I Mina'trentai Sais Na Liheslaturan Guåhan
BILL STATUS

BILL NO.	SPONSOR	TITLE	DATE INTRODUCED	DATE REFERRED	CMTE REFERRED	PUBLIC HEARING DATE	DATE COMMITTEE REPORT FILED	FISCAL NOTES	NOTES
13-36 (COR)	Mary Camacho Torres Tina Rose Muña Barnes Amanda L. Shelton	AN ACT TO *ADD* A NEW ARTICLE 3A TO PART 1 OF CHAPTER 12, DIVISION 1, TITLE 10, GUAM CODE ANNOTATED, RELATIVE TO ADOPTING THE NURSE LICENSURE COMPACT; AND TO *ADD* A NEW § 12307(d) OF ARTICLE 3, PART 1, CHAPTER 12, DIVISION 1, TITLE 10 GUAM CODE ANNOTATED, RELATIVE TO ESTABLISHING ADDITIONAL DUTIES OF THE GUAM BOARD OF NURSE EXAMINERS TO FACILITATE THE LICENSURE OF NURSES UNDER THE COMPACT; AND TO FURTHER APPROPRIATE THE SUM OF SIX THOUSAND DOLLARS FROM THE HEALTH PROFESSIONAL LICENSING OFFICE REVOLVING FUND TO THE DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES TO FUND THE ANNUAL MEMBERSHIP FEE TO THE NURSE LICENSURE COMPACT IN FISCAL YEAR 2022.	1/6/21 4:08 p.m.	1/13/21	Committee on General Government Operations, Appropriations, and Housing	2/3/21 9:00 a.m.	2/11/21 10:21 a.m.	Request: 1/13/21 1/15/21	2/11/21 4:54 p.m. Supplement Document" to the Committee Report on Bill No. 13-36 (COR).

Vice Speaker
TINA ROSE MUÑA BARNES
CHAIRPERSON, COMMITTEE ON RULES
I Mina'trentai Sais Na Liheslaturan Guåhan

GUAM CONGRESS BUILDING
163 CHALAN SANTO PAPA
HAGÅTÑA, GUAM 96910
TEL 671-472-2461
COR@GUAMLEGISLATURE.ORG

February 11, 2021

MEMO

To: **Rennae Meno**
Clerk of the Legislature

From: **Vice Speaker Tina Rose Muña Barnes**
Chairperson, Committee on Rules

Re: **Supplemental Document to the Committee Report on Bill No. 13-36 (COR)**

Buenas yan Håfa adai,

Please include this memo and attached document as a "Supplement to the Committee Report" for the Committee Report on **Bill No. 13-36 (COR).**

Please make the appropriate indication in your records and forward to MIS for posting on our website. I also request that the same be forwarded to all Senators.

If you have any questions or concerns, please feel free to contact Mary Maravilla, Committee on Rules Director, at 472-2461.

Si Yu'os Ma'åse',

Vice Speaker Tina Rose Muña Barnes
Chairperson, Committee on Rules

SENATOR JOE S. SAN AGUSTIN
COMMITTEE ON GENERAL GOVERNMENT OPERATIONS, APPROPRIATIONS & HOUSING
I MINA'TRENTAI SAIS NA LIHESLATURAN GUÅHAN

February 11, 2021

The Honorable Tina Rose Muña Barnes
Chairperson, Committee on Rules
I Mina'trentai Sais Na Liheslaturan Guåhan
163 Chalan Santo Papa
Hagåtna, Guam 96910

SUBJECT: Supplemental Information for Committee Report on Bill 13-36 (COR)

Bueñas yan Håfa Adai!

Please find appended to this letter additional testimonies which the Committee on General Government Operations, Appropriations, and Housing received after the Committee Report was submitted. I respectfully request that the documents be included as a supplemental to the Report on Bill 13-36 (COR) As Introduced.

Thank you for your attention to this important matter and I look forwarded to your responses and information.

Respectfully yours,

Joe S. San Agustin
Chairperson, Committee on General
Government Operations, Appropriations,
and Housing

COMMITTEE ON RULES
RECEIVED:
February 11, 2021
10:49 A.M.

