Original Research Article

How COVID-19 Emergency Practitioner Licensure Impacted Access to Care: Perceptions of Local and National Stakeholders

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ABSTRACT: The COVID-19 public health emergency required US states to respond rapidly on regulatory issues, including the process for licensing healthcare practitioners. At least 45 states enacted some form of a licensure waiver, enabling practitioners to temporarily work across state lines. We conducted 22 interviews with national and local (New Jersey) licensure stakeholders in September and October 2021 to capture perceptions of how emergency licensure impacted access to care. Five themes emerged: (1) Emergency licensing helped shift the nation's healthcare workforce supply into regions and specialties of high need; (2) Expanded telehealth capacities complemented emergency licensure programs; (3) Concerns about care quality were mitigated by the urgency of the pandemic, credentialing processes, and investigative authorities; (4) Relocation packages and the need to replace staff could lead to higher costs of care; and (5) Views on licensure reciprocity and interstate compacts were favorable, but smaller provider organizations need to be protected. Overall, stakeholders perceived emergency licensure as successful in expanding access to care during the pandemic. Findings suggest that stakeholders view interstate licensure compacts more favorably now than pre-COVID. While stakeholders may be in favor of licensure reciprocity, they raised concerns about its feasibility, cost, and quality.

Introduction

The COVID-19 public health emergency required US states to respond rapidly on multiple regulatory issues, including the process for licensing healthcare practitioners to address health personnel shortages during the crisis. The temporary suspension of licensing requirements has long been a strategy for responding to public health emergencies.[1] During the COVID-19 pandemic, at least 45 states activated emergency-response licensure laws—some using existing statutes and others passing new laws[2]—which enabled healthcare practitioners to temporarily work across state lines.[3,4]

In general, healthcare practitioner licensing is important, as it ensures that a practitioner has the required training, knowledge, and experience to perform as a professional in their field. Licensing, which is the formal recognition by a regulatory agency or body that an individual has met designated requirements,[5] is rooted in the tenth amendment of the Constitution (ie, reserving rights to states),[6] meaning that licensing is conducted at the state level. Licensure serves as revenue for state governments and professional licensing boards and, in some instances, may also be used to mitigate professional competition across state lines.

Currently, most states only allow practitioners to treat patients within the state in which the practitioner holds their license.[5] Obtaining a license is a lengthy process, however, as licensure requirements and processes vary vastly by state and practitioner type. For example, to become a licensed professional counselor, an individual typically needs to complete a 2-year master's program with direct, supervised clinical hours ranging from 1500 to

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4500.[7] They may then apply for licensure by taking exams, submitting documentation of coursework and supervised hours, and paying application and licensure fees (initial and renewals)—all of which have different specifications by state. Given the variability in state requirements, becoming licensed in more than one state can be difficult and time consuming. While there are some mechanisms to address professional licensure portability issues,[8] they vary in scope, adoption, and implementation across states,[9] posing challenges for the provision of health care not only during the pandemic but also non-pandemic times.

The state of New Jersey, which was greatly impacted during the first wave of the COVID-19 public health emergency,[10] had a multi-faceted response to practitioner licensing that utilized some of these mechanisms. In March 2020, New Jersey declared a public health emergency[11] and enacted temporary healthcare workforce provisions, including the Temporary Emergency Reciprocity Licensure program.[12–15] The program aimed to respond to pandemic-related healthcare workforce demands, especially for hospital staffing and care for underserved populations, by allowing out-of-state, currently licensed healthcare practitioners in good standing to obtain temporary licensure and provide services to New Jersey patients via telehealth[16] or in person. In May 2022, around 50,000 temporary licenses had been approved in New Jersey.[17]

IN MARCH 2020, NEW JERSEY DECLARED A PUBLIC HEALTH EMERGENCY AND ENACTED TEMPORARY HEALTHCARE WORKFORCE PROVISIONS, INCLUDING THE TEMPORARY EMERGENCY RECIPROCITY LICENSURE PROGRAM.

