NURSE LICENSURE COMPACT

Executive Committee
September 6-7, 2018
Del Mar, CA

COMMITTEE MEMBERS

S. Tedford, AR, Chair	Present
J. Douglas, VA, Vice- Chair	Present
K. Glazier, OK, Member-at-Large	Present
S. Pfenning, ND, Member-at-Large	Present
K. Weinberg, IA, Member-at-Large	Present
Treasurer position (vacant)	

OTHERS PRESENT
J. Ridenour, Co-Chair, Rules Committee
R. Masters, Legal Counsel

STAFF PRESENT
J. Puente, Director, NLC
M. Bieniek, Senior Coordinator, NLC

#	Agenda Item	Minutes
	Thurs, September 6	
1.	a) Call to Order b) Roll Call c) Declare Quorum Present	The meeting was called to order at 9:25 am pacific. All members were present. Tedford declared a quorum present.
2.	Approve Executive Committee Meeting Minutes of July 10, 2018	K. Weinberg made a motion to approve the minutes as written and S. Pfenning seconded. The motion carried.
3.	Advocacy a) Legislative Update	a. Pending legislation: • R. Fotsch reported that she recently testified at interim committee at IN legislature and gave overview of NLC and answered questions. There was a lot of support from hospitals and nursing organizations. The state nursing association was neutral. They do not have a good understanding of the discipline process and therefore have some concerns. The bill will be introduced in the next session. The interim committee will make a recommendation as to whether the bill will be filed. The IN BON did not testify or state a position on the NLC.

	b) APRN Compact Update	• MI session will restart in next two weeks and there are efforts to get NLC on the fall agenda but it may not be on the agenda until next year. There is significant support. • In NJ, NLC is in the budget committee and lobbyist are working to get NLC included on the agenda. There has been no opposition. TAANA has asked some questions related to discipline. 2019 forecast: • IL will file NLC bill in Jan 2019. • In MA, bill made it to Ways and Means Committee. On Nov ballot, there will be a binding referendum regarding patient staffing ratios and this may mean that the state will need more nurses. The bill will be refiled in 2019. • NV will file a bill in 2019. NLC is opposed by the nurse union in NV. Staff will meet with NV BON in Sept 2018. • WA will introduce NLC bill and there is union opposition. • VT will file in 2020. Results from a legislative NLC study are due in March 2019. • Staff will meet with RI BON EO to discuss future strategy. Support is needed from stakeholders. b. APRN Compact: NCSBN BOD decided to appoint a task force to recommend what may need to be changed in the APRN Compact. The task force members have not yet been selected. K. Thomas will lead the task force. There is a teleconference September 7 to discuss next steps.
4.	**<u>Committees</u>** a) Rules I. Proposed Rules and Current Work of the Committee	a.I. J. Ridenour requested that members review the crosswalk document, in particular, pages 10-13. Potential tier 3 proposed rules will be proposed at the 2019 NCSBN midyear meeting. Members suggested that CLIS always be spelled out as coordinated licensure information system. 407. Deactivation In the rationale, include or link to the definition of deactivation. 408. Encumbrance Members expressed concerns about limiting to drug screens in the proposed rule but recommended a broader term be considered based on limitations that need to be reported to NPDB. Members suggested the following re: 408.1: • Explore defining monitoring. • Broaden the term of limitation. • Consider retaining 408.2 with modifications. • Reference NPDB in the rationale for the rule Ridenour to research articles related to NPDB. K. Russell may be a resource to further clarify.