SUITE 3, 2ND FLOOR, RAN CARE BLDG. CBU# 230 761 S. MARINE CORPS DR., TAMUNING, GUAM 96913
TEL: 671-989-5445 FAX: 671-969-6737 EMAIL: SENATORJOESSANAGUSTIN@GMAIL.COM

111 E. Wacker Drive, Ste. 2900, Chicago, IL 60601
312.525.3600 nlc.gov

February 9, 2021

Chairman Joe S. San Agustin
Committee on General Government Operations, Appropriations, Housing
and the Office of Finance and Budget
761 S. Marine Corps Drive
Tamuning, Guam 96913

Dear Chairman San Agustin and Committee members,

I respectfully submit the following supplemental testimony on Bill No. 13-36 (COR). It is organized to address the primary points verbalized in opposition to the NLC bill at the hearing on Feb 3, 2021.

West Coast States and Other States Have Not Joined Nurse Licensure Compact (NLC)

It was mentioned by opponents of the NLC legislation at the Feb 3, 2021 hearing that West coast states and other states have not adopted the NLC. This information is misleading and intended to convey that there is a lack of interest in the NLC. In fact, 34 states (greater than two-thirds of states) have adopted the NLC. **(See Appendix A)** That alone is indicative of the considerable desire of states to be members of the NLC.

Further, there is presently NLC legislation pending in:

1. California
2. Oregon
3. Washington State
4. Alaska
5. Guam
6. Illinois
7. Ohio
8. Michigan
9. Vermont
10. Rhode Island

In this current session, legislation will be introduced in:

11. Nevada
12. Pennsylvania
13. Massachusetts (filed)

The list of states above demonstrates the clear intent of the nursing stakeholders of this country for the US to become a compact nation of all states and territories wherein a nurse with a multistate license can practice in any state or territory. The era of a nurse obtaining one license valid for one jurisdiction is

transitioning nationally to a multistate license model. The single state licensure model is outdated due to increased mobility of professionals and advances in technology.

Other Territories are Not Interested in the NLC

It was mentioned by opponents of the NLC legislation at the Feb 3, 2021 hearing that CNMI and other territories have not joined the NLC. **This is misleading and deserves clarification.** Both CNMI and the USVI have expressed strong interest in adopting the NLC as well as the APRN Compact. I have personally worked with the officials of these jurisdictions to provide information about the NLC as they do their due diligence to pave the way for these respective territories to join the NLC in future.

Occupational Licensure Reform and the Growth of Interstate Compacts for Licensure

Although nursing was the first licensed healthcare profession to develop (in 2000) an interstate compact to enable license portability, since 2015, licensure compacts were also developed by:

1. Physicians
2. Physical Therapists
3. Emergency Medical Services / Technicians
4. Psychologists
5. Advanced Practice Nurses (new)
6. Speech Language Pathologists and Audiologists
7. Occupational Therapists (new)
8. Counselors (new)

Each year, more and more legislation is enacted by states which become a member of these licensure compacts. **(See Appendix B)**

Furthermore, the following professions are in the initial phase of developing an interstate compact for licensure:

9. Dental hygienists and dentists
10. Physician Assistants
11. Social Workers
12. Genetic Counselors
13. Acupuncturists
14. Chiropractors
15. Massage Therapists
16. Cosmetology/Barbers
17. Teachers

The opponents to the NLC on Guam are likely not aware of the current status of occupational licensure reform throughout the US and the metamorphosis of the model of licensure of professions. From the list above, you can easily see that all primary professions in the healthcare field will embrace a modern model of licensure that is significantly better for the practice of the profession and meets the needs of today's consumers and patients.

Military and Military Spouses

The support of the military and military spouses for the NLC in Guam was expressed during the Feb 3, 2021 hearing. Unfortunately, this significant support did not seem to influence the opponents. This is

despite the significant military presence on Guam which includes spouses and residents who are veterans.