During this time in which the US has a growing workforce supply shortage and challenges in meeting the access to care demands of patients,[18,19] the natural experiment provided by COVID-19 is an opportunity to examine the impact of introducing flexibility into state professional licensure processes and identify important contextual considerations for any future licensure reform that may mitigate barriers to access to care. The aim of this study is to examine the perceived impact of emergency licensure on access to care. Perception is important for study because it is a critical driver in policymaking;[20] studies have shown that what people think and believe influences their behavior, particularly in the absence of data to inform decision-making.[21] This is the first qualitative study to examine perceptions regarding emergency licensure of healthcare practitioners.[22]

Methods

Design

In this qualitative study, we conducted semi-structured in-depth interviews to capture stakeholder perspectives on the impact of emergency practitioner licensing on access to care during the COVID-19 pandemic (ie, a phenomenological approach).[23] Stakeholders represented different types of healthcare organizations and health professions, which helped us explore different viewpoints on emergency licensure (ie, constructivist paradigm).[24] Although the study team interviewed licensure stakeholders nationally, we purposively oversampled participants in one state (New Jersey) to gain a deeper understanding of licensure policies at the state-level. Our reporting adheres to the Standards for Reporting Qualitative Research.[25] The study was approved by the Rutgers University Institutional Review Board.

Sample

To recruit participants, we used purposive sampling with a snowballing strategy.[26] To create the initial stakeholder list, we consulted with local content experts (eg, health policy researchers and state government officials who oversee licensure) to identify stakeholders who met the following inclusion criteria: (1) had an active role with healthcare practitioner licensing (not necessarily during the pandemic); and (2) worked in a health organization or trade organization representing key practitioner groups (physicians, nurses, mental health providers, and long-term care providers), payer organizations, and government. Across these groups, we purposely over-recruited from New Jersey organizations. However, we also recruited nationally. Literature reports that 9-17 homogenous interview participants is sufficient to reach thematic saturation.[27] As our participants had some heterogenous characteristics, we aimed to recruit beyond 17, targeting 20-25, and used iterative, post-interview discussions to assess saturation.

We e-mailed an invitation to an initial selection of stakeholders (ie, purposive sampling), and during interviews we asked participants to recommend additional stakeholders (ie, snowball sampling). We sent email invitations to 36 stakeholders and enrolled 22 individuals (61% participation rate), who represented 17 organizations. Eleven individuals were non-responsive, and three declined for reasons including: recommended speaking to another stakeholder in their organization, recommended speaking to another organization that was more directly involved, and scheduling conflict. All participants provided informed consent. No incentives were provided.

Data Collection

We conducted semi-structured, in-depth interviews in September and October 2021 virtually using Zoom. Each interview employed two interviewers (AMN, JJF), with one serving as lead and the other taking notes and asking clarifying questions. The interviewers had training in health services research, health policy, and qualitative methods. One interviewer had prior relationships with 4 participants; biases were mitigated through adherence to the semi-structured interview guide and independent review of notes by the second interviewer. Most interviews were conducted with 1 participant; 3 interviews had 2 participants. Interviews lasted 45-60 minutes and were audio-recorded with consent.

Questions followed an interview guide, drawing upon Pechansky and Thomas' five domains of access to care (see Appendix). The domains (availability, accessibility, acceptability, affordability, and accommodation; see Table 1 for definitions)[28] reflect the fit between characteristics and expectations of the healthcare practitioners and their patients/clients. At the end of each interview, the study team collected demographic characteristics from the participant: highest degree, gender, Hispanic or Latinx ethnicity, race, years worked at current organization, and years directly working with licensing.

ALTHOUGH THE STUDY TEAM INTERVIEWED LICENSURE STAKEHOLDERS NATIONALLY, WE PURPOSIVELY OVERSAMPLED PARTICIPANTS IN ONE STATE (NEW JERSEY) TO GAIN A DEEPER UNDERSTANDING OF LICENSURE POLICIES AT THE STATE-LEVEL.

Data Management

Audio recordings were stored on a secure server. We used Zoom's automatic transcription service to generate transcripts. A team member (JJF) reviewed the transcripts for accuracy, checking the audio file and notes as needed. Transcripts were then de-identified and imported into *NVivo Pro*[29] for coding and analysis.

Table 1
Access definitions

Access Domain	Definition
Availability	The relationship between the volume and type of services offered in a system and the volume and type of patient needs
Accessibility	Where patients live and where services are located, and accounts for distance, availability of transportation, travel time, and cost of transportation
Acceptability	The relationship between expectations of healthcare practitioners and of patients
Affordability	The price of services and availability of existing insurance coverage for services as well as the patient's view of costs and coverage
Accommodation	The way in which the system is organized to accept patients, how well this organization meets patient needs, and patient perception of the appropriateness of accommodation

[a]Definitions are from Penchansky and Thomas (1981).[28]

Data Analysis

We used a modified rapid qualitative analysis approach,[30] which starts with the team briefly debriefing following each interview and populating a structured template that corresponded with central topics of the interview guide. During the debriefing process, we assessed data saturation, finding no new major themes after interviewing the 18th participant.[26] We continued interviewing to 22 in order to attain higher participation from then-underrepresented stakeholder types (see Table 2).

