Feasibility of Establishing a Multistate Compact For Physical Therapy Licensure
Report to the Delegate Assembly on 2010 Delegate Assembly Motion DEL-10-05

DEL-10-05:
Multistate Compact Exploration

Motion:
Direct the Federation Board of Directors to explore the feasibility of establishing a multistate compact for physical therapy licensure and report back to the 2011 Delegate Assembly. Request the board to consider and report the potential fiscal and legal impact on state jurisdictions.

Rationale:
Twenty four states have enacted the Nurse Licensure Compact to improve practitioner mobility and streamline the endorsement process.

This model may bring benefits to patients, consumers, and licensees by facilitating short-term mobility and telehealth consultation for physical therapists. It could also enable member states to share investigative data, which currently is not possible for many states.

Proposed by: Mississippi & Texas Amended by: Kentucky

History of the Motion
At its 2010 Annual Meeting, the FSBPT Delegate Assembly passed a motion to explore the feasibility of establishing a multistate compact for physical therapy licensure. This motion originated from the acknowledgement that a multi-state licensure compact for physical therapy, similar to that of nursing, would improve licensure portability from state-to-state and facilitate the sharing of disciplinary information.

Delegates discussed details of the Nurse Licensure Compact (NLC) and desired more information on the feasibility of a similar arrangement for physical therapy. Many issues were discussed to justify the possible need for a multistate licensure compact: workforce distribution, inability to share full licensure and disciplinary data, workforce shortage, licensure portability, and challenges of regulating telehealth practice. Several members felt their jurisdiction’s ability to participate in the FSBPT ELDD was limited due to state laws prohibiting the sharing of certain personal information such as social security numbers or dates of birth and that a compact would allow them to share more useful information.

Background Information: Interstate Compacts
An interstate compact is an agreement between states to enact legislation and enter into a contract for a specific, limited purpose or address a particular policy issue. Interstate compacts should not be entered into casually by a state. “Once a state ratifies a compact, its provisions have legal superiority, taking precedence over conflicting state laws.”[1] Compact agreements are unique in their duality as statute and contract. Each state must understand the implications of entering into a contract and must meet the terms required of all compact members. There is little flexibility to alter the initial or future versions of the statutory language. Changes to the statutory language implementing the compact cannot be made if the effect would qualify as a material difference to the Compact.
Like any other contract, modification of the compact is only possible with the unanimous consent of all party states. In addition, because the compact is law, it is subject to the traditional principles of statutory interpretation. As statute, it takes precedence over prior statutory provisions. An interstate compact gains its forcefulness because of its dual contract/law nature.  

Compacts vary in scope and number of participants; a compact may be an agreement between two states, a region of states, or have national reach involving all fifty states. According to the National Center for Interstate Compacts, more than 200 interstate compacts are currently in existence, and any one state is on average a member of 25 interstate compacts. The majority of compacts in effect currently fit into one of three categories: Border, Advisory, or Regulatory. Whereas border and advisory compacts have been seen since colonial times, regulatory compacts, such as the Nurse Licensure Compact, are a phenomenon of the 20th century. This type of compact is typically used to “create ongoing administrative agencies whose rules and regulations may be binding on the states to the extent authorized by the compact.”

Healthcare Professions: Interstate Compacts, Licensure Portability Issues, and Federal Influence
At this time nursing is the only medical profession with an interstate compact to implement a mutual recognition model for licensure. The nursing profession recognized a need for a simplification of licensing and improved mobility for nurses. The mutual recognition achieved with the NLC allows for seamless practice across state lines without delay and sharing of disciplinary action amongst all compact states. Under the terms of the NLC, each state still maintains its own unique and independent Nursing Practice Act in statute. Every nurse practicing in a given state must abide by that state’s specific Practice Act, regardless of the type of nursing license held. “The mutual recognition interstate compact is the mechanism to provide for practice across state lines, while the state Nursing Practice Act still remains the authority to regulate nursing practice in the state.”

The Federal government has had significant influence on the discussion and development of methods to increase licensure portability for healthcare professionals. Although the states and the professions have been slow to embrace alternative licensure processes, in the last two decades there has been much Federal interest in the areas of interstate practice and increased licensure portability.

- 1996- The Telecommunications Act passed and called for development of standards and an infrastructure for telecommunications in healthcare.

- 1997- The Department of Health and Human Services (HHS), in collaboration with the Department of Commerce, submitted the 1997 Report to Congress on Telemedicine containing a chapter on licensure issues impacting telehealth.

- 2001- HHS submitted a Report to Congress that updated and expanded upon the chapter on licensure from the 1997 Report. Both the full report and the chapter from the 1997 report identified licensure as a major barrier to the development of telehealth.

- 2002- U.S. Congress passed the Health Care Safety Net Amendments of 2002. Section 102 authorized the award of incentive grants to state professional licensing boards to promote cooperation and encourage development and implementation of state policies that will reduce statutory and regulatory barriers to telehealth.
• 2006-With funds appropriated by Congress in FY 2006, the Health Resources and Services Administration (HRSA) implemented Section 102 of the Health Care Safety Net Amendment of 2002 by creating the Licensure Portability Grant Program (LPGP). Grants were awarded to both the Federation of State Medical Boards (FSMB) and the National Council of State Boards of Nursing (NCSBN).  

• 2009- Funds provided by The American Recovery and Reinvestment Act of 2009 allowed for grants to be awarded to FSMB and the State of Wisconsin Department of Regulation and Licensing to promote physician licensure portability.  

• 2010- Federal Communications Commission (FCC) released its National Broadband Plan, which advised the states to revise their licensure requirements to enable e-care (electronic healthcare practice).  

NCSBN had already begun discussion of the best options to achieve improved licensure portability, but with the passage of the 1996 Telecommunications Act, the issue took on more prominence. In August 1997, the NCSBN delegate assembly voted unanimously to endorse a mutual recognition model for nursing regulation. That December, a special session of the NCSBN Delegate Assembly was convened and approved the legislative language for the compact. The 1998 Delegate Assembly adopted the Mutual Recognition Master Plan; approving a policy to remove regulatory barriers, confirming the intention to move forward with the compact, and continuing to educate and resolve stakeholder concerns about a mutual recognition model and the workings of a compact. In the summer of 1998, twenty-plus states attended a legislative strategies meeting hosted by NCSBN “to help the states develop a process to effectively pursue multistate regulation.” The initial states expressing the most interest in adopting a compact and introducing the legislation in the 1999 or 2000 sessions included: Alaska, Arkansas, Arizona, Delaware, Idaho, Iowa, Massachusetts, Maryland, Mississippi, Minnesota, Montana, Nebraska, North Carolina, New Jersey, Nevada, South Dakota, Texas, Tennessee, Wisconsin and Puerto Rico.  

Twenty four states have adopted the Nurse Licensure Compact between 2000 and 2010. The NLC was first implemented in Utah on January 1, 2000 followed soon after by Maryland, Texas, and Wisconsin. Missouri was the most recent state to enact the compact on June 1, 2010. In the 2011 legislative session, six states: Georgia, New York, Illinois, New Jersey, Massachusetts, and Minnesota have brought legislation forward to enact the NLC; Minnesota and Illinois were the most active bills. However, none of the bills passed the 2011 legislative session.  

The blue states on the map below show the 24 member states.
The goal of NCSBN is to have the legislative language be uniform from state to state, thus NCSBN provides model legislative and regulatory language for states interested in entering the compact. Every effort is made to keep the language as identical as possible to the model legislation. In order to join the NLC, the state must pass legislative language to implement the Compact that in no way materially changes it. There are some situations which require NCSBN to offer some enabling language provisions. For example, in order to pass the compact in some states specific language regarding strike-busting was included to address concerns of the union. NCSBN will have any proposed language changes to model legislation reviewed by their attorneys to see if the changes qualify as a material difference. If so, they notify the legislation sponsor that the bill as written cannot be implemented, even if it has passed the legislature.

