however, it becomes a complication when having to cross the border. If food items are inspected by CBP and deemed acceptable they may be permitted for personal use and consumption. Dr. Dale Rajacich, from the University of Windsor’s Faculty of Nursing commented, “for individuals who commute on a daily or weekly basis, they get to know the CBP and CBSA officials and vice versa. This helps to build relations and has helped to make this process more efficient (Rajacich, personal interview, 2014). However, Dr. Michelle Freeman notes, “even if new policies are developed for frequent commuters who work in the U.S., there is always the issue of trust. While it may seem realistic, there is always the possibility that one individual compromises the trust for others and therefore there are no guarantees that harmonizing policies would be more effective in terms of border security for temporary and frequent travellers to the U.S.” (Freeman, personal interview, 2013).

There have been discussions at the Canada Institute of the Wilson Center in Washington, DC proposing that Canada and the United States establish and develop a Trusted Employer Program (TEP) that would modernize the occupation lists under NAFTA. However, this would make the employer ultimately responsible for the compliance of its employees. This is currently under consideration as a potential policy alternative but discussion is in its very early stages, since this type of program is not outlined in the Beyond the Border Action Plan. The current Beyond the Border Action Plan between Canada and the United States outlines that the objective of their initiatives is “to develop a timely, predictable and efficient program shared by Canada and the United States that streamlines processing for eligible employers. Precedents for a program of this nature exist in Canada and US with programs such as CBP’s ‘trusted shipper’; CBP’s Free and Secure Trade (FAST) or Nexus ‘trusted travellers’;

and Transportation Security Administration (TSA's) pre-check" (CERC, 2013: 1). The Canada Institute at the Wilson Center explains that they are examining the possibility of the benefits of updating and developing more consistent border policies in terms of processing and decision-making by inspectors. They note that the benefits of the TEP are to increase levels of certainty and efficiency in processing and operation of personnel across the border. Additionally, it will allow greater productivity and innovation, encourage competition, streamline the admissions process and reduce barriers for cross-border professionals and port-of-entry officials that are trusted employees (CERC, 2013: 13).

Licensing Requirements to Work in the United States

Nursing professionals must first meet licensing requirements before being able to work across the border in the United States. To do so they must pass the NCLEX exam. The NCLEX exam is designed to test the knowledge of prospective nurses and determine if they have a sufficient understanding of U.S. policies and procedures in the medical profession, thus enabling them to ensure the best delivery of services to American citizens. For an individual to take the exam they must submit proof of education and state licence to demonstrate they are eligible to write the exam (Freeman, personal interview, 2013).

Coupled with the differences from the U.S. healthcare system, Canada is also challenged with internal jurisdictional issues of its own. Each individual province is responsible for providing and delivering health care to its constituents; therefore, services may be different from province to province. According to Dr. Freeman, "over the past couple of years, the Canadian Council of Registered Nurse Regulators (CCRNR) was developed with members from all of the provincial and territorial bodies in Canada in order to address some of the challenges for nurses living and working in different provinces" (Freeman, personal interview, 2013). The CCRNR was established in 2011 and serves as a national forum which promotes nursing regulation and professional excellence of its membership, dealing with local, national, regional, territorial and international regulatory issues in the health profession (CCRNR, 2014).

Through the CCRNR there is a process underway to have a common NCLEX exam that would encompass nurses across Canada by 2015 (CNO, 2014). This framework, developed jointly with the National Council of State Boards of Nursing (NCSBN), will give nurses seeking licensing/registration greater flexibility. Dr. Rajacich noted that "the goal is to make the process of obtaining the TN visa to work in either country under NAFTA an international standard" (Rajacich, personal