After all interviews were completed, we met to identify a list of preliminary themes, referencing the populated structured templates. Next, a team member (JJF) used *NVivo Pro*[29] to code transcripts using the preliminary themes as a coding template (deductive approach) and created new codes as needed to capture any not reflected in the theme list. Any questions were discussed in weekly team meetings and resolved through consensus. The team reviewed the resulting theme list and revisited transcripts to identify quotes that best illustrate our key findings.

Results

Characteristics of our 22 participants are shown in Table 2. Stakeholders represented 17 unique

Table 2
Characteristics of interview participants (*N* = 22)

	Count	%
Stakeholder type		
Physician organization	5	23%
Nurse organization	2	9%
Mental and behavioral health organization (incl. social work)	5	23%
Long-term care organization	2	9%
Hospital or health system	2	9%
Payer organization	1	5%
Telehealth organization	1	5%
Government	4	18%
Geographic region[a]		
NJ state	16	73%
Non-NJ state	1	5%
National	7	32%
Highest degree		
Bachelor (incl. BS, BSN)	3	14%
Master (incl. MPA, MPP, MSN)	5	23%
Juris Degree (JD)	6	27%
Doctor of Medicine (MD or DO)	3	14%
Doctor of Philosophy (PhD)	5	23%
Gender		
Female	10	45%
Male	12	55%
	Mean	**SD**
Years at current organization	11.0	9.6
Years directly working with licensing	19.1	10.7

[a]Percentages exceed 100% because some participants belong to more than one category.

organizations focused on physicians, nurses, behavioral health (including social work), long-term care, hospital or health system, payer, telemedicine, and government. Most participants were from New Jersey organizations (73%), and their professional training varied (clinical, law, policy, and research). On average, participants had 19 years of experience working directly on licensing issues.

Overall, stakeholders perceived that emergency licensure programs had a positive impact on access to care during the COVID-19 pandemic. Figure 1 outlines the five key themes corresponding with the five access domains.

Below, we describe the themes in detail and present representative quotes.

Availability: Emergency licensing helped shift the nation's healthcare workforce supply into regions and specialties of high need

There were perceptions that pre-existing workforce shortages were exacerbated by the pandemic, especially for nurses, long-term care professionals, and psychiatrists. The pandemic accelerated retirement and burnout in these fields, adding pressure to staffing issues across the country. Emergency licensure programs were perceived as a potential, temporary release for that pressure.

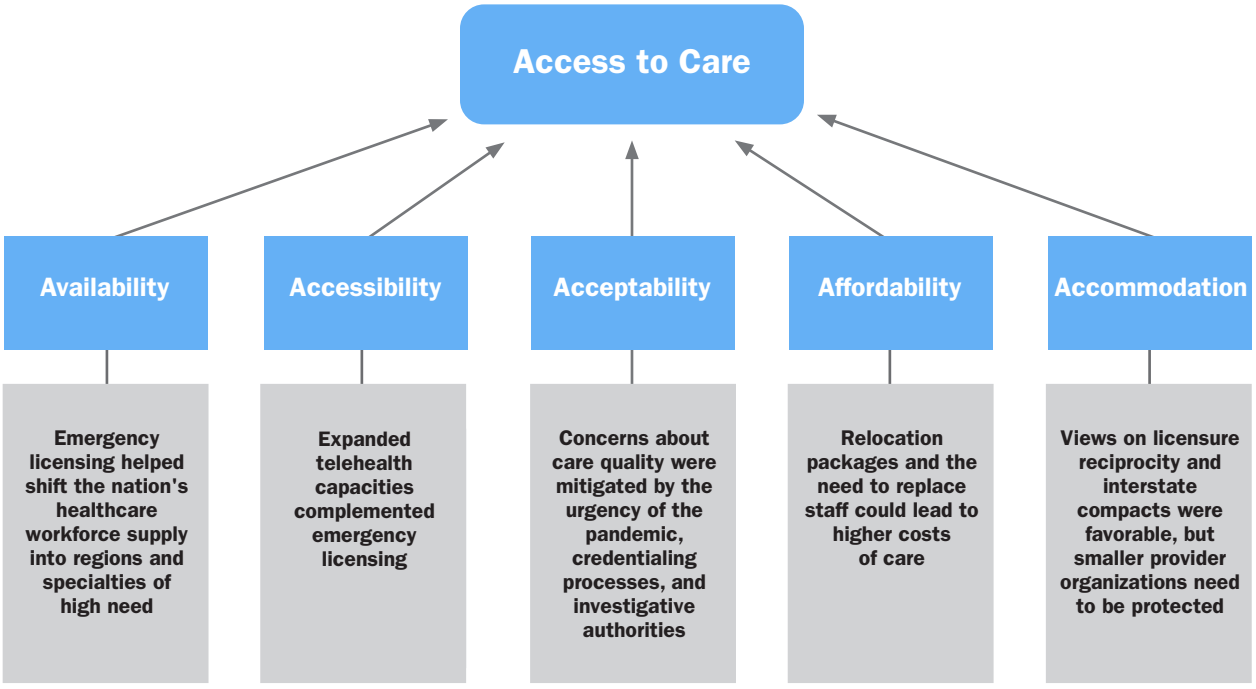
> "*When COVID hit, staffing was already one of the biggest issues, and it remains a huge issue. We're continuing to lose folks from retirement and burnout. We still need temporary nurses to want to come here to New Jersey, even if we have to pay the extra premium*." (Hospital stakeholder)