The Nurse Licensure Compact essentially works the same and has the same requirements in all member states. A nurse in a member state applies for licensure in the state in which he/she resides; this is called the home state. The nurse may choose to have single state or multi state practice recognition. The home state license is the only license issued to the nurse unless he/she wants to work in a non-Compact state. In that case, the nurse would pursue traditional licensing with the non-compact state. For purposes of working in a compact state however, the nurse has the home state license which grants him/her multistate licensure recognition. The nurse may then practice in any other member state without an additional license or notification of any state Board. The nurse is expected to know and abide by the differences in the Nursing Practice Acts in any state in which he/she practices. If the nurse moves to another state, he/she must apply for licensure in the new state of residence and forfeit the original home license; a nurse may not hold more than one home state license at any given time. If the nurse moves to a non-compact state, then the home license converts to a single-state license which is not recognized for multi-state privileges. At this time, the NLC only applies to Registered Nurses and Licensed Practical Nurses/Vocational Nurses.

When it is necessary to discipline a nurse with a home state license and multistate recognition practice privileges, both the home state (state of licensure), and remote state (state where the incident
occurred) may take disciplinary action through the terms of the NLC.\textsuperscript{[2][p5]} However, only the state of residency/licensure can take action against the actual license. Action by the home state means “any administrative, civil or criminal penalty permitted by that state's laws which is imposed on a nurse by the board of nursing or other authority in the state of residency and licensure. This includes actions against an individual's license.”\textsuperscript{9} The NLC grants the authority to the remote state to take action against the nurse for an infraction in the state. In the single-state licensure model this authority may or may not have existed dependent on whether statutory authority existed to discipline unlicensed practitioners within the state. Remote state action is “any administrative, civil or criminal penalty imposed on a nurse by a remote state’s licensure board or other authority. This includes actions against an individual’s multistate licensure privilege to practice in the remote state.”\textsuperscript{9}

One of the hallmarks of the Nurse Licensure Compact is the mandatory reporting and sharing of disciplinary information between member states through the coordinated nurse licensure database maintained by NCSBN, NURSYS.\textsuperscript{8} When a complaint is filed against a nurse in either the home or a member state, that state is required to report to NURSYS any significant current investigative information, a point of contact regarding that information, and any final disciplinary action.\textsuperscript{8} As a condition for enacting the compact, all NLC states have agreed to share significant information relevant to any current investigation. If this investigation is taking place in a non-resident state, NURSYS will be used to notify the state of residency/licensure of any significant investigative information and any actions on the privilege to practice.\textsuperscript{8} If the home state takes action against the nurse’s license, this must also be reported to other party states.

The use of the determination made by another Board for deciding discipline in your own state is not new. Current HIP-DB Basis for Action Code 39, Licensure Revocation, Suspension or other Disciplinary Action Taken by a Federal, State, or Local Licensing Authority, allows a state to base its own disciplinary action on the action by another State Board. For a nurse that holds multiple non-NLC state licenses, disciplinary action in one state will typically mean facing action in all other states of licensure. However, with the mandatory reporting requirements, the NLC makes it much more likely that all of the states will get the disciplinary information.

One limitation of NURSYS is that the data on each nurse does not have a unique identifier such as the social security number or date of birth, and NCSBN reports they cannot move to require either until all states are participating.\textsuperscript{8} NURSYS has 43 states participating with a signed agreement for four more to come on board.\textsuperscript{8} After the agreement is reached, NCSBN funds some necessary cleanup work of the state’s data. Because of this work that must be done on the data, the delay to actually join may be up to a year. NURSYS is both a private and public website, with different functions available to different parties. Some states continue to report disciplinary and licensing information on their websites while some do not.

In addition to housing disciplinary information, NURSYS is used as an equivalent to primary source document verification for endorsement of licensure.\textsuperscript{8} The NLC staff liaison claims that the information contained in NURSYS mirrors what the State Board has in their database.\textsuperscript{8} When a nurse applies for licensure, he/she still fills out the state application which is scrutinized by the Board employee, and if something significant is missing such as a criminal background check then the applicant must meet those requirements prior to licensure. However, nursing boards historically have only required a single verification for endorsement. All states will accept the electronic verification sent by NCSBN for licensure purposes.\textsuperscript{8} The fee for the individual licensed nurse is $30 per Board of Nursing to which the verification is sent.\textsuperscript{10} Some state Boards of Nursing will still do verifications, however for most
verification has been out-sourced to NCSBN. A recent improvement in the database will now allow the NURSYS system to attach PDF documents to the verification. Typically the state level employee that was doing verifications is freed from this responsibility and the resources can be re-allocated to potentially processing the applications more quickly.8

For over ten years, the state boards of nursing have had the option of joining the NLC, yet fewer than half of the states have joined. There has been fierce opposition in many states to enacting the NLC, often with one of the most active opponents being the professional association for nursing, the American Nurse Association. Typically arguments in opposition of the NLC fall into one of five categories: control/loss of authority, lack of uniform standards, cost/loss of revenue, concerns about increased ease of strike breaking, and misinformation about the Compact/lack of independent evaluation.4 Opponents argue that if the NLC was adopted in all fifty states would be akin to national licensure. However, each state still retains the independence to withdraw from the compact as well as its own Practice Act. Implementation by all states does not automatically default to a national license due to the influence of state practice acts. As the NLC administrators and staff believe that much of the opposition to the NLC comes from misunderstanding and improper assumptions that still exist around the Compact.8 Correcting this misinformation is deemed so vital that most of the key elements of the Nurse Licensure Compact Administrator’s 3 year strategic plan focus on educational objectives geared toward nurse licensees, employers of nurses and NLC administrators.11

However, the less than enthusiastic response by the states to join the NLC has not kept NCSBN from beginning the development process for a Compact for Advanced Practice Registered Nurses. Beginning in 2000, NCSBN began developing the Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements. A potential APRN Compact will be based on the same mutual recognition model as the NLC. States will not be eligible to join an APRN compact unless they belong to the NLC. On Aug. 16, 2002, the NCSBN Delegate Assembly approved the adoption of model language for an APRN licensure compact. Between 2004-2007 three states, Utah, Iowa, and Texas, have actually passed legislation regarding an APRN compact although there have been no rules written and none of the states have actually implemented the law. At its September 2008 meeting, the NCSBN BOD endorsed the Consensus Model for APRN Regulation: Licensure, Accreditation, and Certification & Education. In September 2010, states with passed APRN Compact legislation began discussing implementation.11

Exploring Alternative Licensure Models
Although there have been numerous changes in the health care practice environment, until the NLC was introduced in the late 1990s, there had been little in the way of innovation in the fundamental processes of health professional licensure. Improvements such as on-line processing and electronic renewals have been seen, but generally the single-state system remains the current model for most professions in most states. The state does not collaborate with other states to create requirements for licensure, collect and verify the application, set fees, or process the license for the provider. A license secured in a state, other than for a NLC state, allows for practice in only that state. Employees of state licensing boards spend a great deal of their time tracking down and processing the required paperwork for initial and endorsement licensure.8 It has been suggested that reducing some of the barriers to cross-state practice may be “a way of improving the efficiency of the licensing system in this country so that scarce resources can be better used in the disciplinary and enforcement activities of state boards, rather than in duplicative licensing processes.”4

Healthcare licensure has always fallen under the purview of the state without federal government influence. States have been given full independence to determine the most appropriate system for use
in their jurisdiction. However, with the growth and interest in telehealth, implications for potentially reduced costs in healthcare including for the Medicare and Medicaid programs, the federal government is showing more interest in the licensure of healthcare personnel. The FCC’s National Broadband Plan contains a bold recommendation regarding federal intervention into professional licensing:

If collaboration between state governors and state legislators failed to develop effective licensure policies to reduce barriers to electronic practice across state lines within the next 18 months, then the Congress should intervene to ensure that Medicare and Medicaid beneficiaries are not denied the benefits of e-care. 4(p 33)

Many organizations are currently having discussions concerning alleviating unnecessary barriers to licensure portability among states. Federal and state governments, National Governors Association, consumer groups, American Telemedicine Association, professional associations, and regulatory bodies have all looked into how to expedite the mobility of professionals while still maintaining high standards and protecting the public. The diversity of these groups leads to different end-goals in the improved mobility of health professionals, but overall most groups agree it is one way to address workforce needs and improve the public’s access to health care services.

