**ANA Issue *Brief* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nurse Licensure Compact**

**Frequently Asked Questions**

**April, 2021**

**What is the Nurse Licensure Compact (NLC)?**

As the first interstate compact for a health profession, the NLC is a form of mutual recognition in which “the licensing authorities voluntarily enter into an agreement to legally accept the policies and processes (licensure) of a licensee’s home state.” The foundation for this agreement is a shared consensus on standards for nursing licensure and professional practice. Once a registered nurse obtains a license in her or his “home” state, (state of residence), this license is recognized by any of the other “mutual recognition” (party) state in which the Compact has been enacted. Should the state of residence change, a new license must be obtained. A nurse may hold only one home state license at a time.

The American Nurses Association (ANA) first deliberated the NLC during the 1997 House of Delegates. At that time, delegates expressed a number of concerns related to the multi-state licensure model and requested further exploration.

**What issues did the 1997 delegates request ANA to investigate or monitor?**

* Undue influence on collective bargaining activities.
* Increased difficulty collecting data for workforce projections.
* Differences in educational qualifications for licensure/re-registration requirements (such as recognition of non-traditional programs) as well as mandatory continuing education.
* The impact on resources for State Boards of Nursing.
* Ensure there is transparency with rule-making.
* Sharing information related to disciplinary matters, other than final orders and emergency suspensions, should be prohibited unless there is a clear and convincing need to do so to protect the public.

**Where are we now**

**How many states participate in the NLC?**

Maryland was the first state to implement the original NLC in 1999. Between that date and 2015, 29 states adopted the Compact. In May 2015, the National Council of State Boards of Nursing (NCSBN) adopted two new Compacts: the “enhanced” RN Compact and the APRN Compact. Since the adoption of the eNLC, 34 states have enacted legislation to recognize. (as of 4/ 7/ 21) [Nurse Licensure Compact (NLC) | NCSBN](https://www.ncsbn.org/nurse-licensure-compact.htm)

The “enhanced” Compact is based on higher standards to which NCSBN identifies as: (1) the required criminal background check (CBC) (state and federal) on initial licensure and (2) restriction from acquiring a multistate license if ever convicted of a felony. Additionally the enhanced Compact must include the NCSBN’s Uniform Licensure Requirements (ULRs) [Uniform Licensure Requirements | NCSBN](https://www.ncsbn.org/107.htm). The ULRs establish consistent standards for initial, endorsement, renewal and reinstatement licensure needed and must be adopted by any Compact state.

The 2015 APRN Compact was revised in 2020. It allows an advanced practice registered nurse to hold one multistate license with a privilege to practice in other compact states. The APRN Compact will be implemented when 7 states have enacted the legislation. [FINAL\_APRNCompact\_8.12.20.pdf (ncsbn.org)](https://www.ncsbn.org/FINAL_APRNCompact_8.12.20.pdf)

Under the NLC, licensed nurses must comply with the nursing practice laws in the state where the patient is located at the time of service. Such laws include the methods and grounds for imposing disciplinary actions.Participation in a national data base, Coordinated Licensure Information System (CLIS), or Nursys is required by all states in the NLC. It permits states to share information for verification of nurse licensure, discipline and practice privileges.

**What are ANA’s current concerns**?

With almost two decades of experience with the NLC, many of ANA’s original issues have been refuted. However, two major areas of concern were reaffirmed by ANA representatives during the 2015 Membership Assembly.

1. ANA and the National Council of State Boards of Nursing (NCSBN) have a fundamental difference of opinion about the **location of practice**.

In 1998, ANA took the position that the location of practice is where the registered nurse is located, given the knowledge, skill, and judgment applied to practice rests with the registered nurse. ANA’s position on the state of practice was reaffirmed by the 2015 Membership Assembly. However, the Compact is based on the understanding that the location of practice is defined as where the patient is located.

An overview of the policy, legal and legislative trends reveals that the movement is toward identifying the location of the patient as the site of practice. While the nursing community has not agreed upon the location of practice, other health professions pursuing interstate compacts have taken the policy view that the location of care is where the patient is located*.*

1. **Variations between states in relation to licensure / re-registration requirements**

Variations in licensure are confusing and burdensome for nurses.Examples include:

* frequency & requirements for re-licensure and re-registration;
* recognition of non-traditional education programs particularly with regard to number of clinical hour requirements for entry into practice;
* required continuing education, if any;
* what constitutes an infraction and resultant actions taken by the Board.
* criminal background checks (CBC)
	+ As of June 2015, 36 states require criminal background checks, 20 of the 25 NLC states require a CBC. Of the 14 states that do not require fingerprint-based criminal background checks, five require a state record search for information on past criminal history by name checks and state court records; nine states require self-disclosure of any criminal history;
* how nurse diversions & addictions are addressed; is a program to support nurses available?

The APRN Compact (revised in 2020) has added 2080 practice hours in order to achieve full practice authority and possess a multistate license.

**What’s next?**

The ANA Board of Directors directed staff to focus on moving forward with related areas of work that will contribute to creating an environment that will support interstate care delivery by striving for standardization of licensure processes across the state jurisdictions. Initial activities include a focus on:

1. Development of a standardized decision tree for determining scope of practice.
2. Uniform implementation of the federal biometric background licensure requirement.
3. Review, evaluate and make recommendations for alternative discipline programs for nurses with substance use disorders.

Note the following when considering adoption. As with any interstate compact, major provisions may not be changed.

* Verify that codification of a for-profit entity (The Nurse Licensure Commission) in statute is not a violation of the state’s Constitution. Note: the Commission describes themselves as quasi-governmental.
* Have an opt in / out for multistate licensure with associated fee differential.
* Seek an amendment that identifies who / how many nurses are working in the state using a multistate license. Collection of nursing workforce data is imperative for more effective planning.

**Other Compacts**

Although designed and operated differently than the Nursing Compacts, Medicine, Physical Therapy, Psychology and Emergency Medical Services have advanced Compacts in several states, while other groups are considering.

Revised 2021