interview, 2014). As noted by the NCSBN, the NCLEX is offered at any Pearson Professional Center in Canada or the United States (the permanent test sites) as well as any of its temporary locations (NCSBN, 2013b: 6). Writing the one exam will be accepted by all provinces and by both countries; however, the NCSBN states that, once the exam is passed, “boards of nursing in the US and regulatory bodies in Canada may require additional evidence, such as successful completion of approved nursing education and meeting language proficiency requirements, prior to granting that privilege. Since specific licensure/registration requirements may differ from jurisdiction to jurisdiction, reciprocity of registration is at the discretion of the regulatory bodies involved” (NCSBN, 2013b: 6). Jason Kiernan commented that the NCLEX has been in place since 1994, and by now has gone through many updates and revisions. The challenge comes when Canadian nursing students have to begin taking the exam, a requirement that comes into force in 2015. Up until this point, Canadian nurses have taken their own entry-to-practice exam, and Canadian Bachelor of Science in Nursing (BScN) programs were designed for it. NCLEX is an attempt to create a Canada-U.S. exam versus the former U.S.-only version. This exam is critical for individuals who live in border cities, especially Windsor, Ontario, because nurses by law must write and pass the exam in order to practise in the state of Michigan (Kiernan, personal interview, 2014).

2014 Licensing Changes for Ontario Nurses

Changes to licensing coming into effect in 2014 could potentially keep cross-border nurses from coming back to work in Canada, specifically Ontario. Beatrice Fantoni, a local journalist, commented that “local nurses who work in Michigan are being told they cannot keep their professional licence in Ontario because they don’t work in the province, despite having been able to do so for years” (Fantoni, 2013). This poses a significant policy challenge for Windsor’s nurses, who rely on cross-border employment opportunities.

According to the CNO there are three options for nurses working outside of Ontario who wish to renew their memberships. An individual can renew, join the college’s ‘Non-Practising Class’ (NP) or resign membership entirely. The purpose of this change in membership classification is to provide more transparent and accurate information about Ontario nurses and thus help with future health care planning (CNO, 2014). In order to maintain and renew a ‘General Membership’ in the CNO the following criteria must be met: “Each year, members of the General Class are asked to declare if they have practised as a RN or RPN (as applicable for the certificate of registration that they hold) in Ontario within the previous three years. Those who

declare that they have not practised accordingly, are not eligible to remain registered in the General Class and must either join the College's Non-Practising Class or resign from the College. Members who hold two certificates of registration, either as an RN and RPN or as an NP and RPN, are required to make the declaration for each certificate" (CNO, 2014). As such, nurses in the 'Non-Practising Class' are not permitted or licensed to practise in Ontario in any capacity, either paid or unpaid. However, they are permitted to practise in other provinces or territories in Canada if they meet their provincial requirements (CNO, 2014). Should a 'Non-Practising Class' nurse wish to renew their membership they must apply for reinstatement. The CNO notes that "reinstatement is a means by which former members of the College of 'Non-Practising Class' members can re-apply for their General or Extended Class membership without having to meet all of the requirements of the first-time College applicants" (CNO, 2014). Finally, if nurses choose to not enlist in either the 'renew' or 'Non-Practising Class', they can revoke their membership entirely.

This policy is seen by some nurses as a potential obstacle that will keep Ontario nurses out of the province should they wish to return to Canada in the future. Fantoni cites Professor Deborah Kane in the University of Windsor's Faculty of Nursing who commented, "I fear we're going to shut the door on really qualified nurses. Ontario will face a nursing shortage in the coming decade, so this move by the CNO could actually backfire. Nurses who have kept their Ontario credentials – paying the fees and taking continuing education – through the years might not bother looking for work in Ontario in the future because reinstating their CNO membership might be a hoop-jumping exercise" (Fantoni, 2013). This new policy has not been well received by many current nurses, especially those in border cities like the Windsor-Detroit region. Mary J. Voutt-Goos commented that "the CNO has new rules in place to make this process simple; however, in reality they appear to be going in the opposite direction and in effect making the process more difficult" (Voutt-Goos, phone interview, 2014). Similarly, Mary Parent posed the question, "Why would Ontario not want their own nurses' talent here and therefore ask them to revoke their membership if they are practising in the U.S.? What if there was a disaster and you could not help in Ontario because you were no longer licensed in the province?" (Parent, phone interview, 2014). Julie Hunter also believes that this will deter nurses from coming back to work in the province. Many of the Canadian nurses who work in Michigan hospitals work in highly specialized areas like intensive care units, operating rooms and/or emergency departments, but even for the bedside, floor registered nurses working in high-acuity, complex settings such as Henry Ford Hospital, which is a level-one trauma centre (the highest trauma designation), it really makes no sense to