			409. Federal Criminal Records Will ensure consistent use of the term criminal history in the rule. 601. Action following Discipline Need to determine if states need additional legislative authority to conduct CBC post disciplinary action if not currently in the state statutes. Members suggest that the rules committee continue to research. 602. Agreed disposition Members inquired about the original intent of this term as it is used in the ULRs. Members suggested revising the double negative in the second sentence of this draft rule. 603. Misdemeanors related to the practice of nursing Rather than developing a list of relevant misdemeanors, it may be more appropriate to utilize criteria. Ridenour suggested members review version A and B of #2 on page 16 of crosswalk. On page 17, delete "directly" in the first sentence. Rules subcommittee will continue to work on clarifying misdemeanors related to nursing at the October 25, 2018 meeting.
	II.	Public Hearing Process Suggestions	a.II. Proposed Rules Public Hearing Process Members agreed that the current public hearing on proposed rules is to continue and will be staff-led. The procedure is often referenced when states express concerns about how the public provides comments on proposed rules.
	III.	Requirement for an Active License when Endorsing into NLC State (Article IV (a))	a.III Masters to draft legal memo regarding applicability of Article IV(a) when a nurse is required to hold an active license upon application to an NLC state.
	IV.	Is independent credentials review required for Canadian nurse who graduated 20 years ago and licensed in the US?	a.IV. Members affirmed NLC BONs must adhere to ULRs when issuing a multistate license. A rule is not necessary to further clarify.
	V.	Is a felony while a juvenile a disqualifier for the multistate license?	a.V. Members reviewed Masters' email on this topic in the meeting materials. Topic to be referred to the rules committee agenda for consideration of a rule or inclusion in legal FAQs.
	VI.	Consider development of a Rapid Response Advisory Committee	a.VI. Members declined to develop the suggested committee. Questions related to policy and interpretation shall be directed to the Executive Committee.
	VII.	Consider a scheduled one-hour party state BON dial-in to rules committee meetings and its goal and purpose	a.VII. Members support the concept of a member dial in to the rules committee meeting so that committee members can understand the questions that members have. Interpretation and policy issues shall continue to be referred to the Executive Committee.
	VIII.	Consider if a Rule Related to Self-Disclosure of Convictions on Applications is Needed	a.VIII. Members suggested that a recommendation for a self-disclosure statement be included in all applications and directed that this item be added to a self-assessment for compliance.

	b) Compliance I. GA BON: Memo for Review	b.I. Members reviewed a letter from GA BON. S. Pfenning made a motion that Executive Committee accepts the GA BON letter of July 31, 2018 as satisfactory progress in resolving concerns related to the NLC and K. Glazier seconded. The motion carried. Staff is directed to draft a letter to GA BON.
	II. LA Rulemaking	b.II. Members discussed the most recent update from K. Lyon and will monitor the LA rulemaking process for implementation.
	III. Alternative to Discipline Indicator Audit Report	b.III. A member questioned the accuracy of the ATD (alternative to discipline) report due to a data discrepancy. The issue has been sent to NursysAdmin and pending resolution, staff are directed to educate party states on use of the ATD indicator and share the most recent report.
	IV. Self-Assessment Tool	b.IV. Staff will update the original NLC self-assessment for compliance in light of the enhanced NLC. The revised version is then to be reviewed by the Compliance Committee, followed by the Executive Committee.
	c) Training & Education	
	I. New Video: Planning	c.I. Members suggested the video be directed to the public regarding "how the NLC works". Specifically, the video should be directed to employers. Staff are to develop recorded webinars, for specific stakeholder groups.
	II. 2019 Conference: Planning	c.II. Staff is to plan a conference for spring 2019. A special conference committee will be formed with two members from each of Rules, Compliance, Operations and Training & Education Committees. Conference is to be 1.5 days.
	III. Fact Sheet Dissemination	c.III New and revised fact sheets will be distributed to the Commission in mid-September.
	d) Policy I. Nursys Audit Report: MSL Issued to Encumbered Licensee: consider policy	d.I. Nursys Audit Report Nursys Team demonstrated the audit report which shows multistate licenses issued to an encumbered licensee and allows the BON to add a comment to explain why the multistate license was issued. Webinars are needed for the NLC audit reports. Issues with reports need to be addressed prior to rollout.
	e) Elections: Discuss Nominees	e. Remove "nominated by…." from the ballot. Add to slate: "current" Executive Committee participation. Add discussion of related bylaws provisions to the next Executive Committee agenda. J. Douglas made a motion that Executive Committee has discovered that there are two nominations from the same jurisdiction whereas the bylaws and statute require that there is only one commissioner per jurisdiction and staff and legal counsel are to contact the jurisdiction to determine which individual will be designated as the commissioner and such information will be communicated to the Elections Committee for an amendment of

