Multi-State Licensure:
What is it? What are the concerns? How does it affect nursing practice?

By Ann Robinette, BSN, RN

One of the foremost policy issues facing interstate nursing today is the multistate licensure compact. The nursing profession must learn to adapt to a rapidly changing health care environment. The American workforce as a whole is much more mobile than it historically has been (King, 1999). This trend is also true of the nursing profession. Geographic boundaries are fading as the nursing profession strives to keep up with current trends (Gaffney, 1999).

Design of compact

The interstate compact is the result of several years of study and was endorsed by the National Council of State Boards of Nursing (NCSBN) in 1996. Utah was the first state to adopt the Nursing Regulation Interstate Compact in 1998 (Poe, 1999). Currently twenty states have signed on to the Nurse Licensure Compact (NLC). Being centrally located geographically, Missouri is feeling the pressures from neigh-boring states to make its stance known. Four of its eight neighboring states have already enacted the NLC. They are Nebraska, Iowa, Arkansas and Tennessee (NCSBN, 2002).

The compact is based on the driver's license model. A nurse ay practice in any state that has adopted the compact under the license from their home state. However, the nurse must practice under the regulations of the remote state in which they practice (King, 1999). Under this framework, a critical component is a centralized database called the Coordinated Licensing Information System (CLIS). The database will make easy access to licensing and disciplinary actions available to each state board of nursing (Heimericks, 2001).

A compact is defined as "the mechanism that states use to adopt the mutual recognition model. In simplest terms it is a legal agreement between two or more states that enables nurses licensed in states to practice in the other states agreeing to the compact" (Kulig, 2002, p.2). The concept of compacts is not new to Missouri and neighboring states. The Missouri River coalition is an example of a compact that is comprised of several states agreeing to regulate the water flow rate along the Missouri River. Thus the legislators have a frame of reference when discussing compacts.

Many nurses work across state borders. For example, five of the six largest cities in the state in Missouri are near the state border. Registered nurses and licensed practical or vocational nurses in these cities are going to cross the state line on a regular basis. Hospitals exist in the metro areas on both sides of the border. Currently, these nurses obtain a license in each state in which they practice. This is a burden for each nurse who practices in multiple states (Poe, 1999).

Issue concerns

The most pressing reason to consider the Nurse Licensure Compact (NLC) is the nature of the evolving nursing environment. In recent years, there has been rapid growth of telehealth and telemedicine. At the same time, multistate health care systems have expanded and registered nurses have significantly increased their mobility (Glazer, 1999, May 4). The resulting mandate is that "... nursing must adapt to the changing environment by altering the sys-tem for regulating interstate significant costs to the individual nurse who practiced across state lines. Duplication in licensure paperwork and fees add to their workload and creates extra expenses (Poe, 1999).

Although the Nurse Licensure Compact (NLC) potentially solves many current problems with interstate nursing, there are still many concerns. Nurses may face double compliance. This means that the compact requires the nurse not only to comply with the nursing regulations in the state in which he/she practices but also in the state in which he/she is licensed. This is similar to following traffic regulations in the state that one is visiting. The nurse will also have to comply with regulations in a home state to renew a license (Franklin, 1998). The Coordinated Licensing Information System (CLIS) has been developed to assist with this issue but it has raised new concerns. A centralized database might facilitate sharing of personal data, which raises confidentiality issues. For example, CLIS administrators might consider selling personal data to interested parties like HMOs (Franklin, 1998).

The content of the database poses another question and concern. Will it contain only disciplinary actions or also include complaints? Potentially, a nurse's career could be unfairly damaged by an abundance of unfounded and frivolous complaints (Heimericks, 2001). Conversely a nurse facing disciplinary action in one state would be able to apply for a temporary license in another state and begin practicing in a new jurisdiction. Once these temporary licenses are issued, history has shown that retraction of these licenses is difficult to achieve (Gaffney, 1999). Disciplinary history is often a great challenge to track across state borders especially if the nurse fails to completely report his/her prior work record. In addition, disciplinary actions vary from state to state. For example, Missouri requires a formal hearing while Arkansas utilizes an informal hearing. Those focusing on the standards of quality of nursing care are fearful of "dumbing down the process" (Beth Traudes, personal communication, October 31, 2002).

States are being asked to adopt the compact while the details of the CLIS are still under development. A major area of concern is that database administrators are being given immunity for database errors and/or omissions. This immunity undermines accountability (ANA, 2002). Secondly "The states of Kansas and Nebraska have opinions from their State Attorneys General stating that the Interstate Compact is unconstitutional because it violates the state's rights to regulate nursing practice" (Resolution 99-3, p.12). Another concern of the ANA and MONAs government affairs committee is the flawed language of the compact. The ANA and their legal experts closely examined the specific language of the compact. They listed 14 points of concern with 7 of the points being critical to the nursing practice (ANA, 1998; Belinda Heimericks, personal communication, October 30, 2002). More information is available concerning ANAs 14 points at ANAs website http://www.nursingworld.or/gova/charts/intrst.htm.

The role of the individual states' regulatory control over the quality of their licensed nurses must still be defined. A lot of uncertainty remains regarding implementation of the Nurse Licensure Compact (NLC). States that have already adopted the NLC are doing so assuming good faith in future refinements to the compact. Even if not immediately adopt-ed, the NLC does serve as a framework for further discussion. At the present time the Missouri Nurses Association (MONA) and the American Nurses Association (ANA) are opposing the current NLC stating that the language of the compact is flawed and does not provide enough protection for the nurse from complaints that may be filed against their license. MONA and ANA are also concerned about a possible paradigm shift in regulation policy, which shifts regulation control from the state in which the nurse practices to the nurse's state of residence. It is obvious, however, that something must be done to regulate interstate nursing. Increasing technology and an increasing mobility in the American population demand evolution of the nursing profession and new methods for delivering health care services. The National Council of State Boards of Nursing (NCSBN) views NLC as a positive move for the nursing profession. Nursing practice is positively being affected by the dialogue resulting from the debate of the Nurse Licensure Compact and is vital to the continuing development of the nursing profession.

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