Licensure portability is seen as one element in the panoply of strategies needed to improve access to quality health care services through the deployment of telehealth and other electronic practice services (e-care or e-health services) in this country. But licensure portability goes beyond improving the efficiency and effectiveness of electronic practice services. Overcoming unnecessary licensure barriers to cross-state practice is seen as part of a general strategy to expedite the mobility of health professionals in order to address workforce needs and improve access to health care services, particularly in light of increasing shortages of healthcare professionals. 4(p 1)

The chart below from the 1997 United States Department of Commerce, Report to Congress on Telemedicine, describes the most common alternatives to the single-state licensure model: 4(p 9-10)

| Consulting Exceptions | With a consulting exception, a physician who is unlicensed in a particular state can practice medicine in that state at the request of and in consultation with a referring physician. The scope of these exceptions varies from state to state. Most consultation exceptions prohibit the out-of-state physician from opening an office or receiving calls in the state. In most states, these exceptions were enacted before the advent of telehealth and were not meant to apply to ongoing regular telehealth links. However, some states permit a specific number of consulting exceptions per year. The Model Practice Act has a telehealth consulting licensure exemption. |
| Endorsement | State boards can grant licenses to health professionals in other states with equivalent standards. Health 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. Endorsements allow 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 time consuming and expensive for a multi-state practitioner.

*Endorsement is the current means for a physical therapist to become licensed in more than one state.*

| **Reciprocity** | A licensure system based on reciprocity requires the authorities of each state to negotiate and enter agreements to recognize licenses issued by the other state without a further review of individual credentials. These negotiations can be bilateral or multilateral. A license valid in one state would give privileges to practice in all other states with which the home state has agreements. |
| **Mutual Recognition** | Mutual recognition is a system in which the licensing authorities voluntarily enter into an agreement to legally accept the policies and processes (licensure) of a licensee’s home state. Licensure based on mutual recognition is comprised of three components: a home state, a host state, and a harmonization of standards for licensure and professional conduct. The health professional secures a license in his/her own home state and is not required to obtain additional licenses to practice in other states. |
| **Registration** | Under a registration system, a health professional licensed in one state informs the authorities of other states that s/he wished to practice part-time there. By registering, the health professional would agree to operate under the legal authority and jurisdiction of the other state. Health professionals would not be required to meet entrance requirements imposed upon those licensed in the host state but they would be held accountable for breaches in professional conduct in any state in which they are registered. California had the legal authority to implement a registration system, but never did so. |
| **Limited Licensure** | Under a limited licensure system, a health
professional must obtain a license from each state in which s/he practices but has the option of obtaining a limited license for the delivery of specific health services under particular circumstances. Thus, this model limits the scope rather than the time period of practice. The health professional is required to maintain a full and unrestricted license in at least one state. The Federation of State Medical Boards “Model Act to Regulate the Practice of Medicine Across State Lines” followed the limited licensure model, requiring physicians engaged in cross-state medical practice by electronic or other means to obtain a special (limited) license issued by each of the states in which they practice remotely. According to the Federation, sixteen states had adopted a limited licensure model.

| National Licensure | A national licensure system could be adopted on the state or national level. A license would be issued based on a universal standard for the practice of healthcare in the U.S. If administered at the national level, questions might be raised about state revenue loss, the legal authority of states, logistics about how data would be collected and processed, and how enforcement of licensure standards and discipline would be administered. If administered at the state level, these questions might be alleviated. States would have to agree on a common set of standards and criteria ranging from qualifications to discipline. If the Nurse Licensure Compact is ever adopted in all 50 states, it in effect would create national licensure. |
| Federal Licensure | Under a Federal licensure system health professionals would be issued one license, valid throughout the U.S., by the Federal government. Licensure would be based on federally established standards related to qualifications and discipline and would preempt state licensure laws. Federal agencies would administer the system. However, given the difficulties associated with central administration and enforcement, the states might play a role in implementation. |

**What are Other Organizations Doing?**
Far and away, nurses have had the most innovation and progress with regards to licensure portability issues. Medicine has been identified as the second most active profession. Subsequently, most of the studies and reports on alternative licensing focus on those two professions. However, there are significant differences in the approaches that organizations have taken. Other organizations such as
NBCOT also have some of the enablers in place to allow for improved licensure processing and portability.

Federation of State Medical Boards - FSMB

The Federation of State Medical Boards (FSMB), representing the 70 medical and osteopathic boards of the United States and its territories, has been discussing licensure portability in some form for the last 11 years. FSMB has acknowledged that physician mobility has been identified as an issue for the organization and steps have been taken to implement improved processes nationally.

The emergence of telemedicine in the 1990s was the impetus for the discussions regarding physician licensure and multi-state practice. FSMB’s first policy on telemedicine, *A Model Act to Regulate the Practice of Medicine across State Lines*, was published in 1996. Beginning April 2000, the FSMB established the Special Committee on License Portability which met for 2 years to explore mechanisms that could significantly improve the portability of state medical licensure. The committee members were selected to include broad representations from the medical regulatory and professional communities, including professional and public members of state boards. Recently the increase in actual and potential use of technology in the practice of medicine has necessitated a fresh look at the FSMB policies regarding telemedicine. FSMB hosted a 100 person symposium regarding telemedicine challenges and the resources that are needed to move telemedicine in March 2011. A white paper based on the discussions and findings from this symposium will be forthcoming later in 2011.

One initiative towards improving physician mobility is the Federation Credentials Verification Service (FCVS) developed by FSMB which provides for primary source verification of a physician’s core credentials. FCVS obtains direct, primary source verification of credentials in the following categories: identity, medical education, postgraduate training, licensure examination history, educational commission for foreign medical graduated certification, board action history, and ABMS certifications. Fourteen jurisdiction medical boards require the FCVS profile for licensure and 63 accept the FCVS Profile. This is a service that physicians and physician assistants pay FSMB to perform for them. An initial application fee of $295 creates the personalized profile created and it may be sent to one recipient. Additional requests are processed for a $90 fee but additional profiles mailed at the same time as an Initial or Subsequent request are reduced to $60 each. Applicants have electronic access to the information in their profile where they can communicate with FSMB staff or make approved additions/edits to their profile. Additionally, FSMB has created separate communication portals for the member state Boards which allows secure access to the FSMB services.

Initiated in 2003 to address license portability issues, FSMB introduced the idea of a common license application that would be accepted by any state medical board. The goal was to reduce licensure application and processing time by reducing the variability of state requirements. FSMB received federal grant money to facilitate development of the uniform application. In 2009, a second grant was received to support the development of the Uniform Application for State Medical Licensure (UA) and enhancement of the Federation Credentials Verification Service. April 2010, FSMB received a grant from the American Recovery and Reinvestment Act of 2009 to put toward furthering these initiatives. The efforts have seen mixed results. As of March 2011, 18,000 medical professional have submitted a Uniform Application to the states. Of seventy Boards that FSMB represents, twelve use the Uniform Application, another twelve are developing state-specific addendums with the help of FSMB, and fourteen other medical boards are actively discussing benefits of the UA for use by their Board.
FSMB anticipates that 6 additional boards will fully implement use of the Uniform Application by the end of 2011.12 (p D-9)

National Board for Certification in Occupational Therapy- NBCOT

Unlike FSBPT and FSMB, the NBCOT defines itself primarily as “a not-for-profit credentialing agency that provides certification for the occupational therapy profession.”14 The organizational structure is very different from that of FSBPT, yet NBCOT also has public protection as its main function and concern. Many of the services offered by NBCOT and the processes in place create improved conditions for the mobility of Occupational Therapists from state to state while still acting in the public interest. The occupational therapy profession has much of the infrastructure to facilitate the alternative licensure models. NBCOT’s services and set up is not a response to new challenges however. In an interview with Paul Grace, President and CEO from NBCOT, he reports that NBCOT acting as a centralized portal for certification and a disseminator of information to the states has been the way of business since OTs began certification in the 1970s.