	f) Appointments Operations Committee: • Lori Scheidt nominated Melissa McDonald (NC) • Cynthia LaBonde nominates Lisa Hastings (WY) • Anne Oertwich nominates Sherri Joyner (NE) (nominates for either Operations or Compliance) Compliance Committee: • Stacey Pfenning nominates Melissa Hanson (ND) • Kim Glazier nominates Jackie Ward (OK) Elections Committee: • Ratify Sasha Poole as Co-Chair replacing Joe Baker. Rules Committee: • Joey Ridenour nominates Brett Thompson as Vice Chair replacing Nathan Goldman	the slate and S. Tedford seconded. The motion carried. Operations Committee: S. Pfenning made a motion to appoint M. McDonald and K. Glazier seconded. The motion carried. Compliance Committee: K. Weinberg made a motion to appoint J. Ward and M. Hanson and S. Pfenning seconded. The motion carried. J. Douglas resigns from the Compliance Committee. Election Committee: K. Glazier made a motion to ratify the appointment of S. Poole and K. Weinberg seconded. The motion carried. Rules Committee: K. Glazier made a motion to appoint B. Thompson May as Vice-Chair and K. Weinberg seconded. The motion carried.
	Recess	Members recessed at 4:20 pm.
	Fri, Sept 7	
6.	Licensure Model	It has been brought to the attention of the Executive Committee that clarity is needed regarding the ability of a party state to offer licensure options. The Executive Committee and Special Counsel to the Commission reviewed and discussed the 2013-2015 EO forum minutes (walk in the woods), the eNLC statutes, and the 2015 Financial Impact Team overview regarding adoption and implementation of the Nurse Licensure Compact (enhanced). In consultation with Special Counsel, the Executive Committee issues the following clarifying statement: The general purposes of the compact include facilitating public protection, decreasing redundancies in licensure and providing opportunities for interstate practice by nurses who meet uniform licensure requirements. Party states are required to comply with the compact statutes and rules when issuing a multistate license.

		However, pursuant to Article III f, "… nothing in this compact shall affect the requirements established by a party state for the issuance of a single state license." Therefore, a party state is not prohibited from offering an option for a single-state license. K. Weinberg made a motion to approve the above statement and S. Tedford seconded. The motion carried. The vote was unanimous.
7.	Scheduling of FY19 Executive Committee Meetings	Members scheduled FY2019 Executive Committee meetings by teleconference at 2:00 pm central on the following dates: • Nov 13, 2018 • Feb 5, 2019 • July 9, 2019 Face to face meetings were scheduled on: • May 1-2, 2019 • Sept 4-5, 2019 • Dec 4-5, 2019
8.	Strategic Planning Retreat: Qualitative Data Collection	• Members selected 17 individuals to be interviewed by the strategic planning facilitator for qualitative data collection. • Members directed staff to complete a strengths and weaknesses inventory which will then be reviewed by the Executive Committee.
9.	Annual Meeting Evaluation Results	• Add "Open Dialogue" to all Commission meeting agendas, time permitting. • Add question to future meeting evaluations: "If there is one thing that could have been done differently at this meeting, what would it be? "
10.	Other Business	J. Douglas made a motion for the meeting highlights to be distributed and K. Glazier seconded. The motion carried.
	Adjourn	The meeting adjourned at 4:10pm.

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Executive Officer Forum
Licensure Models

July 15-16, 2013
Chicago, Illinois

Background

At the 2013 NCSBN midyear meeting, the executive officers (EOs) requested a meeting to discuss the future of licensure models. Two major licensure models currently exist in the U.S. for nursing: a single state model and the mutual recognition model implemented through the Nurse Licensure Compact. Recently, interest increased in a national model of licensure related to improving access to care through telehealth. The growing number of insured through the Affordable Care Act and the aging population drives this interest. Members of Congress and stakeholders such as the telecommunications industry propose legislation on alternative national licensure models. This meeting was convened and a facilitator was engaged by NCSBN for the purpose of framing the issues related to nursing licensure and achieving resolution to the differences in nursing licensure regulation.

Facilitator

Leonard J. Marcus, Ph.D., is the Director of the Program for Health Care Negotiation and Conflict Resolution at the Harvard School of Public Health and Co-Director of the National Preparedness Leadership Initiative. Dr. Marcus pioneered development of the *Walk in the Woods*, a negotiation and conflict resolution exercise. He is experienced in high-level national negotiations.

Framework and Process

Prior to the meeting, Dr. Marcus spoke with eight EOs, both compact and non-compact states, to discuss their perspectives regarding the licensure models so he was introduced to the issues and past conversations regarding the models.

At the meeting, Dr. Marcus began by presenting an introduction to meta-leadership. He discussed a "predictable crisis" or predictable surprise." The premise is that most crises are predictable because usually some people have certain information, and others have different information; if the information and people had come together with all of the information the crisis could have anticipated.