Stakeholders perceived that emergency licensing helped states shift the nation's healthcare workforce supply to meet local needs—making health services more available to those who needed it.

> *"As a representative of payers, I would say that provider shortages are a problem and a barrier to access. To the extent that you can alleviate those shortages through augmentation of the supply side of qualified, appropriately licensed folks, I think it's good."* (Payer stakeholder)

A telehealth company participant reported similar experiences, noting that emergency licensure programs allowed them to expand and flex services to areas of high need:

Figure 1
The perceived impact of emergency licensure programs on access to care



> *"We can sometimes see the spikes before the CDC does because we manage everything real-time. If we knew there was a spike developing in 'State X,' we knew that we had to identify our 'State X'-licensed physicians and get them ready."* (Telehealth stakeholder)

Participants reported that workforce needs were particularly high for nursing and, as described below, behavioral and mental health.

> *"Our demand actually went up during the pandemic based on the telepsychiatry availability and the sheer demand for behavioral health services, so we took advantage of the licensees from outside of New Jersey."* (Behavioral health stakeholder)

Notably, demand for non-emergency services decreased during the pandemic, resulting in decreased demand for healthcare workers in those service lines. Examples of these services included: elective procedures, preventive care (eg, routine primary care visits, routine cancer screenings), and non-COVID emergency room care.

> *"Emergency rooms used to be overcrowded with people hanging out in the hallways. When the pandemic hit, you only saw COVID patients in emergency rooms, and we know for a fact that patients did not seek medical help for cardiovascular disease, oncology issues, endocrine issues."* (Nurse stakeholder)

Accessibility: Expanded telehealth capacities complemented emergency licensure programs

Healthcare practitioners benefitted from the Centers for Medicare and Medicaid Services telehealth waivers, which, among other measures, relaxed the originating site requirements of the practitioner and patient. Care could be provided outside of the practice and without first establishing the patient in an in-office setting.

> *"Telehealth companies were utilized in New Jersey before the pandemic but not a whole lot until telehealth really exploded—by necessity and during the relaxation of some rules, including the licensure waiver."* (Hospital stakeholder)

A telehealth company stakeholder elaborated that licensure and telehealth waivers allowed their network of 5000 physicians to reach more remote areas.

> *"Until we got the emergency orders and the licensure waivers, we couldn't pivot our physicians to where they were needed most. Telehealth is a great social equalizer. It allowed people in the Appalachian reservations or any other remote area to get the same quality of care that people in New York City and Washington, DC are getting."* (Telehealth stakeholder)

As demand for telehealth services increased, especially for behavioral and mental health, stakeholders reported that expanded telehealth capacities complemented state emergency licensure programs to increase the accessibility of specialized health services.

> *"I've got multiple units where I do specialized care—dual diagnosis mental health and substance abuse; geriatrics with Alzheimer's and mental health issues or autism; self-injuries. Reaching out to specialists in other states who I can get licensed quickly allowed me, because some of our doctors got sick, to fill in for them and still operate a specialized program. That was enormously valuable."* (Behavioral health stakeholder)

Acceptability: Concerns about care quality were mitigated by the urgency of the pandemic, credentialing processes, and investigative authorities

State licensure processes typically require background checks, reference checks, and verification of education and employment history—all of which are important to ensuring public safety but cause delays in licensing of health practitioners. State emergency licensure programs waived different components of the licensing process to accelerate licensing of out-of-state practitioners. However, a few stakeholders shared concerns about possibly lower care quality due to relaxed standards.