This topic is so important to the US Department of Defense (DoD), that it established a grant which it is currently offering to licensed professions seeking to develop an interstate compact for licensure. Awardees may receive $1 million in funding to develop a licensure compact for a profession in which a compact does not currently exist.

Mass Exodus of Nurses from Guam

It was mentioned by opponents of the NLC legislation at the Feb 3, 2021 hearing that Guam joining the NLC would cause an exodus of nurses from Guam. The intent of such an alarming claim is just that – to cause concern among the legislature.

The reality, based in fact, is that there are some NLC jurisdictions which have nurse salary structures similar to Guam. Namely, Kansas, West Virginia and Alabama are very similar. The salary structures in these states were in place before the states joined the NLC. In every case, where we analyze the number of nurses in these states pre-NLC compared to post-NLC implementation, **there is not a decrease in the number of nurses that can be attributed to the state joining the NLC – i.e., no exodus (See Appendix C).** In fact, the number of nurses increased. Bear in mind, that in these mainland states, leaving the state in order to live and work in a higher paying state would be much simpler to do since it would not involve flying thousands of miles. Yet, it has not happened. If the opponents' claims of mass exodus were true, the states with the lowest salaries should be devoid of nurses. That is simply not the case.

As the bill sponsor noted, in a civil society with freedom, people are free to go where they wish. Any notion that any group of people should be made to stay in a geographic location is simply beyond the bounds of a free society and unacceptable.

Nurses did not Come Following Temporary Emergency Orders During the Pandemic

It was mentioned by opponents of the NLC legislation at the Feb 3, 2021 hearing that although the Guam governor issued temporary emergency orders reducing requirements for nurses to come to Guam to practice during the pandemic, they did not come. This is not surprising at all. The rapid spread of COVID-19 cases across the nation forced states to respond to an overwhelmingly high demand for nursing assistance by quickly loosening cross-border licensing restrictions, resulting in dissimilar and often confusing state emergency orders. This confusion existed for licensees, hospitals and nurse staffing agencies. Just because a jurisdiction such as Guam temporarily relaxed restrictions to practice on Guam, does not mean that communication was received by or understood by mainland licensees and nurse staffing agencies **(See Appendix D).**

There are numerous issues with governor-issued executive orders. These orders often lowered the safety and practice standards, focusing more on the quantity of nurses available to help with growing COVID cases, rather than maintaining standards for nurse practice. With a applicants coming from out of state to assist during the pandemic, for noncompact states, it was difficult or impossible to get criminal background checks (CBCs) completed on all applicants due the fact that CBC services were either closed or unavailable. This increased the concern for patient safety.

Additionally, even though executive orders permitted nurses to come and assist in other states, there were issues with enforcement authority. If a violation occurred, states that did not issue the nurse's license had no authority to take adverse action against the license. Finally, due to the temporary nature of the executive orders, they expired at different times in different states, posing issues for hospital

staffing. Whether or not an executive order would be extended beyond expiration was often a last-minute decision from the governor's office and thus a difficult process for health care professionals to manage the authority to practice of nurses based on order expiration dates. For patients, this also posed an issue in terms of continuity of care. As emergency orders began to lapse, health care providers were forced to scramble to coordinate continued care post-executive order expiration.

If all states were a part of the NLC, many issues would have been avoided. The NLC would have allowed for expedited and, most importantly, safe access to licensed, qualified and competent nurses that were required to meet the same uniform licensure requirement standards, including submission to federal and state fingerprint based criminal background checks. Furthermore, if all states were members of the NLC, each state would have enforcement authority when a nurse from another NLC state is practicing in their jurisdiction. Expiration of executive orders and, in turn, nurses' authority to practice would have also been a nonissue.