He spoke about leaders integrating different points of view and beliefs. He provided the "cone in the cube" example noting that those who look into the cube from one angle see the triangle of the cone within the cube, and those who look into the cube from a different angle, see the circle of the cone within the cube. We need to come together to find the cone.

He provided models that guided us through the discussions. First, through arm wrestling he illustrated how to achieve a win-win negotiation. Secondly, he spoke about three "levels" of the brain, and participants used the explanation about the design of the brain to frame the conversation. For example, the basement is the lowest level of the brain and when we are there, we freeze, fight, or flight. We need to realize we are there and then re-set our brains to get to the middle of the brain where our "toolbox" is located. The highest level of the brain is the laboratory, for learning and complex thinking.

Dr. Marcus explained the Walk in the Woods (The Walk) that we used for the remainder of the meeting. The Walk is a problem solving method that examines stakeholders' perceived issues and concerns and assists in finding a resolution for complex problems. There are four steps to The Walk that encourage transition from one step to the next:

- *Self-interests*: Participants state their interests and what they hope to gain or achieve.
- *Enlarged interests*: Participants, having heard the interests of others, list what they view as points of agreement among these interests.
- *Enlightened interests*: Participants craft new ideas and possibilities that prior to the discussion they would have been unlikely to contemplate.
- *Aligned interests*: Participants finalize ideas regarding the issue under discussion.

Outcome of The Walk

During the third step, enlightened interests, the group identified the numerous ideas and identified the following ideas to pursue (not in any particular order):

- Centralized registry/clearing house for nursing credentials to be housed at NCSBN in order to expedite licensure.
- "Diamond" (or national) status for nurses who met all states' requirements
- Telehealth permits
- Update compact requirements
- Tandem licensure
- Revenue sharing between NCSBN and Member Boards
- National school accreditation
- National standards
- Staff hired by NCSBN with regulatory experience

After discussion and exploration of the details of the above "enlightened" interests, we moved to discuss "aligned" interests and there was a vote as follows:

- Look at telehealth issue and other more specified issues – 8
- Explore "diamond"/national status – 2
- Develop a borderless model and a new package – 19

EOs clearly stated a desire to lead in creating and implementing solutions. There was a consensus among the EOs that (1) borderless nursing practice is important; (2) state based nursing licensure is preferred and believed to be the best model for public protection; (3) practice occurs where the patient is located; and (4) NCSBN should remain a united organization.

Next Steps

A large number of EOs were not present for the Forum, and the group agreed it was important to have all EOs involved. The group noted that Board Presidents should be informed. President Myra Broadway will meet with state Board Presidents at the Annual Meeting to inform them about the discussion, what was accomplished, and next steps.

Participating EOs will be asked to contact and provide a summary of the meeting to those EOs who were not able to attend. A summary on the event will be provided, and the meetings and discussion will be on the agenda for the EO Leadership Council at the Annual Meeting.

The group stated that to move forward it would be important to continue working with Dr. Marcus. Dr. Marcus agreed to continue working with the group with plans to meet November 18-19, 2013.

It was a unique and invigorating experience for those of us able to attend and participate. Please let me know if you have any questions and/or comments.

Sincerely,

Myra Broadway, JD, MS, RN
President, NCSBN

Executive Officer Forum II
November 18-19, 2013
Chicago, Illinois

Background: See July 2013 Report

Facilitator: Dr. Leonard Marcus, (See July 2013 Report)

Framework and Process:
Prior to the meeting Dr. Marcus interviewed eight Executive Officers (EOs), some the same he spoke with prior to the July EO Forum and some new. The eight represented both compact and non-compact states. The intent was to discuss their perspectives regarding the work done in July and work yet to be done. In addition, on the October 21, 2013 EO call, the homework assignment to us was to float the idea with trusted colleagues of an Option C notion.

Dr. Marcus began the meeting by summarizing the process and what has been accomplished to date (Please see July 2013 report – attached). Our first instruction – and meeting "mantra" was to "say what's on your mind or you're a failure." What are the obstacles?