> *"When we relax the standard, how will that affect the public? When we allow practitioners who have not been properly vetted to practice medicine, what are the consequences? I don't think we know the answer to that at this point. I would be opposed to an indefinite [licensure] extension without looking at the data and seeing the outcomes."* (Physician stakeholder)

A government stakeholder stressed that vetting was important to protecting public safety:

> *"Bad actors are rare, but they're out there. When you think about physicians, you think about people who are humanitarians, who are good. But there's a segment that are*

not, and we need to protect or assure the public that they're not getting those people." (Government stakeholder)

Some expressed worry that emergency licensees may provide lower quality care due to lack of community connections, referral networks, and knowledge of local regulations:

"If you realize that a patient is a danger to themselves or others or that they have an acute, urgent medical issue, just saying, 'You ought to go to a hospital' isn't sufficient. You need to be able to contact the health system, know who you're contacting, and get them into where the services they need are available." (Government stakeholder)

However, most of the care quality concerns were mitigated by the urgent needs of the pandemic, with stakeholders recognizing that tradeoffs were necessary to meet service demands:

"Patient safety is paramount. But during this pandemic, you're balancing. You're saying, 'Is it better to have somebody who hasn't practiced as a nurse for 5-6 years and who might not be up to date on their continuing education? Or not have anybody at all?'" (Long-term care stakeholder)

Care quality concerns were also mitigated by existing system processes, such as credentialing, which is the process by which the employer verifies that a practitioner has the required education, training, and experience to practice in the state. Some credentialing requirements are waived in public health emergencies, though it is often still a multifaceted, rigorous process.

"When we're credentialing someone during a disaster plan, we need their current licensures. We check OIG [Office of Inspector General] debarment and their board certification. We run a National Practitioner Data Bank report and check malpractice insurance. We get a signature from [hospital leadership] and the chair of the department who's going to oversee them." (Hospital stakeholder)

Large health systems were more able to implement emergency licensure, in part due to their ability to adapt existing resources to credential and orient emergency licensees.

"*We put 10-15 staff members from other areas to do expedited licensing and credentialing. We also have a great IT department. It's tough to pull off anywhere other than a large health system because you don't have the resources, the money, the technology, and the reputation."* (Behavioral health stakeholder)

Smaller organizations had less favorable experiences, reporting administrative challenges to tracking and implementing new credentialling policies.

"Once the temporary licensing came out, there were rules around it, like you must have 'X' number of hours. Who's going to validate those hours? Now you have this additional administrative component to your work, in addition to being short-staffed because people are out because of COVID. It was a huge burden." (Nurse stakeholder)

Finally, care quality concerns were mitigated by the expanded roles of investigative authorities. For patient legal protections, stakeholders noted that states have their own legislation to hold practitioners accountable if needed.

"There were different approaches taken by different states. New Jersey did well with its legislation because it enabled the regulatory board to exercise its investigative authority [on emergency licensees], holding the individual accountable in terms of their privilege to practice, but importantly, it enabled the board to transfer that information back to the state where the individual had their main license." (Nurse stakeholder)

Affordability: Relocation packages and the need to replace staff could lead to higher costs of care

There were few cost concerns associated with emergency licensure. In states like New Jersey, Georgia, and South Carolina, the practitioner did not have to pay to obtain an emergency license; these state licensing agencies may have lost potential revenue that they would typically obtain from full licensing fees. Stakeholders also did not report any issues with payer organizations. Most large payer organizations already operate in multiple states and have infrastructure to track services across states.

The main reported cost concern was relocation packages, used most frequently by travel nurses—some of whom stakeholders believed used emergency licenses. Some stakeholders were concerned that the high cost of relocation packages may lead to long-term, higher costs of care, making health care less affordable for patients.

"The signing bonuses are real. Those wages—the two, three, to four times statement is real. It's hard not to see how that would not trickle down to the patient or at least through hospitals coming back to health insurance companies, asking to renegotiate their rates for higher rates to account for this. It's unsustainable." (Hospital stakeholder)

Stakeholders also cited cost concerns related to the need to replace staff due to COVID-related early retirement, burnout, and attrition.