lose one's practising ability in Ontario due to the new licensing legislation with the College of Nurses of Ontario. Most of the nurses working in Michigan wrote double exams to be able to work in the state of Michigan and now work at high-acuity facilities. They should not have to declare themselves non-practising nurses. In fact, many are working with advanced skill sets in the United States and they may not feel there is room in their life to fit in a second job in Ontario, nor time to volunteer in some nursing capacity in the province. Therefore, they may decide to let their licences expire due to not having worked in Ontario within the past three years. That is very disheartening for the nurses who have kept their Ontario licences, as Hunter has for over 25 years. Hunter further states that Canadian nurses who have been working in Michigan for many years and may desire to retire from their Michigan nursing jobs but want to maintain some part-time work in the Windsor-Essex region could find it a hassle to go back through the reinstatement process. They could potentially decide not to become re-instated resulting in a loss of valuable skills, talents and resources that otherwise could be used in Ontario (Hunter, phone interview, 2014).

The CNO does have a 'Fact Sheet' on its website and a checklist to help determine if one is considered to be practising nursing in Ontario (CNO, 2013). Volunteer activities count, as do consulting and a number of other things. You must be able to demonstrate that you are either practising in some capacity or are influencing patient care in Ontario. Mary J. Voutt-Goos commented that she does this in a number of ways, from planning an international safety symposium in partnership with the Windsor Hospitals to being a guest lecturer at the University of Windsor on the topic of patient safety (Voutt-Goos, phone interview, 2014).

A primary issue in this regard is that the CNO has not clearly defined the critical factors required to remain in the non-practising class, since even volunteering as a nurse is not allowed once you claim this status. If a nurse decides to join the non-practising class but wants to be re-instated in Ontario they must submit a reinstatement application and pay a fee (Hunter, phone interview, 2014). The current fee for this is \$56.50 CAD plus applicable taxes, payable to the CNO. However, the CNO notes that, depending on the individual and their application information, they may be subject to additional fees. These are determined on a case-by-case basis (CNO, 2014). This is justified on the basis that if an individual has not worked in Ontario for a considerable amount of time they may be subject to additional examinations to upgrade their knowledge on the current state of Ontario policies and legislation.

Differences in Compensation and Other Financial Considerations

From an economic perspective there are different pay structures for registered nurses in Ontario depending on their geographic location. Table 4 provides samples of the average wage per hour in Ontario, including the Windsor/Sarnia region.

Table 4 Registered Nurse Salaries in Canada (Canadian Dollars)

Location	Avg. Wage/Hour	Year
Toronto – Ontario	36.22	2010
Ottawa – Ontario	36.22	2010
Windsor / Sarnia – Ontario	35.34	2010

Source: Living in Canada (2014)

Comparatively speaking, this geographical difference in pay is also noticed in American cities. Table 5 provides an overview of mean hourly wages for nurses in Michigan in 2013, where there is a difference in average rate of pay compared to that of Ontario.

Table 5 Salary Rates for Registered Nurses in Michigan (U.S. Dollars)

Location	Mean Hourly Wage	Year
Michigan	31.84	2013

Source: Bureau of Labor Statistics (2013)

The lower average rate of pay for nurses in the state of Michigan may be considered a factor for Ontario nurses, but there is not a substantial enough difference in pay to deter them from going to seek employment in the United States, especially those who have recently graduated and are having trouble obtaining full-time work in Windsor.