Our first exercise was to identify the biggest obstacles to moving forward to solve this problem. Dr. Marcus pointed out that this is much more complicated than "everyone do it my way to get it right." He reminded us that we must face the fact that we have a lot of pride and proclivity toward independence. Eventually – to lift the conversation we must include all the nursing profession. We are not there yet. All obstacles were to be identified and on the table! Six tables individually addressed what these obstacles were, and predictably, there was overlap: coming to an agreement regarding what we will accept; personality entrenchments and EOs as the gatekeepers; fingerprinting for criminal background checks (CBCs); communication – or lack thereof; myths that perpetuate and proliferate; the absence of half the EOs at this forum; questionable reality of federal threat – is it significant?; power and competition among states; trust; lack of knowledge/understanding regarding the origins and development of the Nurse Licensure Compact (NLC); self-interests.

What is possible?
After identification of obstacles, the next exercise was to project what might be possible. In other words, what might Option C look like?

- Option C is a system of credentials that would qualify nurses to practice in all jurisdictions. Option C would be voluntary and optional and predicated upon high agreed upon standards.
- Option C would be state based, borderless, reflect licensure requirements we can all live with, be based on premise that practice occurs where the patient is, and be adopted by state legislatures.

- Option C would incorporate two essential veins of criteria – skill/knowledge and professional conduct (moral character and behavior).
- Option C should include "activation of the privilege to practice" in a non-home state.

Recognizing that there was variance in what Option C could or would be, the group, encouraged and facilitated by Dr. Marcus, agreed to put something together. The good news after the obstacle and possibility exercises was that no one in the room was saying 'let's quit.' Instead, we discussed the criteria and its significance to all present.

What can we agree on?

The next rigorous exercise was to determine what we could all agree upon. After thoughtful and impassioned discussion, the following list emerged with the elements necessary for a successful and acceptable Option C:

1. NCLEX for licensure
2. Fingerprint based criminal background checks
3. English proficiency
4. Third party verification for foreign educated nurses
5. Graduate of a board approved/accredited (or international equivalent) nursing program with instruction in nursing theory and practice across the lifespan
6. NCSBN as repository for primary verification of education
7. Active, unencumbered license with no history of discipline
8. No criminal convictions
9. No impaired nursing program participants
10. Boards are equally competent to make licensure determination decisions
11. One year of nursing experience before eligible to apply for Option C
12. Licensure renewal cycles according to home jurisdiction
13. Practice is where the patient is and licensure is the jurisdiction of the nurse's legal residence
14. Carve out an exception for Washington, D.C. (details to be determined)

We talked about complex problem solving evolving in stages. Working on a continuum of what is feasible to what is ideal takes time and concerted effort. In the context of "what is feasible?" we had to first build confidence and come to a concrete agreement about what is....well...about what IS feasible. This is what we accomplished November 18-19, 2013.

The next phase of the continuum is to build relationships and expand involvement. This phase will reflect the transition to the ideal.

The ideal will incorporate the confidence building from the feasibility stage and the relationship building from the transition phase in order to take us to the level of trusting relationships which is truly, the ideal – to reflect fluid, working relationships for the future.

Important odds and ends noted:

We are all idealists and want to get to the ideal right away!

We must take rivalries and build them into strengths.
It is necessary to build a bridge to the jurisdiction who says "it won't work for me."
From his objective perch, our facilitator observed that there is a lot of state rivalry – and we must get above this.
While not all EOs were present, all perspectives and viewpoints were.
When we struggled with what level of discipline- if any – would be acceptable, the disagreements were not along NLC/non-NLC lines.
We discussed some sensitive issues.
While we know we are not done, we have demonstrated that we can come together to make it happen.
We left believing that with connectivity of method we can get to the next step.
We need to test the reaction to Option C but could never begin to do so until we identified what is feasible.

We have not yet talked about a model to implement Option C. Some understand it to be a separate application by a nurse meeting qualifications (tandem license) for Option C; or will it be a third model? Or would it be an amendment to the current NLC? This will need to be determined.

Option C does not address union resistance and financial issues.

Data needs to be collected to predict the impact of the identified and agreed upon elements for Option C, to include how many nurses have disciplinary action on license and what the incidence of criminal conviction history is. (I.e. how many nurses will Option C exempt from licensure?)

Next steps:
The president will draft a report of the forum meeting which will then be circulated among last weeks' attendees for review and validation of understanding.