Appropriate Subject Matter Knowledge and Expertise

The individuals who vocally opposed the NLC legislation at the Feb 3, 2021 hearing lack subject matter expertise in the areas of occupational licensure and interstate compacts. Their claims are based on fears. They are, in fact, a minority opinion. They ignore the fact that 98% of Guam nurses who responded to a recent survey supported Guam's entry into the Nurse Licensure Compact **(See Appendix E).** Such an overwhelming response is a mandate voiced by the People to the legislature to pass the NLC legislation. Such significant support is no different than found in other states. In particular, it is comparable to the survey of Alaska nurses which resulted in 93% support to join NLC and the Oregon nurse survey which demonstrated 97% support for NLC entry. It would be incomprehensible if the opposition of a very few were able to stand in the way of progress and modernization for a profession charged with caring for the sick and deemed the most trustworthy profession as demonstrated by honesty and ethics, for 19 consecutive years (Gallup poll).

As the director of the Nurse Licensure Compact, I make the above testimony based on my 12 years leading the NLC and expertise in nursing regulation gained in a 33-year career in healthcare. The NLC is regarded as the most successful licensure compact by the Council of State Governments National Center for Interstate Compacts and touted by the US DoD and several federal agencies as the preferred model of licensure for licensed professions.

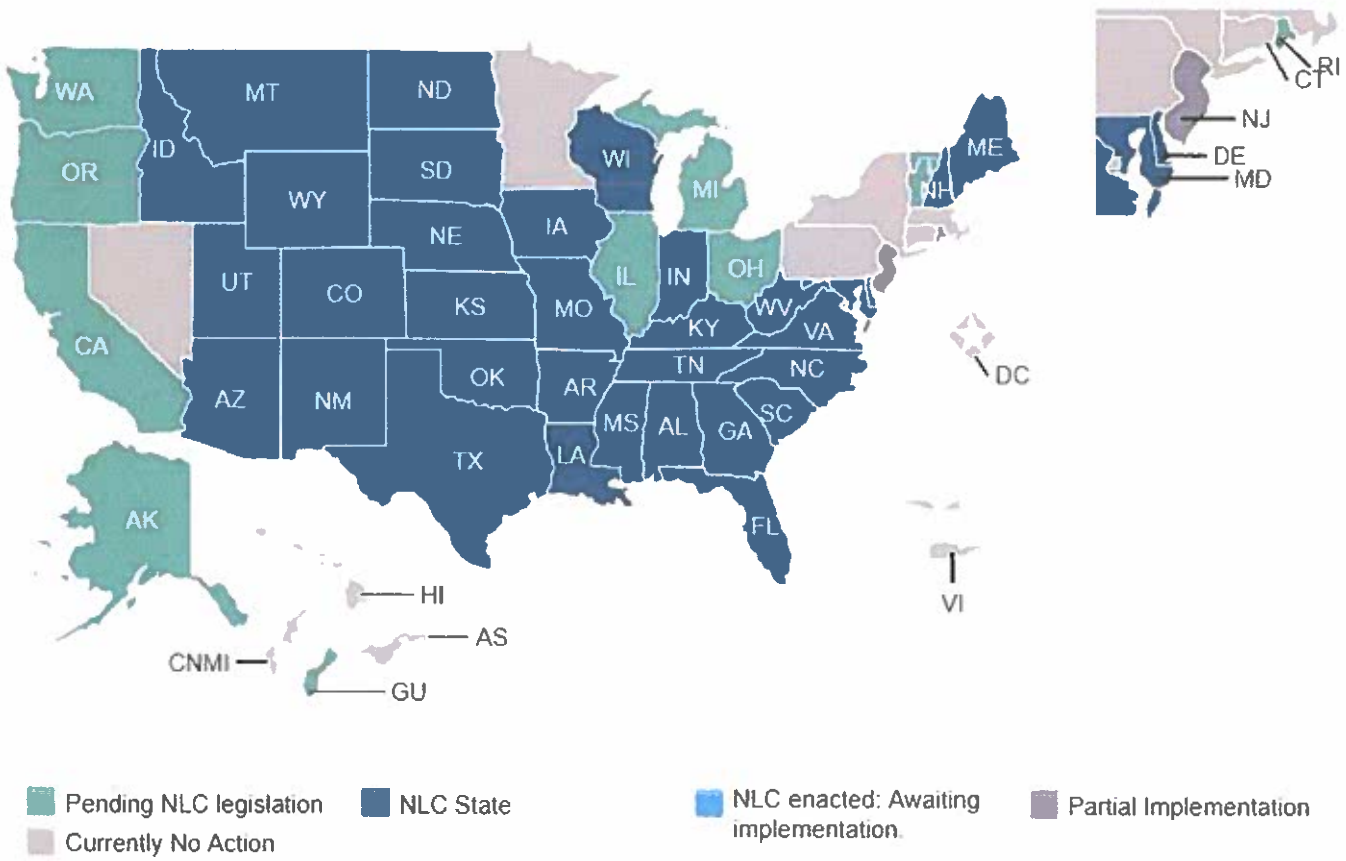
The GBNE and State Boards of Nursing across the US support the NLC. These are the individuals who are the regulatory experts that adopted the model language of the NLC in 2015. Together the model legislation was drafted by a team of legal and regulatory experts. We are fortunate to have the strong support of the staff and elected leadership of the GBNE.