However, there are incentives for nurses to work in the United States. Jason Kiernan pointed out the ability of advance-practice or ‘extended class’ nurse practitioners (not registered nurses) to work ‘moonlight hours’ in the United States,

where an individual can work 36 hours in a row and is essentially on call on the hospital premises, with the ability to sleep when they can. During weekdays the hourly rate is \$65.00 USD per hour, on weekends it is \$70.00 USD, and in short staffing situations the rate increases to \$100.00. This can add about \$10-15,000 to an annual salary, which more than makes up for the \$2,400 USD paid in toll fees to cross the border itself. Additionally, medical students/residents and fellows in Ontario are not allowed to work more than three days in a row due to the policies and legislation in place. This is also true for international medical students/residents due to the rules and limitations set out in their visa requirements. This restriction applies to nurse practitioners in Ontario as a result of labour laws, but it does not apply to them in the state of Michigan; nor is the environment unionized, so stipulations restricting the number of hours worked are not written into contracts (Kiernan, personal interview, 2014). These extended hours and higher hourly wages in certain situations have become an attractive working option for many advanced-practice nurses, especially new or recent graduates. Unfortunately this would not be an option for new BScN graduates (Kiernan, personal interview, 2014).

Another financial consideration that nurse professionals have to take into account is the passenger car toll rates at both the Ambassador Bridge and the Detroit-Windsor Tunnel. In 2010 WilburSmith Associates et al. conducted a study for the Michigan Department of Transportation on traffic and toll revenues between Ontario and Michigan. They showed that between 2002 and 2009 there has been, on average, an annual increase in cash tolls of 5.5%. Broken down, the cost for each passenger vehicle each way at both the bridge and tunnel was \$2.75 in 2002 and rose to \$4.00 in 2009 (WilburSmith Associates et al., 2010: 194). In 2014 the Ambassador Bridge toll was \$5.00 per passenger vehicle, and at the Detroit-Windsor Tunnel it was \$4.50 from Windsor to Detroit and \$4.75 from Detroit to Windsor. (Note that in all of the data presented above, these are not the discounted toll rates that would be used with NEXPRESS ® TOLL.) These toll increases may be an economic factor considered by nurses who would have to pay these rising fees on a daily basis.

The movement of nurse professionals seeking employment opportunities across the border in the United States has also been affected by a fluctuating exchange rate. At the turn of the century the exchange rate was more favourable for Ontario nurses, who would have benefited from a higher U.S. dollar. Even if the rate of pay was lower in the United States, nurse professionals from Ontario could make up the difference by benefiting from a higher exchange rate. Table 6 identifies the exchange rates for the Canadian and U.S. dollars for the periods 1998-2002 and 2013-2014.

Table 6 Comparing Canada/U.S. Exchange Rates for the years 1998-2002 and 2013-2014

Year	Average Rate
1998	0.674779
1999	0.673156
2000	0.673519
2001	0.646223
2002	0.636723
2013	0.971164
2014	0.905912

Source: Canadian Forex-Foreign Exchange Services (2015)

Mary Parent commented that “there is an incentive when the dollar is high for Ontario nurses to seek employment across the border – they follow the money. There are greater opportunities for nurses and recent graduates for full-time employment as well as access to the U.S. healthcare system” (Parent, phone interview, 2014). However, a 2008 research study conducted by Cameron et al. noted that since 9/11 the American dollar has declined, resulting in a loss of income for nurses, and many of those commuters have decided to work closer to home (Cameron et al., 2009: 11). By 2013-2014, with the Canadian dollar nearly at par with its U.S. counterpart, the average hourly rates for Ontario nurses and those in Michigan were essentially the same. The exchange rate therefore became less of a deciding factor as compared to other considerations such as a nurse looking to the United States because of career opportunities they may be unable to attain at home.

While the trend continues for nurses from Ontario to look for work in the United States to fill the demand gap, there are issues which remain for nurses who experience challenges within their work structure and culture, with licensing, the process to cross the Windsor-Detroit border itself and their ability to later return to work in Canada.