NBCOT plays a significant role in licensing and certification of all OTs beginning with initial licensure. In each state’s occupational therapy practice act, it is required that the occupational therapist candidate be credentialed by NBCOT prior to contacting the Board regarding licensure.15 Occupational therapists have a central application for licensure which is required by all state boards. The application includes the requirement for a social security number and is also comprised of common core standards that occupational therapists must demonstrate. Thus, the OT licensure data base is a complete record of licensed OTs, and includes a key personal identifier.15 After credentialing by NBCOT, the applicant gives permission for NBCOT to advise the State Occupational Therapy Board of their certification status, and then the state licensing process begins. The state will approve the candidate to sit for the occupational therapy Certification Examination. NBCOT is responsible for the development and administration of the national examination and dissemination of those scores to the states.14 Scores are sent to state regulatory authorities 26 times/year typically creating a 14-18 day delay from date of testing to release of test scores.15

NBCOT remains significant when an OT licensee applies to an additional state for licensure. NBCOT acts as the credentials verification service as well as the primary verifier of all licenses held. Currently, an applicant pays a $30 fee to NBCOT per verification; the OT is required to have a verification sent for each jurisdiction in which the OT has been licensed.14 These verifications are sent directly by NBCOT to the gaining jurisdiction’s Board. In addition to licensure information, NBCOT also maintains a disciplinary database with which approximately 90% of states participate.15 The applicant applying for endorsement applies with a state and contacts NBCOT where the primary source document verification has already been done and is held, their verification of other state licensure will be sent directly, score transfer sent, and NBCOT includes any history of disciplinary action to the state. Other interested parties, such as employers, can verify an Occupational Therapist’s certification status by requesting a NBCOT Certification Verification Letter for a fee of $35.14

The thorough data that NBCOT is able to collect from the centralized application and verification has built a database that is a rich source of information for the profession and the Boards. The consistency in data reporting from state to state enhances the data mining capabilities of the organization.15

Feasibility of FSBPT as the primary facilitator of a multi-state compact
The NLC began in 2000 requiring the executive directors of the nursing boards in compact states now wear two hats: Executive Director and Nurse Licensure Compact Administers (NCLA). The NLCA now exists as an unincorporated not for profit with its own Articles of Organization, which elects an Executive Committee of six Nurse Licensure Compact Administrators, the governing body of the NLC. This executive committee meets every other month; the intervening month all 24 members of the NLCA meet. The NCSBN has served as secretariat for the NLCA, pursuant to an agreement signed in 2004 and renewed annually since then. The members of the NLC are required to pay member dues to NCSBN and also an additional $3,000 in dues payable to the Compact.

The Secretariat Agreement between NCSBN and the NLC allows the NLC to pay the NCSBN to use the services of the organization for the compact’s needs such as website development and maintenance, legal services, communications, and holding a yearly meeting in conjunction with NCSBN. The NLC employee facilitates the 8-9 committees required to facilitate the compact. Committees include the NLCA committee (24), Exec Committee, Compliance (compliance audits of various states- makes sure states are in compliance with the statutes), Data Analysis and Collection committee (do research), Policies & Procedures committee (policy manual recommendations and amendments), Communication (Review of website and educational resources), Ad Hoc committee (video production), Advanced Practice Nurses compact committee (starting in 2015), and the Interface committee (relationship b/w NCSBN and Compact).

Initially, state boards were very concerned that they would need an additional FTE to administer the NLC; but no state has added/needed additional FTE. The Executive Directors continue presently in their dual role. However, after nine years, the Compact Administrators realized they weren’t making the type of progress they were hoping for and that the time demands were too great to foster the NLC. In 2009, the NLCA approached NCSBN Board of Trustees to fund an employee to assist them in the work of running the compact. With approval, one full time employee was hired to manage day to day operations of the compact and NCSBN continues to fund the 1.0 FTE for the Compact. The responsibilities of this staff person are to assist the compact states in meeting their regulatory obligations and respond to the educational needs of all member boards regarding the Nurse Licensure Compact. The NLC’s employee is also responsible for monitoring of state legislation, but time constraints do not allow for promotion and growing of the compact. In the 24 states that have passed the compact, the efforts of a lobbyist have been significant in advancing the legislative efforts in the difficult states. The Compact may be considering bringing on an additional employee to act as a lobbyist.

Financial Implications
Understandably, the idea of joining a multi-state compact brings many questions regarding the financial implications of doing so. The NCLA are very aware that a common argument against joining the compact will be based on assumptions of revenue loss and/or increased expenditures for the Board and/or state. Certainly the last few years have been a time when state government budgets have little tolerance for even minimal financial changes. Compacts vary significantly with regard to scope, complexity, and requirements to implement due to the variety. “Cost depends largely upon the desired timelines, the level of external stakeholder involvement and the level of education desired within each state.” It is definitely challenging to estimate the costs associated with an interstate compact in general.

NCSBN has performed significant analysis on the financial impact on a state when joining the NLC. At this time they have ten years of data from states with wide variety in geography and demographics from which to base the research. Overall findings from states implementing the NLC in the partnering states
demonstrate that expenses are greatest in the first year the state join due to start up expenses such as
licensee notification and state database changes such as the addition of fields to capture multi-state
versus single-state license privileges. After this first year, the administrators have not reported
notable expenses. Surprisingly, compact administrators report that they have not noted a decrease in
the amount collected in licensure fees. “Revenue gains and losses were primarily associated with
changes in: 1) licensure renewals, 2) endorsements, 3) verifications of credentials, and 4) issuance of
temporary practice permits.”

A 2008/2009 study by NCSBN included data from fifteen states that joined the NLC from 2000-2007,
looked at the actual costs of implementation of the NLC. The study was funded by a federal government
grant and information was collected on four main areas earlier identified as being affected by initial
membership into the Compact: IT costs, communication costs, administrative costs, and revenue
changes. Data from thirteen states was analyzed as two states denied any specific fiscal impact. Not
surprisingly the variation in expenditures for the thirteen states for both initial implementation and
ongoing operation was significant. “On average, the total cost of implementing the NLC was $78,448,
ranging from a gain of $112,800 to a loss of $343,000. The study authors estimate that an average
cost of $1.17 per licensee could be used to estimate the total cost of entry.” The study also suggests
a relationship between the size of the nursing population in the state and the cost of implementing the
NLC. Although not statistically significant, the data suggests “that the larger the nursing population in a
state, the higher the cost of implementing the NLC.”

In May 2011, the NLCA published its most current information from NLCA about the myths and facts of
the financial costs of belonging to the Nurse Licensure Compact. The entire document is included in
Appendix B of this report. The NLC administrators in retrospect have found the impact of NLC
membership “budget-neutral.” It is important to note that no state has repealed the NLC due to
financial issues nor has any member state reported an ongoing financial burden. No state has needed to
increase licensure fees due to joining the NLC.”

**SWOT Analysis of FSBPT to Develop and Administer a Licensure Compact**

A SWOT analysis is used to identify and evaluate the strengths and weaknesses of an organization, as
well as outside opportunities and threats that the organization may have to contend with when
considering a new direction or strategic planning for the future. The first step in the analysis is clearly
defining what the final objective is. Once the objective is defined, the SWOTs identified should help to
determine if this objective is attainable. SWOT analysis should stimulate discussion and the formation
of strategies. The information garnered from the SWOT analysis and the subsequent strategies then
flow into the planning process for implementation of the objective. A SWOT analysis of the feasibility of
the Federation of State Boards of Physical Therapy’s ability to develop and administer a multistate
compact for physical therapy licensure is set out below.