Very respectfully,

Jim Puente, MS, MJ, CAE
Director, Nurse Licensure Compact
jpuente@ncsbn.org
cell [redacted]
www.nlc.gov

Appendix A

Current NLC States and Status



**New Jersey is allowing nurses who hold active, unencumbered, multi-state licenses issued by Nurse Licensure Compact member states to practice in New Jersey under their multi-state licenses.*

Source: www.nlc.gov

- 34 states have enacted NLC, shown on the map in blue.
- 10 jurisdictions have pending NLC legislation as of Feb 7, 2021, shown on the map in green.
- Additional NLC legislation will be introduced in this legislative session in NV, PA and MA.

* As of Feb 7, 2021

Appendix B

State and U.S. Territory Membership to Interstate Compacts

Navigating the various state licensing requirements, rules, regulations and fee structures can present challenges for workers. To address these challenges, states and professions have turned to occupational licensure interstate compacts. These compacts create reciprocal professional licensing practices between states, while ensuring the quality and safety of services and safeguarding state sovereignty. To date, over 40 states and territories have adopted at least one of the following occupational licensure compacts:

PT
Physical Therapy Compact

IMLC
Interstate Medical Licensure Compact

ENLC
Enhanced Nurse Licensure Compact

EMS
Emergency Medical Services Compact

PSYPACT
Psychology Interjurisdictional Compact