Differences in Opportunities for Advancement, Work Structure and Environment

There are considerable differences between work structure and environment for nurses in Canada and in the United States. However, it is important to note that this research

study may have a biased viewpoint because the nurses that were interviewed chose to work in the United States. Mary J. Voutt-Goos noted that “the BScN degree is required for entry to practice in Ontario. This degree is now required in all of Canada; however, Ontario was the last province to implement this requirement. This is a professional goal not yet realized in the U.S., where there are many different programs: two year diploma, three year associate degree, and four year degree programs – all of which are accepted for entry to practise in the U.S.” (Voutt-Goos, phone interview, 2014).

According to Dr. Freeman, “Canadian nurses have more opportunities in the U.S. system to advance their careers. This is because of the size and complexity of the health systems that offers many advanced practice roles for nurses that do not exist in Canada. It is also because of the absence of unions. This allows nurses to advance based on merit rather than on years of service. For example, a nurse specialized in cardiology is able to apply for positions that best suit his/her skills and capabilities, therefore advancing his/her career over time and moving up in their respective field. Their circumstances for promotion and advancement are based on their achievement through a merit system rather than one based on time served which is highly characteristic of the Ontario Public Service through the Ministry of Health and Long-Term Care. Under the U.S. arrangement there are higher levels of competition between employees to offer the best care and service to patients, thereby encouraging individuals to excel.” (Freeman, personal interview, 2013). Similarly, Dr. Rajacich commented that “Canadian nurses working in the U.S. feel more valued for their work. There are also more educational opportunities for practising nurses to return to school for graduate degrees and training, as well as greater autonomy and flexibility in the workplace in terms of scheduling and full and part-time employment, and reimbursement opportunities. They place a high value on these qualitative factors” (Rajacich, personal interview, 2014).

Also pointing nurses toward the United States is the historical difficulty in getting full-time positions in Ontario (Voutt-Goos, phone interview, 2014). According to the Registered Nurses’ Association of Ontario (RNAO), some nurses are continuing to choose to work past the age of retirement, forcing other nurses to move outside their ‘favourite’ field of study/practice and adapt to others just to obtain work in the nursing sector (RNAO, 2014). In terms of full-time nurses employed across the border, Hall et al. note that “a higher proportion of Canadian-educated RNs in the U.S. were under 30 years old than RNs employed in Canada. In addition, more Canadian-educated RNs in the U.S. worked full-time than RNs working in Canada, and more Canadian-educated RNs in the U.S. had only one employer relative to their counterparts in Canada” (Hall

et al., 2007: 4). This translates to nursing professionals seeking more than one employer to establish full-time employment collectively. In Canada, employees are reluctant to leave their current positions even if they are not in their desired field of choice because they will lose their seniority within the union (Freeman, personal interview, 2013).

Furthermore, the U.S. system is seen as more attractive to Ontario workers because of its competitiveness and this flexibility. A study by the National Council of State Boards of Nursing (NCSBN) looked at entry level RNs in the United States and Ontario, finding that there was a significantly higher proportion of Canadians working rotating shift work than in the United States and that more U.S. nurses worked day shifts than in Canada. Additionally, in Canada the orientation period was much lower than in the United States, averaging 38 days, while in the United States it averaged 10 weeks (NCSBNd, 2010). Claudia Campbell commented that as a contingent⁸ staff nurse in the operating room at the Harper University Hospital she is only required to work two eight-hour shifts per month in order to maintain her contingent designation. However, a consideration in this situation which could be problematic for an individual is that such a position does not offer any health benefits. On the positive side, there are many of these positions available at the hospital, which can be an incentive for those seeking more schedule alternatives or the option of moving from part-time to full-time or vice versa.

Another factor making the U.S. system attractive to some nurses is that it is not a unionized environment, which was the biggest draw for an individual who seeks flexible scheduling for personal reasons or choice. (C. Campbell, personal interview, 2014). Nursing associations in Michigan (such as the Michigan Nurses Association) are more of a forum for discussion and teaching. They can be joined if nurses wish but are not compulsory, as they are in Ontario. They do offer members-only benefits and negotiate wages with their bargaining unit, but these only apply to their members. In contrast, more than 60,000 registered nurses and health professionals in Ontario are represented by the Ontario Nurses' Association (ONA), which makes the system very rigid due to its strong influence. Mary J. Voutt-Goos commented that "this issue of divergent cultures, specifically with respect to the issue of unions, continues to be a policy challenge and many Ontario nurses are choosing to work across the border for greater opportunities and career advancement" (Voutt-Goos, phone interview, 2014).