**Strengths**

- Exam, Licensure, and Disciplinary Database is operational, and already receives data from many
  jurisdictions
- Jurisdiction Licensure Reference Guide data would allow for identification and comparison of
  common core of standards/requirements for licensure and/or re-licensure
- FSBPT has operational mechanisms that currently report NPTE scores, score transfers, and
  disciplinary action alerts directly to the jurisdictions; could add other functionality
- NPTE is the only PT or PTA examination and all states have a common pass rate
• Council of Board Administrators is already established as a separate group; could wear the dual hat of Compact Administrators
• CBA meets in annually in tandem with FSBPT Annual meeting; same structure as NLCA with NCSBN

Weaknesses
• FSBPT has a lack the FTEs to fully implement a licensure compact initiative
• Other than licensure compacts, the DA has not communicated an interest in other avenues of licensure
• portability such as the common application or document verification
• ELDD- partial participation by member Boards
• PT Boards have historically been hesitant to implement other uniform standards such as the CWT

Opportunities
• FSBPT would potentially be eligible for the HRSA grants available for improved licensure portability projects
• FSBPT relationship with FCCPT and FCCPT’s expertise in document verification could be explored for a primary source verifier
• There are states already participating in similar programs in other professional disciplines; should be easier to get buy in or participation from them. Legislative or regulatory paths already allow for these types of situations
• Boards would be able to divert current staff resources to other important board functions such as disciplinary procedures rather than document verification or applications
• Have the CBA in place already, much like the NLC administrators
• May help to decrease the barriers to getting PTs where they are needed
• Increase in score transfers by PTs/PTAs suggests increased mobility of PTs/PTAs
• All states are members of inter-state compacts, just not in healthcare
• Growth of telehealth
• Ability to share licensure and disciplinary data may be enhanced with implementation of compacts or common applications.

Threats
• Federal and state legislation that inhibits database participation
• Federal interest in telehealth/licensure issues may force states to make changes
• Low number of PT licensees as compared to MDs and RNs
• Small number of PT state boards as compared to state medical or nursing boards
• Umbrella Board structure may not allow the administrators to be a compact administrator
• Concern of member Board’s about loss of revenue from verifications and other sources
• Cost of implementation of programs to cash-strapped states/boards
• American Telehealth Association Rehab Special Interest Group is researching a multi-disciplinary approach to licensure portability that may not meet PT’s needs

Process to Develop and Implement a Licensure Compact
The Council for State Government has identified the common steps from drafting to implementation of an inter-state compact. The organization interested in a compact should begin with an advisory group
of approximately 20 key stakeholders being convened to take a high level look at the key elements and challenges of an interstate compact. An Advisory Group would likely meet one or two times over a period of two to three months, with their work culminating in a set of recommendations as to what the final compact product should look like. A smaller, more focused group of 5-8 individuals will make up the Drafting Team which pulls from the work of the Advisory Group to create a draft compact. This draft comment should be circulated for wide ranging input and comment from stakeholders in all areas including the public. After revision, the draft compact would go back to the advisory group for final review and approval. “A Drafting Team typically meets three to four times over a period of 10–14 months, with significant staff work and support between sessions.” A compact regarding healthcare licensure is unique in that the initial interest will most likely be from the Board or even the professional association rather than originating with a legislator.

Once the interstate compact is drafted and approved, the states would be free to introduce legislation to implement the Compact. The interested parties will need to secure a legislator as a sponsor of a bill putting forth the legislative language. Education during this stage would be a key to overall success. The professional association, the Board members, the legislature, any overarching Boards, will need to be educated about the terms and advantages of the compact. For all their efforts, the NLC had only four states enact the Compact in its first year. The Compact may be drafted to be effective with the first members or it may pre-determine a minimum at which the Compact becomes active. Obviously until at least two states enact a licensure Compact there is no change in the status quo. Once the Compact is enacted and operational, “a critical component of the transition will be the development of rules, regulations, forms, standards, etc. by which the compact will need to operate. Typically, transition activities run for between 12 and 18 months before the compact body is independently running.”

Conclusion
Interstate compacts are not a novel idea; states have been negotiating agreements between and amongst themselves since the beginning of the country in the 1700s. Article I, Section 10 of the United States Constitution grants states the authority to enter into interstate compacts. The validity of the state’s authority to enter into compacts has been specifically recognized and unanimously upheld by the U.S. Supreme Court in West Virginia v. Sims, 341 U.S. 22 (1951). In areas that have traditionally been of both federal and state concern such as trade, boundaries, etc., the Constitution establishes the requirement for Congressional consent in order for a compact to be enacted. Congressional approval was not necessary for the Nurse Licensure Compact nor would it be required for a Physical Therapist Compact, as health professional licensing “has always been regulated by the states and there is no reason that this compact infringes on an area of federal regulation.”

There are many reasons to explore improving the mobility of licensed therapists. Opportunities such as post-graduate clinical fellowships and residencies, telehealth, practice in bordering states, practice in a medical facility with sites in multiple states, and inter-state practice for consulting has brought the issue to greater prominence. Perhaps the current licensure model should be reconsidered when the typical provider/patient interaction is evolving in ways that could not have been anticipated. Healthcare has seen the development of large healthcare conglomerates with a multi-state presence, technology to deliver services to clients physically located in another state, and insurance companies offering information lines to their clients located all over the country. In all of these examples, situations may arise when a provider may find themselves in a position to deliver services to a patient in a state in which the professional is not licensed. The reality of healthcare now is in-person care in a variety of settings, patients returning home to a different state after an episode of care and following up with a
provider by phone, video conferencing for consultation and home health visits, and Internet consultation.

In order to implement alternative licensure models, an entirely new infrastructure must be created at the state level. Although the “legal and practical challenges of achieving significant progress in licensure portability are not insignificant,” this infrastructure could be implemented incrementally, each change reducing another barrier to improved licensure portability and data exchange. Some of these changes, coined “enablers” by HRSA, include identifying a common core of standards for licensure, creating a common application from those standards/requirements, centralizing verification and storage for primary source documents, centralizing verification of past/present licenses, exempting individuals from licensure in certain situations, and centralizing licensure/disciplinary reporting and storage. The Federation may want explore the enablers to licensure portability and information sharing and determine which, if any, would be most feasible to undertake.

A primary tenant of any interstate compact considered by the Federation should be sharing of disciplinary data. “The broadening of authority to practice in several states necessitates the broadening of information sharing to allow state boards...to discipline, if discipline is needed.” A compact should increase data sharing, most significantly disciplinary data and personal identification data among states, potentially improving public protection by enhancing the reporting between states and the Federation. In turn, the Federation’s Examination, Licensure, and Disciplinary Database (ELDD) would be strengthened and enhanced.

States should be mindful that interstate compacts are not the only way to meets goals of increased sharing of disciplinary information or improved mobility of licensed professionals. There are many licensure models to consider if the primary goal is an increase in licensure portability. States desiring to reduce regulatory barriers might adopt true reciprocity in licensing or enter a contractual relationship with other willing states. A compact on the large scale of the NLC is not necessary; compacts may also be narrow, addressing one specific area such as sharing of disciplinary information among states or very broad encompassing all of licensing. The full force of the contract and statute duality of an interstate contract remains intact regardless of the scope of the compact. If states are exploring a means of improving the reporting of disciplinary information or superseding current state law that prevents reporting, a limited compact may accomplish the goal.

The NLC has encountered significant difficulty and resistance to adding additional states after a strong initial push. The resistance to joining the Compact has been fierce in many states from a variety of stakeholders, most notably the nursing professional association. Ten years after the initial states enacted the compact, fewer than half of the fifty states have become members. The implementation of a licensure compact necessitates legislative action and acceptance of uniform language related to this change in every jurisdiction that participates. This is certainly not an easy process and likely is not the highest legislative priority in many jurisdictions. Prior to embarking on the implantation of a licensure compact focused on portability, it would behoove the Federation and its members to clearly define the goals of the Assembly and determine the best means to achieve those goals versus only looking at one option. An interstate licensure compact may or may not be the best solution particularly when one considers the process to implement in all jurisdictions.