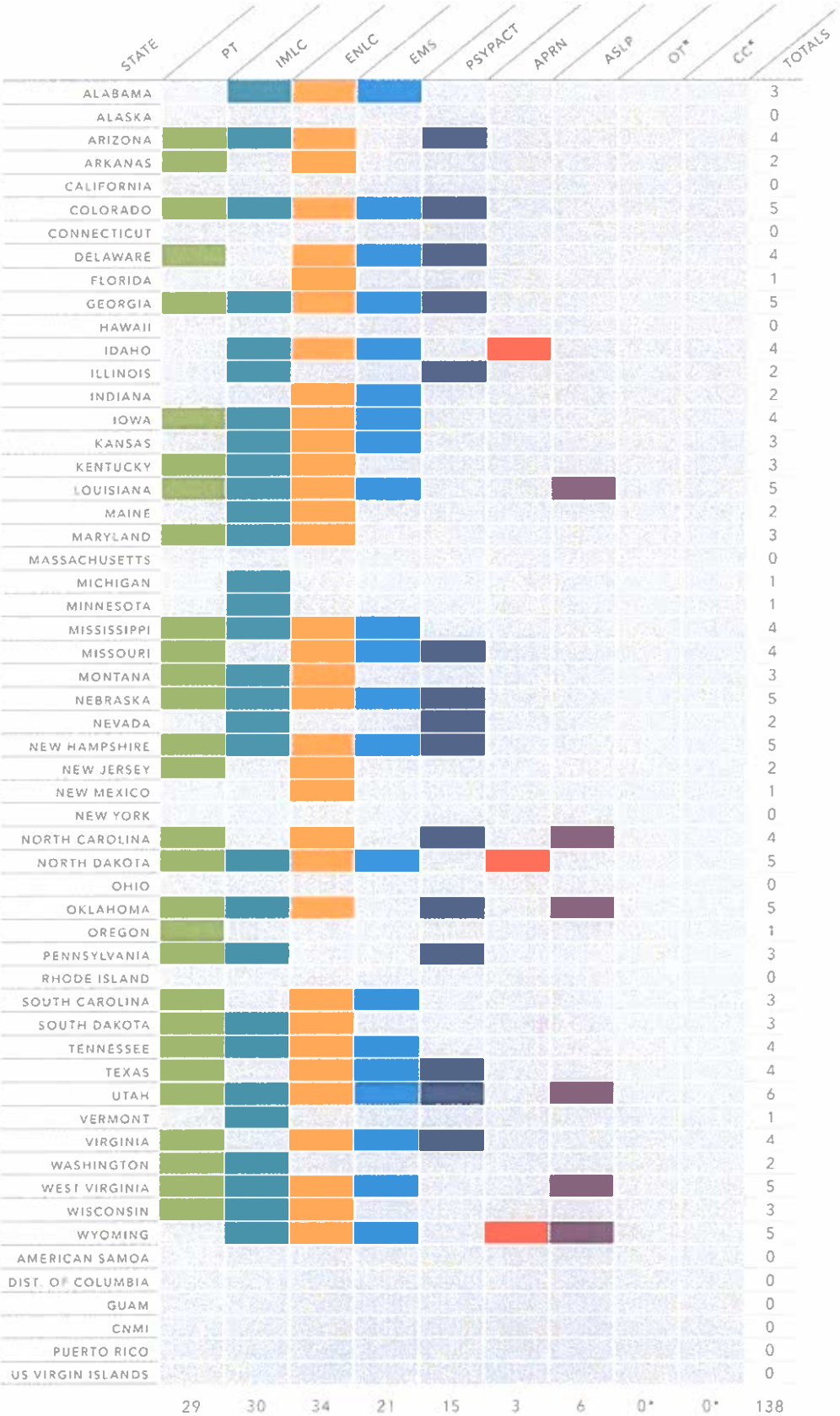
APRN
Advanced Practice Nursing Compact

ASLP
Audiology And Speech-Language Pathology Compact

OT
Occupational Therapy Licensure Compact*

CC
Counseling Compact*

**First enactments expected in 2021*



Number of Active Licenses Over 5 years For Alabama, Kansas and West Virginia

	January 1, 2017	January 1, 2018	January 1, 2019	January 1, 2020	January 1, 2021
Alabama (implemented NLC on Jan 1, 2020)	101,613	104,122	111,487	112,426	115,232
Kansas (implemented NLC on July 1, 2019)	66,662	68,615	70,136	75,829	78,325
West Virginia (implemented NLC on Jan 19, 2018)	39,841	40,642	41,894	42,919	45,890

Median salary for the above nursing careers was retrieved from the Bureau of Labor Statistics (BLS) May 2018 National Occupational Employment and Wages Estimates.

Nursing Salary by State

State	Nursing Assistants	Licensed Practical and Licensed Vocational Nurses	Registered Nurses	Nurse Practitioners	Nurse Midwives	Nurse Anesthe
Alabama	24,110	38,230	59,470	95,970	Unavailable	161,780
Guam	27,270	34,700	59,030	Unavailable	Unavailable	Unavailat
Kansas	26,210	43,240	61,030	99,430	Unavailable	159,600
West Virginia	26,410	36,770	61,780	100,690	113,720	183,080

THE HILL

Looming confusion as COVID-' state emergency orders begin expire

BY JULIA F. COSTICH AND DANIELLE N. SCHEER, OPINION CONTRIBUTORS — 06/17/20 06:30 PM EDT
THE VIEWS EXPRESSED BY CONTRIBUTORS ARE THEIR OWN AND NOT THE VIEW OF THE HILL

Just In...