In terms of working in the United States, Mary Parent commented that "there are less attendance issues because there is a better work ethic amongst the medical teams, and individuals feel more valued as employees" (Parent, phone interview, 2014). Additionally, Julie Hunter commented that the U.S. healthcare system is much more

service oriented and is quicker to cater to patient needs. This is due to the high level of competition in the healthcare industry in the United States. Her role at Henry Ford Hospital is really as a business nurse, one who serves to assist in growth of the hospital. This is not a role one likely sees in nursing in Ontario (Hunter, phone interview, 2014). Individuals take courses on service excellence, which help them deal with difficult situations, patients, patient-nurse relations, etc. Added to this are greater opportunities for nursing professionals to interact with physicians, contrasted with a more visible hierarchy between nurses and physicians in Ontario, whereby the nurse is subordinate to the physician. Jason Kiernan commented that “this is not the case in Detroit since there is much more collaboration and respect amongst colleagues who work together. Because Henry Ford Health System (for example) is more service oriented and a teaching facility, there is competition to always be up to date with best practices, new technologies and service excellence. This is the result of the environment of collaboration that is mostly due to the teaching aspects” (Kiernan, personal interview, 2014). This differs from Ontario, where the environment is not competitive and is heavily unionized. However, this hierarchical work environment appears to be slowly evolving in Ontario. Mark Campbell commented that this may be the beginning of a change in the relationship between physicians and nurses in Ontario, resulting in less of a hierarchy between these two professions, which could be more beneficial for patient care and the services being provided (M. Campbell, personal interview, 2014).

Conclusion

Nurses interviewed in this study have worked in Detroit because they found it a compelling option. Others have not worked in Detroit but have done research on nurses working there. Those interviewed stated that they find greater competition and incentive in the United States to advance in their fields or the fields they studied when compared to the Ontario system of seniority rather than merit. The greater ability to work overtime with U.S. employers is a key incentive, as are flexible scheduling options and career training at high-skills hospitals such as the Henry Ford Health System and the Detroit Medical Center. Just to obtain work in Ontario, many well-educated nurses end up taking jobs in fields that are not their ‘favourite’, whereas across the border they can find employment for which they have trained and specialized, whether part-time or full-time. The ability to have these opportunities is not always possible in Ontario; however, an effort to retain nurses in Canada by changing the structure and culture of the Ontario system would be a daunting task. Developing a Windsor-Detroit region-specific healthcare model that considers greater

collaboration and reciprocity from both sides would no doubt face roadblocks from Ontario's rigid bureaucratic system. Notwithstanding movement in this direction, the current situation presents a unique opportunity for the Windsor region, where healthcare professionals can still live in Canada but have direct access to the benefits of working in the United States.

Nonetheless, the popular perception is that there is no labour mobility between Canada and the United States, or at least that it is a difficult process to partake in cross-border employment. However, nurses from Windsor stated they have not been substantially impeded in terms of the policies and procedures required by the United States in obtaining the necessary documentation to receive their professional TN visas. This process can be accomplished and is aided by hospital administrations that assist with all the associated paperwork, fees and licensing requirements of the U.S. government. Recently, even the licensing process that is required to work in either Canada or the United States has been streamlined through a single NCLEX exam for both countries. This simplified process, which is a prerequisite to obtaining a TN visa, allows those who pass to apply for work in either country. One new challenge associated with licensing does exist in that nurses from Ontario who choose to work only in the United States for more than three years can no longer practise in the province and have to revoke their membership or join the non-practising class with the College of Nurses of Ontario (CNO). They can reinstate their membership, but this may have stipulations which would ultimately deter them from coming back to Canada to work.