A special thank you to Jim Puente, NLC Associate at the NCSBN for all his help.
Appendix A: Model NLC Legislation and Rules
Appendix B: Myth/Fact Sheet on the Financial Burden of the NLC
Appendix C: Job Description NLC Administrator
Appendix D: Job Description NLC Associate
References
8. E-mail and telephone interview May 23, 2011 with Jim Puente, Associate, Nurse Licensure Compact.
15. Telephone interview May 25, 2011 with Paul Grace, President and CEO, National Board for Certification in Occupational Therapy.
Appendix A: Model Language for Legislation and Rules for NLC

Model Legislation for States to Enact the Nurse Licensure Compact (NLC)

Model NLC Legislation serves as the basis for what states need to enact to join the NLC. In order to be eligible to join the NLC, states must pass the model legislation without any material differences. See also Optional Enabling Language and Model Rules below.

Adopted as model law on November 6, 1998

ARTICLE I
Findings and Declaration of Purpose

a. The party states find that:
   1. the health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws;
   2. violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;
   3. the expanded mobility of nurses and the use of advanced communication technologies as part of our nation's healthcare delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation;
   4. new practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;
   5. the current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant to both nurses and states.

b. The general purposes of this Compact are to:
   1. facilitate the states' responsibility to protect the public's health and safety;
   2. ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation;
   3. facilitate the exchange of information between party states in the areas of nurse regulation, investigation and adverse actions;
   4. promote compliance with the laws governing the practice of nursing in each jurisdiction;
   5. invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses.

ARTICLE II
Definitions
As used in this Compact:

a. "Adverse Action" means a home or remote state action.
b. "Alternative program" means a voluntary, non-disciplinary monitoring program approved by a nurse licensing board.

c. "Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws, which is administered by a non-profit organization composed of and controlled by state nurse licensing boards.

d. "Current significant investigative information" means:
   investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.

e. "Home state" means the party state which is the nurse's primary state of residence.

f. "Home state action" means any administrative, civil, equitable or criminal action permitted by the home state's laws which are imposed on a nurse by the home state's licensing board or other authority including actions against an individual's license such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.

g. "Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

h. "Multistate licensure privilege" means current, official authority from a remote state permitting the practice of nursing as either a registered nurse or a licensed practical/vocational nurse in such party state. All party states have the authority, in accordance with existing state due process law, to take actions against the nurse's privilege such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.

i. "Nurse" means a registered nurse or licensed practical/vocational nurse, as those terms are defined by each party's state practice laws.

j. "Party state" means any state that has adopted this Compact.

k. "Remote state" means a party state, other than the home state, where the patient is located at the time nursing care is provided, or, in the case of the practice of nursing not involving a patient, in such party state where the recipient of nursing practice is located.

l. "Remote state action" means any administrative, civil, equitable or criminal action permitted by a remote state's laws which are imposed on a nurse by the remote state's licensing board or other authority including actions against an individual's multistate licensure privilege to practice in the remote state, and cease and desist and other injunctive or equitable orders issued by remote states or the licensing boards thereof.

m. "State" means a state, territory, or possession of the United States, the District of Columbia.

n. "State practice laws" means those individual party's state laws and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline.

o. "State practice laws" does not include the initial qualifications for licensure or requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.
ARTICLE III
General Provisions and Jurisdiction

a. A license to practice registered nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a registered nurse in such party state. A license to practice licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a licensed practical/vocational nurse in such party state. In order to obtain or retain a license, an applicant must meet the home state's qualifications for licensure and license renewal as well as all other applicable state laws.

b. Party states may, in accordance with state due process laws, limit or revoke the multistate licensure privilege of any nurse to practice in their state and may take any other actions under their applicable state laws necessary to protect the health and safety of their citizens. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

c. Every nurse practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time care is rendered. In addition, the practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of a party state. The practice of nursing will subject a nurse to the jurisdiction of the nurse licensing board and the courts, as well as the laws, in that party state.

d. This Compact does not affect additional requirements imposed by states for advanced practice registered nursing. However, a multistate licensure privilege to practice registered nursing granted by a party state shall be recognized by other party states as a license to practice registered nursing if one is required by state law as a precondition for qualifying for advanced practice registered nurse authorization.

e. Individuals not residing in a party state shall continue to be able to apply for nurse licensure as provided for under the laws of each party state. However, the license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state unless explicitly agreed to by that party state.

ARTICLE IV
Applications for Licensure in a Party State

a. Upon application for a license, the licensing board in a party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any restrictions on the multistate licensure privilege, and whether any other adverse action by any state has been taken against the license.

b. A nurse in a party state shall hold licensure in only one party state at a time, issued by the home state.

c. A nurse who intends to change primary state of residence may apply for licensure in the new home state in advance of such change. However, new licenses will not be issued by a party state until after a nurse provides evidence of change in primary state of residence satisfactory to the new home state's licensing board.

d. When a nurse changes primary state of residence by:
   1. moving between two party states, and obtains a license from the new home state, the license from the former home state is no longer valid;
2. moving from a non-party state to a party state, and obtains a license from the new home state, the individual state license issued by the non-party state is not affected and will remain in full force if so provided by the laws of the non-party state;

3. moving from a party state to a non-party state, the license issued by the prior home state converts to an individual state license, valid only in the former home state, without the multistate licensure privilege to practice in other party states.

ARTICLE V
Adverse Actions

In addition to the General Provisions described in Article III, the following provisions apply:

a. The licensing board of a remote state shall promptly report to the administrator of the coordinated licensure information system any remote state actions including the factual and legal basis for such action, if known. The licensing board of a remote state shall also promptly report any significant current investigative information yet to result in a remote state action. The administrator of the coordinated licensure information system shall promptly notify the home state of any such reports.

b. The licensing board of a party state shall have the authority to complete any pending investigations for a nurse who changes primary state of residence during the course of such investigations. It shall also have the authority to take appropriate action(s), and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.

c. A remote state may take adverse action affecting the multistate licensure privilege to practice within that party state. However, only the home state shall have the power to impose adverse action against the license issued by the home state.

d. For purposes of imposing adverse action, the licensing board of the home state shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct had occurred within the home state. In so doing, it shall apply its own state laws to determine appropriate action.

e. The home state may take adverse action based on the factual findings of the remote state, so long as each state follows its own procedures for imposing such adverse action.

f. Nothing in this Compact shall override a party state’s decision that participation in an alternative program may be used in lieu of licensure action and that such participation shall remain non-public if required by the party state’s laws. Party states must require nurses who enter any alternative programs to agree not to practice in any other party state during the term of the alternative program without prior authorization from such other party state.

ARTICLE VI
Additional Authorities Invested in Party State Nurse Licensing Boards

Notwithstanding any other powers, party state nurse licensing boards shall have the authority to:

a. if otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse;
b. issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a nurse licensing board in a party state for the attendance and testimony of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

c. issue cease and desist orders to limit or revoke a nurse's authority to practice in their state;
d. promulgate uniform rules and regulations as provided for in Article VIII(c).

ARTICLE VII
Coordinated Licensure Information System

a. All party states shall participate in a cooperative effort to create a coordinated data base of all licensed registered nurses and licensed practical/vocational nurses. This system will include information on the licensure and disciplinary history of each nurse, as contributed by party states, to assist in the coordination of nurse licensure and enforcement efforts.
b. Notwithstanding any other provision of law, all party states' licensing boards shall promptly report adverse actions, actions against multistate licensure privileges, any current significant investigative information yet to result in adverse action, denials of applications, and the reasons for such denials, to the coordinated licensure information system.
c. Current significant investigative information shall be transmitted through the coordinated licensure information system only to party state licensing boards.
d. Notwithstanding any other provision of law, all party states' licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.
e. Any personally identifiable information obtained by a party states' licensing board from the coordinated licensure information system may not be shared with non-party states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.
f. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information, shall also be expunged from the coordinated licensure information system.
g. The Compact administrators, acting jointly with each other and in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this Compact.