Pilot in fatal Kobe Bryant crash was disoriented flying through clouds, NTSB says
TRANSPORTATION — 2M 18S AGO

NatGeo special on Air Force One teases on-board Trump interview
IN THE KNOW — 6M 45S AGO

Uber and Walgreens to offer free rides to COVID-19 vaccine sites
TRANSPORTATION — 7M 8S AGO

ACLU unveils campaign to end systemic racism
NEWS — 14M 52S AGO

Babies and children deported to Haiti in apparent defiance of Biden order: report
CHANGING AMERICA — 18M 7S AGO

The first step to build back better: Give America a raise
OPINION — 19M 2S AGO

North Dakota House votes to cut early voting period
STATE WATCH — 27M 42S AGO

Schumer vows Democrats will dual-track coronavirus bill with impeachment trial
SENATE — 31M 2S AGO

© Getty Images

As the COVID-19 emergency continues to spread across the country, governors and executive agencies across the United States have taken actions to loosen cross-border licensing restrictions for health care professionals. However, in the absence of a unifying statement of suggested action from the federal government, these actions are a patchwork of disparate state emergency orders.

An example of the problems caused by these waivers comes from Florida, where the last-minute extension of its initial COVID-19 out-of-state provider waiver left frustrated providers scrambling to coordinate coverage in case the waiver was allowed to lapse. While Florida's surgeon general ultimately extended the emergency order, the first approval — and the two extensions that came after — were last-minute announcements. This confusion and uncertainty is unlikely to be an isolated event as the COVID-19 emergency continues and other emergency orders reach their expiration dates.

As of June 3, 49 states and Washington, D.C. have released COVID-19-specific orders relating to licensure modifications for out-of-state medical doctors. Each state has promulgated different modifications to regulations for licensing and many have made changes to scope of service, documentation procedures, manner of establishing a patient relationship, billing and reimbursement protocols and more. Further,

these modifications not only differ as applied to health care professionals across states, but often differ within an individual state as applied to types of health professionals. A state that has released an order loosening the licensing requirements for a medical doctor may or may not apply that order to nurses. A state that applies its order to nurses may cite a regulatory code section that limits eligible nurses to APRNs, and excludes RNs and LPNs. Clinicians who want to focus their efforts on providing services and health care facilities that seek to obtain help for patients in need must first untangle the legal web of what these out-of-state providers can do and where.

Health care professionals who have combed through the hundreds of executive and emergency orders must then navigate the expiration dates. Many of these states have released amendments, expansions and extensions of these orders. These updates are released as new orders which may cross-reference the original order internally, but necessitate a close reading of each new announcement. Of the states with such orders, initial expiration dates ranged from April 9 (Louisiana) to 30 days after the emergency ends (Kansas and Nebraska).

A majority of states have tied the expiration of their emergency orders to the end of the state declaration of emergency. This tactic is beneficial to providers in that they do not have to check for updates continually throughout the crisis, though it may give rise to additional complications for them.

While it is logical for some emergency orders to expire along with the emergency (such as those that shutter businesses or limit non-urgent medical care), it is unrealistic to assume the increased demand for health care workers will stop on a single day. Further, providers will face just as much confusion and uncertainty from disparate state announcements as they will from pre-determined expiration dates. Each state will need to announce the end of their respective statewide emergency for itself; it is unlikely that will occur through a single unified directive and unconstitutional for it to occur through a single federal directive. What is most likely to occur is a period of speculation as to when states will announce the end of their emergency declarations, followed by a variety of formal announcements, with varying levels of advance notice of the declarations actually ending. The worst case scenario for providers and patients would be the termination of the emergency without advance notice.

An abrupt severing of the cross-border licensure waivers will also sever continuity of care for thousands of patients. Providers and health care facilities must be given notice to prepare for the actual end of these emergency orders.

As the extension of Florida's out-of-state provider waiver extension revealed, many decisions that affect health care providers and communities are being made in real time. Increasingly aggressive calls for a return to normality may push political leaders to lift their emergency declarations sooner than public health officials would advise. The best case scenario for providers and patients would be the tactic that Oklahoma, Kansas and Nebraska have taken — to provide for the end of their emergency orders after the state declaration of emergency ends. While it is impossible to know how long the impact of COVID-19 will increase the demand for health care, it is certain that increased demand will outlast the emergency declarations. Giving a buffer period would help care providers to plan ahead.

