

The Nurse Licensure Compact: A Historical Perspective

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The National Council of State Boards of Nursing (NCSBN) became the first organization to develop and implement two interstate compacts to reduce regulatory barriers to cross-border nursing practice for licensed practical/vocational nurses, registered nurses, and advanced practice registered nurses. The compacts were intended to move from the traditional single-state license to a state-of-residence license allowing the licensee to practice in other participating states. After 15 years, adoption of the compacts by states had stalled. In response, NCSBN identified impediments to adoption of the compacts and initiated steps to promote their acceptance. Two new compacts were developed and are being introduced as the preferred regulatory model to preserve state autonomy while providing solutions to the problems of regulating nursing practice across state lines.

Objectives

- Summarize the history of nurse licensure compacts.
- Explain the advantages of nurse licensure compacts.
- Identify the barriers to nurse licensure compacts.

Over a period of more than 100 years of nursing regulation, state licensure has emerged as the standard to protect the public by ensuring that nurses are safe and competent to practice. This single-state regulatory approach has been foundational to the public protection role of boards of nursing (BONs). Historically, most nurses lived and practiced in the state where their patients sought care, and care was delivered primarily at the bedside or in the patient's home. Thus, single-state licensure worked well. However, according to the Pew Commission's 1995 report, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, health care workforce regulation is out of step with health care needs and expectations. The report contends that the single-state licensure model raises costs, limits managerial and professional flexibility, restricts access to care, and has an ambiguous relationship to quality (Finocchio, Dower, McMahon, & Gragnola, 1995, pp. iv, vii). Among the concerns cited in the report is a lack of uniformity among states that limits effective professional practice and mobility, resulting in barriers to integrated health care delivery systems and the use of telehealth and other emerging health delivery modalities. In 2011, the concern was echoed in the Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health*, which identified state nursing regulations as a complication in the delivery of telehealth services by nurses (Institute of Medicine, 2011).

Creating a Mutual Recognition Model

Aware of advances in technology and their potential for the delivery of nursing care, the National Council of State Boards of Nursing (NCSBN) began exploring the practice of nursing over distance, or "telenursing," in the 1990s. (See Figure 1.) In December 1994, NCSBN charged the Nursing Regulation Subcommittee to analyze the then-current model for nursing regulation. The focus was on developments in telecommunications technology and the creation of multistate health care delivery systems as well as the perceived barriers to full implementation of these systems created by the single-state licensure system—a system that required a nurse to hold a license in each jurisdiction in which he or she practiced. NCSBN's inspiration to explore multistate regulation as a possible solution was introduced in the subcommittee's recommendation to "create a multistate license for people who meet specified criteria" (National Council of State Boards of Nursing [NCSBN], 1996a). A multistate license would allow a nurse to practice in all participating states, effectively making state boundaries more transparent and decreasing the difficulty in regulating telenursing.

NCSBN focus groups and task forces postulated that an optimal regulatory model should have the following features:

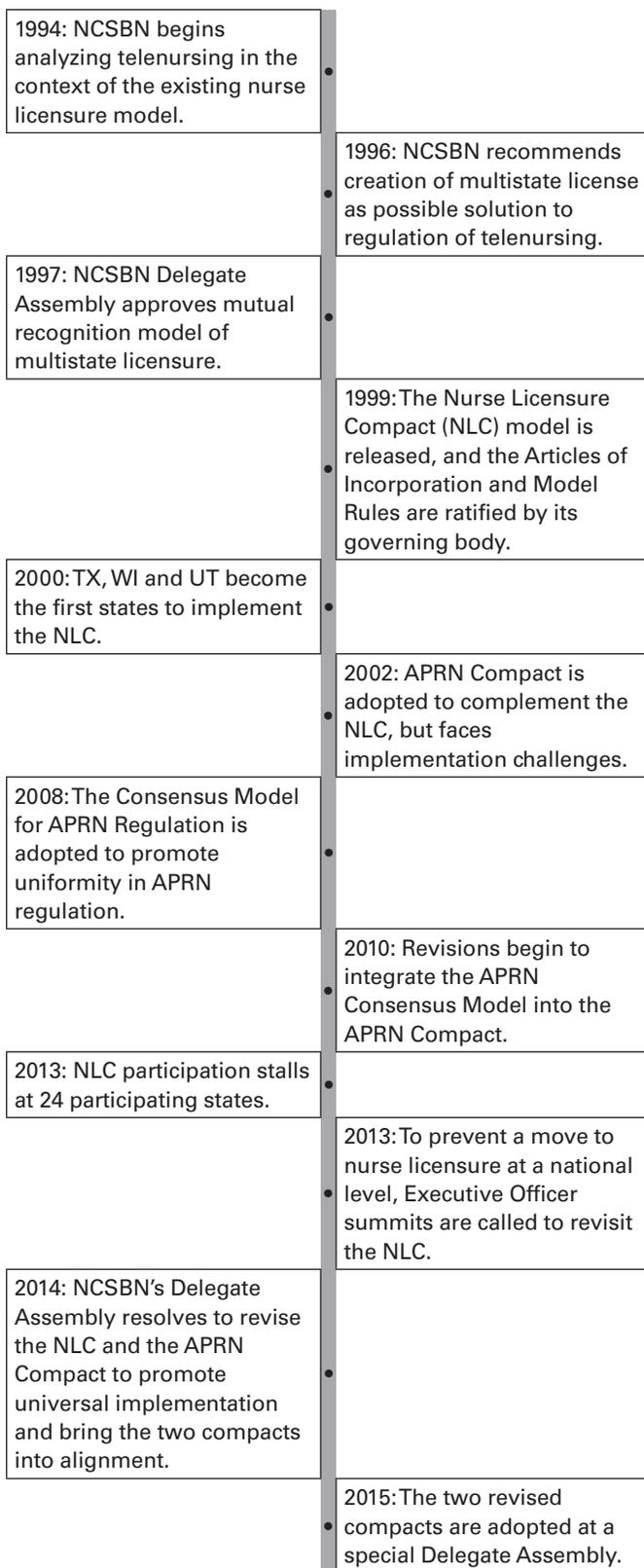
- Permeable state boundaries to enable interstate authority to practice
- A clearly delineated source of legal authority for scope of practice and discipline in the context of multistate practice
- Common standards for licensure and discipline.

Additionally, they proposed that the public should be able to expect the following from an optimal regulatory model:

- Public protection through a system that ensures nurses are competent and meet core standards

FIGURE 1

Timeline for the Two New Compacts



- Increased access to care through the authorization of competent nurses to practice throughout U.S. jurisdictions
- Promotion of safe practice through an expeditious discipline process that ensures due process for all parties (NCSBN, 1996b, p. 8).

In 1997, the NCSBN Delegate Assembly approved a mutual recognition model of licensure, allowing a nurse to have one license issued by his or her state of residency and to practice both physically and electronically in other states that participate in the model. Under mutual recognition, a nurse could practice across state lines unless otherwise restricted. Practice was subject to each state's practice laws and rules (NCSBN, 2011). The mutual recognition model retained the strengths of the traditional single-state licensure model—for example, state-based authority for licensure, practice, discipline, and enforcement of practice—while providing key advantages:

- Acceptance of a nurse's state-based license in other states
- Mutual acceptance of licensure standards across states
- Ability of each jurisdiction to hold nurses accountable for practice within that state by disciplining the privilege to practice
- Incremental implementation by passage of legislation in each state.

Early Compacts

In 1999, the Nurse Licensure Compact (NLC) was released. Originally, the NLC called for an a registered nurse (RN) or licensed practical/vocational nurse (LPN/VN) state license that was enforced locally and recognized nationally (NCSBN, 1997a). This 1999 iteration of the NLC addressed concerns related to the portability of RNs and LPN/VNs through the following methods:

- Enhanced communication among states, including the authority to share information related to disciplinary complaints during the course of an investigation
- Shared responsibility for patient safety not constrained by geographical boundaries
- Shared commitment between states to improving the collective ability to protect patients
- The ability to limit practice through disciplinary action on the privilege to practice by any remote state
- Uniform statutes, rules, and policies applicable and enforceable in all compact states.

Leading up to adoption of the NLC and after several years of study, NCSBN's Advanced Practice Registered Nurse (APRN) Advisory Committee agreed on a corresponding APRN compact. In 2002, NCSBN adopted the APRN Compact to complement the NLC. Subsequently, this compact was adopted by three states (Iowa and Utah in 2004 and Texas in 2007). However, it was not fully implemented in any of

them in part because of the lack of uniformity of APRN licensure requirements among states. Then, in 2008, the Consensus Model for APRN Regulation (Consensus Model) addressed the lack of uniformity in APRN practice, education, competence, and regulation, and the idea of an effective APRN Compact moved forward.