On the Dec 16th EO Call the narrative will be shared and discussed with all conference call participants.
The EO Leadership Council will discuss and continue this work at the 2014 Midyear Meeting. Should progress of the work necessitate it, this will likely be an agenda item at the EO Summit in June, 2014.
Dr. Marcus is willing to continue to work with us on this....March 24-25, 2014 are possible dates.

If there are any questions or comments please let EO Leadership Council Chair, Paula Meyer, or me know.

Myra Broadway, President, NCSBN

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EO FORUM III - March 24- 25, 2014

Background - Refer to July and November, 2013 Reports

Facilitator – Dr. Leonard Marcus (LM) – Refer to July 2013 Report

Framework and Process

Dr. Marcus once again interviewed a number of people prior to this meeting – to gain perspectives, thoughts and feelings regarding the work done to date and the work yet to be done. More were in attendance at this meeting than the prior two; however, the reasons some EOs provided about not attending were two: "tired of all the bickering" and "don't want anyone to tell my state what to do." With this in mind, LM asked the rest of us why we were here. Essentially the answers reflected a desire to participate in and be part of the process to address the changing landscape of health care delivery and what we as regulators could do to help improve access, eliminate unnecessary barriers, and achieve an agreement regarding a licensure model that would accommodate the country's needs and on which we could all agree to work together to achieve. LM reminded us all at the start that LEADERS DO NOT OWN THEIR POSITIONS; LEADERSHIP POSTS ARE RENTALS. The expectation of our country is that we will do what is best, and that we will rise above differences and respond to the need "to do something."

LM reminded participants that only discussing Compact (NLC) and Non- Compact (non-NLC) created no traction, and no forward motion. Thus we agreed to call the two licensure models currently in place A and B (with neither identified as NLC or non-NLC). At the November Forum we started to rally around an Option C – but we now see we were not clear what Option C means. We have come to realize that history often evolves in different periods of time – what we are working on now could be an interim measure that could lead to something else. What we are committed to is the process that is likely to take at least a year. The outcome will have to be brought to every jurisdiction; other national entities will need to support; it will be our responsibility to foster understanding among all stakeholders.

LM shared recent research from Harvard School of Public Health regarding swarm intelligence. (The paper is titled ***The Ingenuity of Swarm Intelligence).*** Based on research on termites and ants, the question was asked as to what enabled them to work together with success? The following were identified:

1. Unity of mission that will get any obstacle out of the way and overcome any challenge to achieve the ultimate goal
2. Generosity of spirit - how can I help you with your….what do you have and what do you need?

3. Everyone stays in his own lane and helps others in their lanes – we must work together. None of us can make the decision but can bring home the recommendation.
4. No egos, no blame. Check the ego at the door. No finger pointing.
5. Know one another and trust one another.

This methodology may be applied to the challenges we are facing; LM asked the EOs to consider applying this methodology to the challenges we face and use it to help one another move the process in their states and jurisdictions.

The following areas were discussed and agreed upon as requirements for Option C:

1. NCLEX testing for initial licensure
2. English proficiency testing/evaluation
3. Graduation from or eligible (individual has met all the program requirements and yet to complete the graduation ceremony) to graduate from a Board approved program
4. U.S. Social Security Number
5. One year of nursing experience
6. Third party verification of credentials for foreign educated nurses
7. Active, unencumbered license with no history of discipline
8. State and federal biometric-based record checks for initial licensure; the rap back system for ongoing notification of criminal offenses
9. No felony convictions
10. Only minor misdemeanor convictions, such as fishing without a permit, could be acceptable; other misdemeanors would be evaluated according to the Uniform Licensure Requirements (ULRs) or on a case-by-case basis
11. Cannot be enrolled in an Alternative Program for Chemical Dependency (if successfully completed, after 5 years, may be eligible)
12. Cannot be enrolled in a Practice Remediation Program
13. Cannot have any non-disciplinary order(s) also known as confidential/private orders or deferred discipline, that are dismissed after 5 years if there are no further complaints; these are not public discipline)

In addition, the following criteria must be met or would apply for Option C licensing:

1. Continued competency based on the home state requirements
2. Revenue neutrality or implemented so that no state loses money
3. Full participation in Nursys (submission of licensure and discipline data)
4. Licensure renewal cycles based on the home jurisdiction
5. Practice is where the patient is located and licensure is the jurisdiction of the nurse's legal residence
6. NCSBN would become a national repository for primary verification of education