Accommodation: Views on licensure reciprocity and interstate compacts were favorable, but smaller provider organizations need to be protected

There is no single data source to measure how state licensing agencies accommodated for pandemic-related healthcare workforce needs. However, stakeholders commended states—citing New Jersey, Colorado, and Washington, as some exemplars—on efforts to quickly start up programs that were robust and relatively easy-to-use by practitioners and health systems, particularly as state licensure can be an administratively burdensome process.

"The time to initial licensure can be frustratingly long, especially if a state's licensing process is not electronic. Every state requires lots of pieces of paper and lots of people reviewing them." (Physician stakeholder)

Some states benefitted from existing infrastructure or leadership primed to support emergency licensing.

"Having a Commissioner of Health who recently ran hospitals was an enormous advantage to us in New Jersey because she knew the other side of the equation. She knew how to cut through the regulatory world and make it affordable, accessible, and available to us in the business. Licensure was probably the key cog which needed to be solved, and the state came through." (Behavioral health stakeholder)

Stakeholders agreed that practitioner licensure needs to draw lessons from the pandemic and adapt to a modern, changing society, including a population that has become more diverse, portable, and mobile. Most perceptions expressed on this topic, however, centered on the combined roles of technology and emergency licensure, rather than the role of emergency licensure alone:

"*In person you're stuck with whatever languages you're able to speak, but I think technology may have enabled broader delivery of care to communities not fluent in English*." (Physician stakeholder)

"With the increase in telehealth, which allows people to be more mobile; with the idea that you don't grow up and live in the same town your whole life; and with continuity of service, it shouldn't have taken a pandemic for us to look at how we work with other states with regard to licensure reciprocity." (Social work stakeholder)

Stakeholders noted the parallel between emergency licensure and interstate licensure compacts. Most had favorable opinions of interstate compacts, especially after their observations of the COVID-19 emergency licensure programs. A government stakeholder reflected that more widespread adoption of interstate compacts pre-pandemic would have saved resources.

"Had the US been a little bit more equipped through multi-state licensing contracts across professions that allow for an agile or nimble response in case of emergency, where you have an infrastructure that's designed to have some quality controls in place, we all would have been better off. We could have devoted time elsewhere." (Government stakeholder)

Despite mostly favorable remarks about interstate compacts, some stakeholders shared reservations, particularly regarding the potential of compacts to introduce competition into local markets.

"What it's basically allowing is large corporate-type practices to begin to infiltrate many states, displacing some of the private practice physicians. That's where you get a plurality of opinion among the physician community around whether the compact is good or bad." (Physician stakeholder)

Regardless of how policies change, stakeholders were in consensus that public safety should be prioritized.

Discussion

Through this study, we learned that state and national stakeholders perceived emergency licensure programs as successful in expanding access to care during the COVID-19 pandemic. They perceived that emergency licensing helped shift the

nation's healthcare workforce supply into regions and specialties of high need (availability). The COVID-19 federal telehealth waivers were also seen as complementary to local emergency practitioner licensure waivers, as this allowed practitioners to provide care remotely and across state lines, particularly enhancing access to behavioral and mental health services (accessibility). Stakeholders had concerns about potentially reduced care quality due to relaxed standards; however, concerns were mostly, temporarily mitigated by the urgency of the pandemic and existence of credentialing processes and investigative authorities (acceptability). The key cost concern was from relocation packages, often used by health systems during staffing shortages to attract out-of-state nurses. Some stakeholders conceived that signing bonuses and inflated wages may lead to higher costs of care long-term (affordability). Finally, stakeholders viewed licensure reciprocity and interstate compacts more favorably now than pre-COVID-19 and recommended that states consider ways to streamline licensing processes across states, such as participating in interstate licensure compacts, and innovative ways to reduce administrative redundancy while still maintaining rigorous vetting (accommodation).

In summary, our study suggests that emergency licensure programs were perceived to have positively impacted two domains of access to care—availability and accessibility. These findings support and expand upon the findings of Lipschitz et al,[31] which examined provider perspectives on COVID-19 telehealth implementation in Massachusetts. The authors reported that state licensure policies were seen as a barrier to care provision and care continuity during the pandemic, restricting access to care for patients who live in neighboring states, students who travel home for the summer, and adults who travel for work.[31] Similarly, our stakeholders saw state practitioner licensure and telehealth waivers as having complementary roles in expanding the availability and accessibility to care during the pandemic.