ARTICLE VIII
Compact Administration and Interchange of Information

a. The head of the nurse licensing board, or his/her designee, of each party state shall be the administrator of this Compact for his/her state.
b. The Compact administrator of each party state shall furnish to the Compact administrator of each other party state any information and documents including, but not limited to, a uniform
data set of investigations, identifying information, licensure data, and disclosable alternative program participation information to facilitate the administration of this Compact.

c. Compact administrators shall have the authority to develop uniform rules to facilitate and coordinate implementation of this Compact. These uniform rules shall be adopted by party states, under the authority invested under Article VI (d).

ARTICLE IX
Immunity

No party state or the officers or employees or agents of a party state's nurse licensing board who acts in accordance with the provisions of this Compact shall be liable on account of any act or omission in good faith while engaged in the performance of their duties under this Compact. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness.

ARTICLE X
Entry into Force, Withdrawal and Amendment

a. This Compact shall enter into force and become effective as to any state when it has been enacted into the laws of that state. Any party state may withdraw from this Compact by enacting a statute repealing the same, but no such withdrawal shall take effect until six months after the withdrawing state has given notice of the withdrawal to the executive heads of all other party states.

b. No withdrawal shall affect the validity or applicability by the licensing boards of states remaining party to the Compact of any report of adverse action occurring prior to the withdrawal.

c. Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.

d. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

ARTICLE XI
Construction and Severability

a. This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any state party thereto, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

b. In the event party states find a need for settling disputes arising under this Compact:
   1. The party states may submit the issues in dispute to an arbitration panel which will be comprised of an individual appointed by the Compact administrator in the home state;
an individual appointed by the Compact administrator in the remote state(s) involved;
and an individual mutually agreed upon by the Compact administrators of all the party
states involved in the dispute.
2. The decision of a majority of the arbitrators shall be final and binding.

Optional Enabling Language

Optional enabling act provisions may be appropriate for states to utilize when looking to enact the NLC
into law depending on the needs of the state.

1. The Nurse Licensure Compact is hereby enacted and entered into with all other jurisdictions that
legally join in the compact, which is, in form, substantially as follows:
2. "The head of the nurse licensing board" as used to define the compact administrator in Article
VIII(a) shall mean xxxxxxx.
3. To facilitate cross-state enforcement efforts, the legislature finds that it is necessary for [this
state] to have the power to recover from the affected nurse the costs of investigations and
disposition of cases resulting from adverse actions taken by this state against that nurse.
Coordinating language shall be inserted in the appropriate location in the Nurse Practice Act.
4. This Compact is designed to facilitate the regulation of nurses, and does not relieve employers
from complying with statutorily imposed obligations.
5. This Compact does not supersede existing state labor laws.
6. To facilitate workforce planning, the legislature finds it necessary for [this state] to grant the
board of nursing the authority to collect employment data on nurses practicing on the multi-
privilege in the NLC, on a provided form, provided that the submission of this data is not a
requirement for practice under the multi-state privilege.

Nurse Licensure Compact (NLC) Model Rules and Regulations for RNs and LPN/VNs

Article 6D and 8C of the Nurse Licensure Compact grant authority to the Compact Administrators to
develop uniform rules to facilitate and coordinate implementation of the Compact.

As Amended August 4, 2008

1. Definition of terms in the Compact.

For the Purpose of the Compact:

a. "Board" means party state's regulatory body responsible for issuing nurse licenses.
b. "Information system" means the coordinated licensure information system.
c. "Primary state of residence" means the state of a person's declared fixed permanent and
principal home for legal purposes; domicile.
d. "Public" means any individual or entity other than designated staff or representatives of party
state Boards or the National Council of State Boards of Nursing, Inc.
Other terms used in these rules are to be defined as in the Interstate Compact.

2. Issuance of a license by a Compact party state.

For the purpose of this Compact:

a. As of July 1, 2005, no applicant for initial licensure will be issued a compact license granting a multi-state privilege to practice unless the applicant first obtains a passing score on the applicable NCLEX examination or its predecessor examination used for licensure.

b. A nurse applying for a license in a home party state shall produce evidence of the nurse’s primary state of residence. Such evidence shall include a declaration signed by the licensee. Further evidence that may be requested may include but is not limited to:
   i. Driver’s license with a home address;
   ii. Voter registration card displaying a home address; or
   iii. Federal income tax return declaring the primary state of residence.
   iv. Military Form no. 2058 - state of legal residence certificate; or
   v. W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence.

(Statutory basis: Articles 2E, 4C, and 4D)

c. A nurse on a visa from another country applying for licensure in a party state may declare either the country of origin or the party state as the primary state of residence. If the foreign country is declared the primary state of residence, a single state license will be issued by the party state. (Statutory basis: Article 3E)

d. A license issued by a party state is valid for practice in all other party states unless clearly designated as valid only in the state which issued the license. (Statutory basis: Article 3A and 3B)

e. When a party state issued a license authorizing practice only in that state and not authorizing practice in other party states (i.e. a single state license), the license shall be clearly marked with words indicating that it is valid only in the state of issuance. (Statutory basis: Article 3A, 3B, and 3E)

f. A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multi-state licensure privilege during the processing of the nurse’s licensure application in the new home state for a period not to exceed thirty (30) days. (Statutory basis: Articles 4B, 4C, and 4D[1])

g. The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance and the thirty-(30) day period in section 2f shall be stayed until resolution of the pending investigation. (Statutory basis: Article 5[8])

h. The former home state license shall no longer be valid upon the issuance of a new home state license. (Statutory basis: Article 4D[1])

i. If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten (10) business days and the former home state may take action in accordance with that state’s laws and rules.

3. Limitations on multi-state licensure privilege - Discipline.
a. Home state Boards shall include in all licensure disciplinary orders and/or agreements that limit practice and/or require monitoring the requirement that the licensee subject to said order and/or agreement will agree to limit the licensee's practice to the home state during the pendency of the disciplinary order and/or agreement. This requirement may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and such other party state Boards. (Statutory basis: State statute)

b. An individual who had a license which was surrendered, revoked, suspended, or an application denied for cause in a prior state of primary residence, may be issued a single state license in a new primary state of residence until such time as the individual would be eligible for an unrestricted license by the prior state(s) of adverse action. Once eligible for licensure in the prior state(s), a multistate license may be issued.

4. Information System.

a. Levels of access
   i. The Public shall have access to nurse licensure information limited to:
      a. the nurse's name,
      b. jurisdiction(s) of licensure,
      c. license expiration date(s),
      d. licensure classification(s) and status(es),
      e. public emergency and final disciplinary actions, as defined by contributing state authority, and
      f. the status of multi-state licensure privileges.
   ii. Non-party state Boards shall have access to all Information System data except current significant investigative information and other information as limited by contributing party state authority.
   iii. Party state Boards shall have access to all Information System data contributed by the party states and other information as limited by contributing non-party state authority. (Statutory basis: 7G)

b. The licensee may request in writing to the home state Board to review the data relating to the licensee in the Information System. In the event a licensee asserts that any data relating to him or her is inaccurate, the burden of proof shall be upon the licensee to provide evidence that substantiates such claim. The Board shall verify and within ten (10) business days correct inaccurate data to the Information System. (Statutory basis: 7G)

c. The Board shall report to the Information System within ten (10) business days
   i. disciplinary action, agreement or order requiring participation in alternative programs or which limit practice or require monitoring (except agreements and orders relating to participation in alternative programs required to remain nonpublic by contributing state authority),
   ii. dismissal of complaint, and
   iii. changes in status of disciplinary action, or licensure encumbrance. (Statutory basis: 7B)

d. Current significant investigative information shall be deleted from the Information System within ten (10) business days upon report of disciplinary action, agreement or order requiring participation in alternative programs or agreements which limit practice or require monitoring or dismissal of a complaint. (Statutory basis: 7B, 7F)
e. Changes to licensure information in the Information System shall be completed within ten (10) business days upon notification by a Board. (Statutory basis: 7B, 7F)
Appendix B: Myth/Fact Sheet on the Financial Burden of the NLC

**Myth:**
Joining the Nurse Licensure Compact (NLC) causes a significant financial burden on the state board of nursing.

**Fact:**
There are expenses associated with joining the NLC. The expenses are primarily pre-implementation and concurrent with implementation.