Further, there are additional points for future discussion

- How to handle expunged records
- How to carve out an exception for Washington, DC (About 80% of its nursing population are endorsement applicants)
- When and how would a Option C license be withdrawn
- How would discipline be handled across the states

On the second day of our March meeting we ventured into identification of Allies and Obstacles. We conversed about labor unions that at first blush might appear an obstacle but ultimately could/would be an ally since unions are state based, not federally based. If we as states do not

remedy the licensure dilemma it is possible the feds will – and therefore not likely the unions would support - understanding their base of support is in the state. Nursing associations could also be an ally- those states with unions for the reason so noted. Those without unions for the ease of practice electronically AND cross border. Businesses would also be allies due to nature of supporting platforms for telehealth industry. Further, insurance companies, case management companies also have an interest in this success.

By the end of our group discussion as a whole, we dialogued amongst our seven tables. There were two questions posed for each table to address: 1. Did we miss anything? Where are the holes? 2. When we each go home and talk about this package with local colleagues, legislators, and governor's staff, what would be the questions, the issues, and the pushback? Ultimately there was agreement that posing a third option to stakeholders would not be well received and given the framework for a mutual recognition model is in the current NLC, what would it take to amend models A and B and come up with D (a modified NLC). The non-NLC states asked if the NLC states were in agreement to make modifications as discussed, and all NLC states present agreed.

What happens next is to look at the agreed upon elements in the context of the NLC – and to keep it at the EO Forum level. The expectation is that we will continue this discussion at the EO Summit in June 2014.

Myra Broadway
President, NCSBN

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National Council of State Boards of Nursing

Financial Impact Team

Overview

Regarding Adoption and Implementation of the

Nurse Licensure Compact

January 31, 2015

Introduction

In September 2014, the NCSBN Board of Directors (BOD) appointed a Financial Impact Team (FIT) as a subcommittee of the BOD. The FIT consists of Board Members Julie George, Betsy Houchen, and Gloria Damgaard. Rob Clayborne provides staff support assisted by Jim Puente. FIT met on October 27, 2014, December 10, 2014 and January 21, 2015.

Charge

The charge for FIT is to provide information related to the fiscal impact of adopting the Nurse Licensure Compact (NLC).

Macro-Level Assessment

FIT determined that in the aggregate if all states joined the compact, the total revenue generated from licensing nurses would decline. Revenue would fall because the volume of licenses issued would decline. The volume of licenses would decline because nurses would no longer need to be issued multiple licenses.

The number of licenses issued for all jurisdictions totals approximately 5.2 million, while the number of nurses equals 4.5 million. A significant number of the licenses are issued because some nurses hold multiple licenses. FIT reviewed data from NURSYS that indicated a relatively small percentage (10% to 15% for RNs) of the nurses hold multiple licenses. As a result, that population currently pays the cost to generate additional licensing fee revenue for Boards of Nursing.

The percentage of nurses holding multiple licenses (10-15%) is reflective of a national picture. FIT recognizes that the percentage of nurses holding multiple licenses is very state specific and varies from state to state.

FIT considered the impact of a possible fee increase to the majority of nurses not needing a multi-state practice privilege. FIT also wondered if the NLC model could allow states to charge a different fee for a multi-state practice privilege. If possible, would it make sense to charge more to the nurses who are currently willing to pay more in licensing fees, as they are already paying additional fees to acquire multiple licenses to practice in more than a single state? FIT concluded that this is a revenue generation option that could be implemented at the discretion of each state.

As stated above FIT noted that the shrinkage in the number of licenses issued could vary significantly for states. FIT reviewed data from NURSYS that clearly illustrated some states licensed a larger percentage of non-resident nurses than other states. If all states joined the compact, jurisdictions with a large number of licensees residing outside of the state would issue fewer licenses. Nurses residing

outside of the jurisdiction would be licensed in their state of residence and would not be required to have another license to practice in the remote state. FIT also recognized the District of Columbia (DC) as the extreme case of a jurisdiction which has a large proportion of licensees residing outside of DC. Because of its unique situation, the possibility exists that it may not be financially feasible for DC to join the Compact.

State Budget Considerations in Adopting the Compact

In assessing the financial impact to adopt the Compact, states should consider one-time and on-going costs. One-time costs could include expenses for communicating the changes to licensees, for any changes to IT systems, and related travel. On-going costs could include any loss in various licensing revenue due to the NLC residence rule, or for those states not already a member of NURSYS, losses in verification revenue. Currently, states also pay an annual fee to help support the NLCA ($6,000 per year).