In contrast, we found that the perceived impact of emergency licensure programs was less clear on the acceptability, affordability, and accommodation domains of access. The acceptability of emergency licensure remains uncertain in part due to the uncertainty of care quality delivered by out-of-state practitioners. While credentialing and investigative processes were cited as important quality assurance checks, it should be noted that practitioners who are not affiliated with hospitals may not be required to undergo these processes. The topic of care quality of out-of-state practitioners is a major focus area for new, on going research, ignited by increased interstate telehealth provision.[32–34]

The affordability of emergency licensure programs was unclear, as employing out-of-state practitioners was perceived to be a risk for long-term, higher costs of care—especially if many practitioners physically relocated. According to a report by Merritt Hawkins,[36] 74% of the nearly 2,500 US healthcare organizations studied offered a relocation allowance in 2020-2021. For physicians, the average relocation allowance was $10,634, compared to $9,555 in 2012-2013. For nurse practitioners and physician assistants, the average was $8,363, compared to $6,904 in 2012-2013. We could not find data on how many practitioners relocated to estimate the overall impact on spending. Another facet of cost not mentioned by our stakeholders is the role of professional licensure as a source of state revenue.[37] In some states, including New Jersey, emergency licensure programs waived licensure fees for temporary licenses.[16] Changes to licensure policies would affect state revenue.

THROUGH THIS STUDY, WE LEARNED THAT STATE AND NATIONAL STAKEHOLDERS PERCEIVED EMERGENCY LICENSURE PROGRAMS AS SUCCESSFUL IN EXPANDING ACCESS TO CARE DURING THE COVID-19 PANDEMIC.

Finally, the accommodation of emergency licensure programs was perceived to be unclear, as stakeholders were generally in favor of interstate licensure reciprocity during the COVID-19 public health emergency but held reservations about the feasibility, cost, and quality of licensure reciprocity beyond the emergency. Two of the main licensure reforms that have been proposed or introduced are well-summarized by Mehrotra, et al, and focus on moving the US toward universal cross-state licensure.[39] The first proposal is widespread participation in the interstate licensure compacts, in which all US states and territories would need to pass legislation to join the compacts. Compacts would need to be created for additional practitioner types; there are currently compacts for physicians,[40,41] nurses,[42] and psychologists,[43] and efforts have started to create compacts for social workers[44] and professional counselors.[45] Of note,

Lippert [46] and Adashi, et al, [47] emphasize that the thorough vetting process for interstate compacts can help ensure public protection, potentially addressing the quality concerns raised by stakeholders in our study. However, to get widespread support for interstate licensure compacts, policymakers need to take measures to protect local, smaller practitioner groups from external market competition, such as through anti-trust regulation or more thorough examination of market penetration from out-of-state practitioners.

The second type of licensure reform proposal is the use of federal authority to encourage national licensure reciprocity (ie, legal authorization to use a license across state lines, such as with a driver's license). Several opinion articles[35,39,48] believe this is the most promising strategy, as it builds upon existing legislation that mandates licensure reciprocity for physicians practicing in the Veterans Affairs system as well as the various emergency licensure programs implemented during the pandemic.

THE TOPIC OF CARE QUALITY OF OUT-OF-STATE PRACTITIONERS IS A MAJOR FOCUS AREA FOR NEW, ONGOING RESEARCH, IGNITED BY INCREASED INTERSTATE TELEHEALTH PROVISION.

There are strategies to mitigate stakeholder concerns about the feasibility, cost, and quality of universal licensure reciprocity. To streamline local licensure processes, states need to modernize their licensure systems to include digital documents (including finger prints), online portals (including clear specification of requirements), and preapproved school curriculums (rather than requiring transcripts).[37] To address cost concerns, the federal government should consider incentivizing licensure reciprocity[35] and funding studies to monitor costs associated with staffing relocation. Finally, to address quality concerns, Chandrashekar and Jain recommend widespread use of resources like the National Practitioner Data Bank to document and track disciplinary actions.[45] These are just the start of a list of strategies that may facilitate more successful licensure reform.