**Communication:** States joining the NLC must notify all licensees of their status as a compact state. Nurses licensed in more than one compact state must declare their primary state of residence. Postage costs associated with notifying licensees varies state to state.

**Education:** Many executive directors have made state-wide trips to educate various groups (e.g., nursing programs, hospital associations, nurse executives) about the NLC. Costs associated with this in-state travel vary. The NLCA is also producing an educational video which will help state boards to educate their constituencies about the NLC.

**Training:** The executive director of the board of nursing will spend several hours training board staff about their role and function as it relates to the compact. The NLCA also offers the board an onsite one-day orientation to the NLC at no cost. The NLCA is also presently coordinating the production of a series of webinars to be utilized for staff training.

**IT:** The board of nursing licensure system must now be able to accommodate a new “field” in their database to indicate whether a license is single state or multistate. There is generally little or no expense associated with this modification which board staff typically makes internally.

**Nursys:** States joining the NLC are required to participate in the Nursys database if they are not already. Forty-four jurisdictions currently participate (https://www.nursys.com/LQC/QuickConfirmJurisdictions.aspx). There are no costs associated with this. Prior to joining Nursys, a state may need to perform necessary data preparation. States are able to apply for funds to cover any data-related expenses not budgeted for. Nursys staff also conducts an onsite orientation to Nursys functionality and reporting capabilities at no cost to the board and provides ongoing support as required.

**NLCA Fees:** There are membership fees of $3,000 per year which must be paid to the NLCA commencing in the year following implementation.

**Rule-making:** Member states are required to promulgate the NLC Model Rules. There are potential costs associated with this.

**Personnel:** Although it is possible for a state to hire an additional staff to be the NLC Administrator, it has been logical for the executive director to wear an additional “hat” as the state’s NLC Administrator.

**Budget Impact Related to Licensure Revenue:** When a state joins the NLC, nurses licensed in that state who reside in and hold a multistate license in any other NLC state will no longer need to hold a license in that newly joined state. Conversely, nurses residing in the newly joined state who hold licenses in other NLC states will now need to be licensed in the newly joined state (their state of residency). NLC Administrators, looking back on their experience in the NLC over the past ten years, have described this balance of licensees gained and licensees lost as “a wash.”

**Overall:** NLC Administrators, looking back on their experience in the NLC over the past ten years have described joining the NLC as “budget-neutral.” No state has repealed the NLC due to financial issues nor has any member state reported an ongoing financial burden. No state has needed to increase licensure fees due to joining the NLC.
For more information about the NLC, you may contact Jim Puente, Associate, NLC at 312.525.3601 or jpuente@ncsbn.org.
APPENDIX C: NLC Administrator Job Description

Job Title: Nurse Licensure Compact Administrator (NLCA)

Job Description

The head of the nursing licensing board, or his/her designee, of each party state serves as the Nurse Licensure Compact Administrator for his/her state. The compact has the force and effect of statutory law and is a legally binding contract. Therefore the administrator is legally accountable to: ensure and encourage cooperation between of party states in the areas of nurse licensure and regulation; facilitate the exchange of information between party states in the areas of investigation and adverse actions; promote compliance with laws governing the practice of nursing in each jurisdiction; resolve disputes and controversies among compact states and hold nurses accountable for meeting state practice laws in the state in which the patient is located at the time care is provided through the mutual recognition of party state licenses.

Job Responsibilities:

1. Responsible for coordinating a states participation in the interstate nurse licensure contractual agreement.

2. Participates in the NLCA for purposes of communication, rulemaking, education, collaborative/cooperative state action and enforcement.

3. In conjunction with others establishes uniform policies and guidelines and procedures to implement the compact statutory requirements as it applies to all states.


5. Provides information about the Nurse Licensure Compact to other boards of nursing, various agencies, practitioners and the public.
   A. Demonstrates knowledge of the laws, policies and procedures of the Nurse Licensure Compact.
   B. Updates related agencies and public about any changes in compact rules and regulations.

6. Participates in a cooperative efforts to create/enhance the consistency and standardization of compact investigations of all licensed nurses to assist with licensure and enforcement efforts.
   A. Attends meetings of the NLCA in order to make suggestions and advise of problems. Investigative cases are confidential by law and therefore may not be shared with boards that are not in the compact.
   B. Contacts NCSBN Information Technology when problems arise.
   C. Assures staff is properly trained in Nursys computer program.

7. Develops new policies/procedures and enhances existing policies directly related to the NLC.
A. Identifies NLC policies that are ambiguous and needing clarification.
B. Recommends/drafts changes to policies and forwards to Nurse Licensure Executive Committee/Members as needed

8. Assist in establishing uniform standards for collecting and exchanging data.
   A. Collects agreed upon appropriate statistics on compact investigative cases.
   B. Prepares statistical reports as agreed upon by NLCA using prescribed format.

9. Serves as member of the Nurse Licensure Compact Administrator in organization accordance with state law.
   A. Participates actively in NLC meetings and assists in formulating rules/regulations/policies to more effectively carry out the work of compact.
   B. Serves as officer, executive board member, and committee chairperson as required.
APPENDIX D: NLC Associate Job Description

Job Description

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Group</th>
<th>Department</th>
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<tbody>
<tr>
<td>Associate, NLC</td>
<td>Executive Office</td>
<td>Executive Office</td>
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</table>

**Accountable to:**
Chief Executive Officer

**FLSA Status/Band:**
Exempt/8

**Job Summary:**
Administers and manages operational aspects in support of the Nurse Licensure Compact (NLC). Monitors regulation implementation and compliance. Provides information, education, and outreach regarding the NLC. Conducts data and trend analysis. Provides administrative support to the Nurse Licensure Compact Administrators.

**Principle Responsibilities**

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Description</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>1</td>
<td>Regulation Compliance and Implementation:</td>
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<td></td>
<td>• Develops implementation strategies for regulation compliance and implements a systematic process for monitoring compliance of party states with compact statutes, rules, and policies.</td>
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<td>• Annually reviews policies and procedures for currency and compliance.</td>
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<td>• Monitors and reports on implementation of uniform core licensure requirements in all party states and provides an annual compliance report.</td>
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<td>• Assists and supports states implementing the Nurse Licensure Compact.</td>
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<td>2</td>
<td>Outreach &amp; Public Relations:</td>
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<td>• Provides external presentations and develops briefing papers on issues of concern.</td>
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<td>• Monitors all relevant legislation and works collaboratively with all stakeholders.</td>
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<td>3</td>
<td>Education, &amp; Communication:</td>
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<td>• Develops and maintains a repository of informational and educational materials regarding the Nurse Licensure Compact.</td>
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<td>• Ensures the website is current and accurate and publishes a newsletter.</td>
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<td>4</td>
<td>Data &amp; Trend Analysis:</td>
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<td>• Collects and analyzes pertinent data related to the Nurse Licensure Compact.</td>
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<td>• Develops and implements a uniform system of data collection for financial, disciplinary, non-disciplinary alternative programs, workforce, and privilege to practice utilization.</td>
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<td>5</td>
<td>Administrative Support:</td>
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<td>• Works in consultation with NLCA chair to develop meeting agendas, materials, and minutes and provides staff support for all NLCA meetings.</td>
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<td>• Monitors and reports on strategic plan progress and implements record and retention procedures.</td>
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<td>6</td>
<td>Performs other duties as assigned.</td>
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**Job Specifications**

(Education, Certification, Special Knowledge and Skills)

- Bachelor degree required; Master’s degree preferred in business, healthcare administration or related field with 3 – 5 years project management experience in business development, management, government relations, or regulation. Experience with 501 (c) organizations (membership or constituency based) preferred.

- Excellent oral and written communication, presentation, technical, organizational, customer service, analytical and critical thinking, and problem solving skills required.

- Knowledge of professional licensure or credentialing; Public protection models preferred.

- Detail-oriented, resourceful, innovative with the ability to work collectively and/or independently to resolve issues.

- Microsoft Office experience at intermediate level is required.