The budget impact will vary for states depending on the technical resources and administrative configuration, as well as the residency of practicing nurses in the state. Some states may need to increase fees to cover any losses for a reduction in the number of licenses issued. If the Compact could allow for a different licensing fee for a multi-state practice privilege, additional revenue could be generated by charging a higher fee for a multi-state license.

The tables below illustrate hypothetical examples of possible revenue loss and the impact of financing the loss via a licensing fee increase. The numbers are merely assumptions and are not based on actual data for any state. Each jurisdiction would need to make projections based on licensees residing in and out of its state. Example 1 assumes the loss is spread proportionately to all remaining licensees in the state. Example 2 assumes the loss is recovered by charging a higher fee to those licensees who are issued a multi-state license.

Example 1

The tables below compare hypothetical losses in revenue using different loss percentages, and a calculation for the increase in the license fee to cover the loss. The illustration is based on the assumption that as a result of joining the Compact, the Board of Nursing loses a percentage of its licensees. The different loss percentages used for the number of licensees are assumed to be 2% and 5%. One example (BON 2) assumes a 5% loss in the number of licensees plus a loss of verification revenue.

Three different loss assumptions for Boards after joining the Compact:

- Board of Nursing 1 (BON 1) loses 5% of its licensees
- Board of Nursing 2 (BON 2) loses 5% of its licensees and verification revenue
- Board of Nursing 3 (BON 3) loses 2% of its licensees

Table 1: Total revenue before joining the Compact (Number of licenses multiplied by average license fee equals total revenue for each scenario (BON 1, BON 2, and BON 3).

	BON 1	BON 2	BON 3
Number of Licensees	100,000	100,000	100,000
Average fee per license	$100	$100	$100
Total Revenue	$10,000,000	$10,000,000	$10,000,000

Table 2: A calculation for the projected loss in revenue after joining the Compact

	BON 1	BON 2	BON 3
Number of Licensees before Compact	100,000	100,000	100,000
Percent of licensees lost	5%	5%	2%
Total licensees lost	5,000	5,000	2,000
Average fee per license	$100	$100	$100
Lost Licensing Revenue	$500,000	$500,000	$200,000
Lost Verification Revenue	0	$25,000	0
Total Revenue Lost	$500,000	$525,000	$200,000

Table 3: Fee Increase to All Licensees to Recover Lost Revenue

	BON 1	BON 2	BON 3
Total Revenue Lost	$500,000	$525,000	$200,000
Remaining Licensees (100,000 less lost licensees)	95,000	95,000	98,000
Fee increase to licensee to cover lost revenue	$5.26	$5.53	$2.04
Percent Increase to Licensee	5%	6%	2%
New Average Fee per Licensee (rounded to $1)	$105	$106	$102

Example 2

Table 4: Fee Increase to Licensees Issued a Multi-State License to Recover Lost Revenue

	BON 1	BON 2	BON 3
Total Revenue Lost	$500,000	$525,000	$200,000
Licensees issued a multi-state license (estimated at 10% of 100,000 licensees)	10,000	10,000	10,000
Fee increase to licensee to cover lost revenue	$50.00	$52.50	$20.00
Percent Increase to Licensee issued multi-state license	50%	53%	20%
Fee for Multi-State License (rounded to $1)	$150	$153	$120

Fiscal Analysis: Knowing that the financial impact for adoption and implementation of the NLC is very state specific, the following questions will assist jurisdictions in beginning their own fiscal analysis.

1. How many nurses licensed by your state reside outside of your state (possible revenue loss)?
2. How many nurses are licensed in another state but live in your state without licensure (possible new revenue as the nurse would now have to be licensed in your state)?
3. If you do not currently participate in licensure verification with Nursys, what is your annual verification revenue (possible revenue loss)? If a loss, is the loss offset by elimination of verification staff or reassigning staff resources?
4. What is your annual trend for endorsement applications? What percent of licenses issued by endorsement reside in your state (projected annual revenue)? How will this add to your renewal revenue in future years?
5. Do you have future workforce data projections for nurses in your state (possible revenue generation or revenue loss projections)?
6. Can you raise your nurse licensure fees? (revenue generation)
7. Can you designate a higher licensure fee for issuance of a multistate license (revenue generation)?