The other common consideration found was the ability to physically cross the border at either the Ambassador Bridge or the Detroit-Windsor Tunnel. Nurses must plan their commutes as best they can based on the volume of traffic during specific times of day and the speed at which people are being processed through customs. The onus is then on the cross-border commuter to ensure they are fully prepared when physically arriving at the border itself. In addition, higher levels of scrutinization and security often mean longer processing times and greater unpredictability for commuters. This can be an issue even with all the knowledge, appropriate paperwork and documentation required upon entry into the United States. Jason Kiernan notes that "it is not just the rules, regulations and policies in place, but also there is a human element that is an important factor, including the exchange of emotions and biases. The wealth of human variability outside of these rules, regulations and policies is one of the most critical challenges to crossing the border" (Kiernan, personal interview, 2014).

As with any cross-border movement, there are considerations that must be made; however, the case of nurses commuting from Windsor to Detroit has been one of the notable success cases under the NAFTA. Nurses have in fact found accessing the U.S. health care profession to be less difficult, and NAFTA's rules facilitate significant cross-border mobility in this listed occupation. There is no doubt that the needs and demands of the medical field are changing, which is highly evident when examining the Windsor-Detroit region. Ground-breaking research is underway, and greater collaboration has become the norm to deliver necessary services that are timely, efficient and productive. The question becomes how to effectively pursue the inclusion of cross-border commuting in this equation. While policy challenges exist, there are new ideas being proposed to mitigate them, endeavours which may formally recognize what the 'new reality' for cross-border workers may look like in the region. The challenge is in evolving the existing framework in order to meet market demands and encourage innovation and advancement in the medical field. From an economic perspective, cross-border movement of Ontario nurses has been mutually beneficial to both the United States and Canada. Ontario nurses from Windsor are helping to satisfy the demand in the Detroit area, and nurses who would otherwise not be able to obtain full-time work in Ontario are able to do so just minutes across the border.

In contrast, there is not a two-way flow: nurse professionals from the United States are not seeking work in Canada. In Ontario, the opposite of the Michigan situation exists – there are too many qualified nurse professionals unable to obtain work in their respective fields as a result of the structure of Ontario's health care system. As a result, Ontario nurse professionals are seeking work across the border in Michigan because the state is unable to meet the demand for these types of professionals and NAFTA facilitates their ability to legally work there. Even though NAFTA does provide opportunities for professionals to move in both directions, other factors preclude many in this field from looking to Windsor at the moment.

Cross-border employment of Ontario nurses also has a positive benefit to the Windsor economy, since these nurses spend their U.S.-earned dollars in Windsor (Voutt-Goos, phone interview, 2014). Likewise, decision-makers' ability to address the related policy challenge may realize the potential effect of drawing further Ontario nurses to the region to supply demand in the United States, thus increasing the density of healthcare professionals living in the Windsor area. This provides potential future economic opportunities to this bi-national region and may open the door to other professions adopting a similar process and being added to the TN visa list to become more integrated with the U.S. market as well.

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Endnotes

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² The NCLEX is explained in more detail in Part 4 of this article.

³ NEXUS is a service provided in Canada and the United States to expedite the border clearance process for low-risk, pre-approved travellers. The fee is \$50.00 Canadian or U.S. and is renewable every five years.

⁴ In the Windsor-Detroit region there are two border crossings, one at the Ambassador Bridge and the other at the Detroit-Windsor Tunnel as well as a public tunnel bus that crosses several times a day.

⁵ New Year's Day, Family Day, Good Friday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Thanksgiving Day, Christmas Day, and Boxing Day.

⁶ New Year's Day, Martin Luther King Jr. Day, Presidents' Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas.

⁷ The Wilson Center "seeks to be the leading institution for in-depth research and dialogue to inform actionable ideas on global issues. The Wilson Center is the nation's key non-partisan policy forum for tackling global issues through independent research and open dialogue to inform actionable ideas for Congress, the Administration and the broader policy community" (Wilson Center, www.wilsoncenter.org).

⁸ A contingent is hired similarly to a contract worker who can work to fill positions for individuals who are on leave or holidays. This can initially be a part-time or even full-time position depending on the hours or work available.