In 2010, with the Consensus Model for APRN Regulation in place, executive directors and attorneys from the three APRN Compact states and Idaho, which expressed an interest in adopting the APRN Compact, as well as the Nurse Licensure Compact Administrators (NLCA) Chair and special counsel began meeting as a work group to discuss what was necessary to support implementation of the APRN Compact. At the initial meeting, the work group determined that the APRN Compact needed to be amended before implementation. Proposed changes included the following:

- Incorporation of Consensus Model licensure requirements in Compact model rules
- A grandfathering provision for licensed APRNs who do not meet Consensus Model requirements
- Strengthened Compact enforcement provisions
- Rule-making authority by the Interstate Commission of APRN Compact administrators
- APRN prescriptive authority for noncontrolled substances
- Requirement for biometric-based criminal background checks
- Eligibility to join the APRN Compact without regard to whether the state is a member of the NLC.

Barriers to Adoption and Implementation

During the creation of the regulatory model for nursing, NCSBN anticipated BONs' concerns about its impact on state-level regulatory processes and the BONs' roles and functions. In fact, the original subcommittee that analyzed various models identified two major areas of concern: discipline and impact on board revenue (NCSBN, 1997b). These concerns and others, including states' resistance to interstate compacts, attorneys' general opinions that the NLC would violate provisions of states' constitutions, differences in state licensure requirements, and opposition from nurse unions, emerged as states began considering legislation to adopt the NLC.

By 2013, 24 state legislatures had adopted the NLC, most of them in the first 5 years of NCSBN's adoption of the original Model Compact language. However, only two states adopted the NLC after 2010 (NCSBN, 2013). The momentum for NLC adoption had stalled, demands for enhanced nurse portability were growing, and the U.S. Congress appeared to be losing patience with state regulatory laws that hampered the expansion of the practice of telehealth.

State BONs recognized the need to address the challenges of a changing health care delivery system and the

demands for better access to quality care while maintaining a state-based system of licensure. They also understood that the growing interest in national licensure as the way to support telehealth created an urgency to adopt compacts for RNs, LPN/VNs, and APRNs. Congress had noted that the historic requirement for a nurse to hold multiple single-state licenses had become increasingly burdensome, redundant, and costly.

The threat of Congress creating a national solution compelled the NCSBN Executive Officer Leadership Council to meet and discuss "licensure models in the context of a fast changing health care environment" (NCSBN, 2013). The first of four Executive Officer Summits was held in July 2013, the purpose of which was to develop strategies to avert the congressional solution, national licensure for nurses, and identify a regulatory model that would address the barriers to the practice of telehealth and practice uniformity.

The Revised Compacts

Several factors were identified as barriers to the adoption of the NLC by the remaining states, and strategies were developed to address these in the revised compact. One of the concerns was the variance of licensure requirements among states. In the time since the passage of the original NLC, NCSBN had developed Uniform Licensure Requirements to assist in aligning licensure regulations among states, addressing such areas as completion of a board-approved education program, passage of the approved licensure examination, English language proficiency, and criminal history. These recommendations were rolled into the revised version of the Compact. As well, the revisions included the establishment of a new governing body for the NLC, the Interstate Commission, and granted the commission additional rule-making authority.

In addition to promoting uniformity and establishing a new governing body, the revisions would need to address the transition from the existing NLC to the revised version. Provisions were drafted to ensure compliance with the Compact by member states, including procedures to be followed in the event of failure by a participating state to comply with terms of the Compact. Specifics of implementing the revised NLC, grandfathering nurses with existing multistate licenses, and rescinding the previous NLC were detailed.

The new APRN Compact was substantially aligned with the NLC in format and sequence, and includes requirements from the APRN Consensus Model. Like the NLC, it strengthens provisions related to participating state compliance, provides for grandfathering of APRNs with existing licenses, and provides for the process by which the new Compact will be adopted and implemented. Features of the APRN Compact include prescriptive authority for noncontrolled substances, biometric-based national criminal background checks, and eligibility for all states, regardless of membership in the NLC.

In a series of meetings, the executive officers affirmed that mutual recognition continued to be the preferred model for nursing regulation and that the 1999 NLC with agreed-upon changes would result in a more adoptable compact.

On August 15, 2014, the NCSBN Delegate Assembly adopted a resolution affirming their endorsement of “a uniform mutual recognition model for state-based nurse licensure” and committing to “revision of the NLC and APRN Compact to achieve their universal implementation by Member Boards” (NCSBN, 2014).