State governments are being called upon to make difficult decisions in a situation with scant precedent. Their decisions must take into account the competing interests of those who demand normal operations and those who caution against the risks of continued spread and a second peak of cases if emergency orders are lifted too soon. State emergency orders are beginning to lapse, and health care providers must be prepared to continue monitoring the changing regulatory environment and coordinate continuity of care once these orders expire.

Reflecting upon the response to the COVID-19 emergency, it is evident that some degree of up-front uniformity would have been beneficial to health care providers and facilities. Despite the variation in current state licensure waivers, lawmakers do, in fact, have access to model laws that would promote such uniformity across states for designated health professionals under specified circumstances. Eighteen states and Washington, D.C., have enacted some part of the Uniform Emergency Volunteer Health Practitioner Act, while 32 have adopted the Enhanced Nurse Licensure Compact. Several state declarations and orders expressly limited liability of health workers under specified circumstances, most commonly those working under the auspices of the Emergency Management Assistance Compact or a state voluntary health professional registration system.

It is possible that in the urgency of the moment, most legislative drafting at the state level did not include direct reference to or think of using these well-established mechanisms. Many medical licensing boards released their own announcements or specifications on emergency licensing procedures, referencing involvement in these compacts or enactment of the act — adding yet another source of information providers were expected to monitor as they struggled to care for patients.

It will take years to understand the impact COVID-19 has had on the world, but health care workers, researchers and policy-makers alike have the opportunity to learn from this crisis and create simpler and more effective solutions for the future.

Advocacy group launches campaign to press Congress on paid family...

Ocasio-Cortez, Schumer announce federal COVID-19 fund to help...

Julia F. Costich, J.D., Ph.D., is a professor in the University of Kentucky College of Public Health, Department of Health Management and Policy, and also serves as associate director of the Kentucky Injury Prevention and Research Center. Her current research focuses on legal and policy issues in public health and health care.

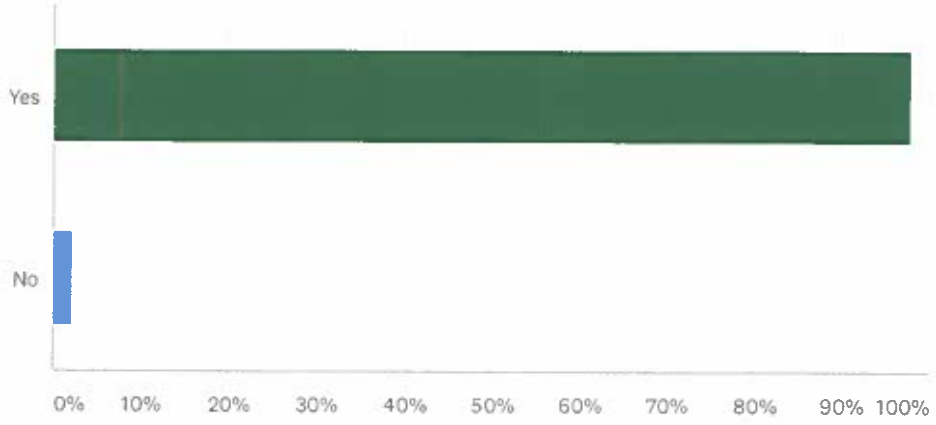
Danielle N. Scheer, J.D., M.P.H., is an associate attorney with McDermott Will & Emery, practicing in their Washington, D.C. office. She advises clients on transactional and regulatory health law matters and is Certified in Public Health by the National Board of Public Health Examiners.

TAGS COVID-19 CORONAVIRUS PANDEMIC RESTRICTIONS LOCKDOWNS CORONAVIRUS REOPENING HEALTH CARE HEALTH CARE PROVIDERS STATES REOPENING

Sent to 1,456 Guam Licensees on Jan 30, 2021. A response rate of 35% reported Feb 3, 2021.

Q2 Do you support Guam joining the Nurse Licensure Compact?

Answered: 519 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	97.88%	508
No	2.12%	11
TOTAL		519