Limitations

Our study has limitations. First, by design, the study oversampled stakeholders in one state (New Jersey). Practitioner licensure is determined at the state level; therefore, it was important to include in-depth analysis at that level. The study benefitted from drawing upon a state which used emergency licensure at high volume, increasing the likelihood that stakeholders would have enough experience with emergency licensure to form an opinion. A drawback of this focus is that the New Jersey experience may not be generalizable to other states. For example, New Jersey stakeholders may be biased as one of the early pandemic hotspot states, which may have felt a greater need for out-of-state practitioner support. We encourage more state-level studies of emergency licensure to determine whether perceptions differ. Second, the sample size may be considered as small considering the number of stakeholder types represented. It is worth noting that some stakeholders represented several stakeholder types. Furthermore, the total number of participants exceeds recommended best practices for qualitative research[27] and was confirmed by assessing thematic saturation, which was reached by the 18th interview. Third, the study reports stakeholders' perceptions only; quantitative data were not available to confirm impact on access to care. It is still important to understand perceptions, as perception is a common driver in policymaking.[20] Finally, comments may have reflected concerns unique to the study time period (September-October 2021, before an anticipated winter spike). Despite elevated concerns about workforce shortages, it has been well-documented that workforce shortages were a pressing issue pre-COVID.[49]

Conclusion

Emergency licensure of healthcare practitioners was perceived to have expanded access to care by enabling the healthcare workforce supply to flex into areas of high need. These experiences with COVID-19 emergency licensure signal that the US has an opportunity to improve licensure processes, and our study highlights important contextual considerations and potential strategies for licensure reform. The road to practitioner licensure reform will not be easy, but it may be possible with strategic state collaboration and federal encouragement and support.

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Appendix. Temporary Emergency Practitioner Licensure Interview Guide

Introduction of interviewers

We'd like to start by telling you a little bit about ourselves. I am [name]. I work at [name] and I am a [name role and describe what you do]. I am really excited to talk with you today because I am very interested in ways we can address access to care issues in public health emergencies.

[Introduce interviewer 2. Interviewer 2 offers a similar introduction.]

Study overview / Consent

We are speaking with you today because you are a stakeholder in healthcare practitioner licensing. We are interested in learning how you think emergency licensing impacted access to care during the COVID-19 pandemic and the implications for future licensing policies.

In the invitation email, you should have received a consent form that further explains the purpose of this study, your rights and freedoms as a participant, and specific contacts in case you have questions about the interview process. What questions can I answer for you?

Permission to record

Do I have your permission to record this interview? Great. I am going to turn on the recording device and ask you that question again for the record.

[Turn on the recording device.]

Do I have your permission to record this interview?

[Invite respondent to introduce him/herself]

1. Tell me about yourself and your role with emergency licenses during the pandemic.

[Thank you so much for that introduction. It is nice to meet you.]

Context
During the COVID-19 pandemic, many states waived requirements that physicians and other health care professionals with out-of-state licenses be licensed in the state in which they are providing services.

2. Do you think emergency licensure programs added value to patients? *Probe: How?*

Impact on Access to Care
Next, I'm going to ask you questions to get your insights on how emergency licensing of healthcare practitioners impacted access to care.

For each, probe: Impact on healthcare practitioners? Patients?

3. Have emergency licensures affected affordability of healthcare? *Probe: How? Ability to pay / accept payment*

4. Have emergency licensures affected availability of healthcare? *Probe: How? Supply of services needed*

5. Have emergency licensures affected accessibility of healthcare? *Probe: How? Location and transportation, telehealth*

6. Have emergency licensures affected accommodation of healthcare? *Probe: How? Hours, languages, etc.*

7. Have emergency licensures affected acceptability of healthcare? *Probe: How? Alignment of patient and provider values and preferences, provider knowledge of local referral networks and regulations*

Facilitators & Barriers
Adapt to stakeholder type:

8. For state: What were the facilitators and barriers to standing-up an emergency licensure program?
For everyone else: What were the benefits and drawbacks of the emergency licensure programs?

Lessons Learned Thus Far

9. What are your recommendations for future licensing policies? *Probe: Public health emergencies? For licensing in general?*

Wrap-Up

10. Is there anything else that you think is important about emergency licensing that we should talk about?

11. Who else should we talk with to make sure we understand the impact of emergency licensures during the COVID-10 pandemic?

Demographics
I'd like to end with some basic demographic questions to help us describe who we interviewed. You may choose to skip any of these questions.

12. What is your formal training?

13. How many years have you worked at [organization name]?

14. How many years have you worked directly with issues concerning licensing?

15. What is your gender identity?

16. Do you identify as Hispanic or Latinx?

17. What is your race?

Closure
Thank you for your time. Your participation is extremely helpful to us understanding the impact of the emergency licensing of healthcare practitioners across the country. If you have any questions or follow-up after this call, please feel free to reach out to me. [Turn off the recording device.]

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