NCSBN appointed work groups to accomplish the following:

- Gather feedback and comments from members, respond to questions, and facilitate a transparent process of building consensus on a final revision to the NLC that would include revisions from the Executive Officer Leadership Council and the NLCA
- Align proposed changes to the NLC and the APRN Compact for improved Compact operations by participating states
- Identify implementation issues and provide for transition to the two new compacts.

At a second NCSBN Special Delegate Assembly held May 4, 2015, delegates adopted the new enhanced NLC and the revised APRN Compact to replace the two existing interstate compacts. This action by the delegates created the pathway for adoption by most states—the preferred solution to enhanced nurse mobility in the 21st century.

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Posttest

Please circle the correct answer.

1. When was the Nurse Licensure Compact (NLC) first released?

- a. 1995
- b. 1997
- c. 1999
- d. 2001

2. According to the Pew Commission's 1995 report, what effect does the single-state licensure model have on health care?

- a. Ensures professional flexibility
- b. Allows for greater access to care
- c. Improves quality of care
- d. Increases costs

3. What issue is cited as one of the driving forces for an interstate compact?

- a. Affordable Care Act
- b. Accreditation
- c. Telecommunications technology
- d. Public protection

4. What is the new governing body for the Nurse Licensure Compact?

- a. Delegate Assembly
- b. Interstate Commission
- c. Institute of Medicine
- d. Consensus Model

5. Which of the following is an optimal feature of a multistate licensure model?

- a. A clear source of legal authority for scope of practice and discipline
- b. Support from nurse unions
- c. Allows for differing individual state standards for licensure and discipline
- d. Revenue for boards of nursing (BONs)

6. Which statement best describes the mutual recognition model of licensure?

- a. A nurse must acquire one license, which is recognized in every state.
- b. A nurse must acquire one license for every state in which he or she practice.
- c. A nurse must acquire one license, which is recognized in all other states that participate in the model.
- d. A nurse must practice in a state before he or she may acquire a license in that state.

7. What should the public understand about nurses with a multistate license?

- a. They are safe and competent to practice.
- b. They have met the NCSBN Guidelines for Practice.
- c. They have prescriptive authority.
- d. They hold a bachelor's degree in nursing.

8. What is the most important advantage of an interstate compact for nurses?

- a. It enables any participating state to discipline a nurse's license.
- b. It allows a nurse to have multiple licenses for the price of one.
- c. It allows a nurse to practice nursing in all participating states.
- d. It protects the right of each state to adopt different standards for licensure.

9. What is the advantage of having the Uniform Licensure Requirements?

- a. Requires strict adherence to identical rules in state laws
- b. Assists in aligning licensure regulation between states
- c. Helps boards of nursing understand the differences in state laws
- d. Mandates acceptable nursing practice

10. Which statement about interstate compacts is correct?

- a. There is one compact for registered nurses (RNs) and another compact for licensed practical/vocational nurses (LPN/VNs).
- b. There is one compact for RNs and LPN/VNs and another for APRNs.
- c. All states are required to participate in the compacts.
- d. Many different licensed professions already have an interstate compact.

11. Which two areas of concern are identified as a barrier to adoption of the NLC?

- a. Discipline and revenue
- b. Citizenship and ability to speak English
- c. Criminal history and history of addiction
- d. Prescription authority and education

12. Which of these factors influenced the BONs' decision to revise the NLC?

- a. U.S. Congress is considering national nurse licensure.
- b. Nursing unions are calling for changes in collective bargaining.
- c. State attorneys general are proposing changes to state constitutions.
- d. BONs are removing themselves from the NLC.

Evaluation Form (required)

1. Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).

• Summarize the history of nurse licensure compacts.

1 2 3 4 5

• Explain the advantages of nurse licensure compacts.

1 2 3 4 5

• Identify the barriers to nurse licensure compacts.

1 2 3 4 5

2. Rate each of the following items from 5 (very effective) to 1 (ineffective):

• Were the authors knowledgeable about the subject?

1 2 3 4 5

• Were the methods of presentation (text, tables, figures, etc.) effective?

1 2 3 4 5

• Was the content relevant to the objectives?

1 2 3 4 5

• Was the article useful to you in your work?

1 2 3 4 5

• Was there enough time allotted for this activity?

1 2 3 4 5

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