COMMONWEALTH OF PENNSYLVANIA

HOUSE OF REPRESENTATIVES

PROFESSIONAL LICENSURE COMMITTEE

PUBLIC HEARING

STATE CAPITOL

ROOM 60, EAST WING

HARRISBURG, PENNSYLVANIA

OCTOBER 22, 2015

10:00 A.M.

PRESENTATION ON

HOUSE BILL 765

BEFORE:

HONORABLE JULIE HARHART, MAJORITY CHAIRMAN
HONORABLE HARRY READSHAW, MINORITY CHAIRMAN
HONORABLE JESSE TOPPER, SPONSOR OF HB 765
HONORABLE ROSEMARY BROWN
HONORABLE GARY DAY
HONORABLE JOE EMRICK
HONORABLE KEITH GILLESPIE
HONORABLE DAVID HICKERNELL
HONORABLE JERRY KNOWLES
HONORABLE STEVEN MENTZER
HONORABLE MARK T. MUSTIO
HONORABLE CURTIS SONNEY
HONORABLE MARCY TOEPEL
HONORABLE WILLIAM KORTZ

COMMITTEE STAFF PRESENT:

WAYNE CRAWFORD, EXECUTIVE DIRECTOR, REPUBLICAN RESEARCH
MAUREEN BEREZNAK, RESEARCH ANALYST, REPUBLICAN RESEARCH
ANGIE KELLY, LEGISLATIVE ADMINISTRATIVE ASSISTANT, REPUBLICAN CAUCUS
MARLENE TREMMEL, EXECUTIVE DIRECTOR, DEMOCRAT CAUCUS

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MAJORITY CHAIRMAN HARHART: Good morning, everybody; and I mean everybody. Okay. Well, the hour of 10 a.m. has arrived; and I'd like to call the meeting of the House Professional Licensure Committee to order.

The only thing I have to ask is that we have to keep the aisles clear and we have to keep the door -- you'll have to step away from the door so that the door, if anybody needs to access it, can leave without climbing over everybody.

And we also have another room, which is B 31, that does have a screen, that if the overflow would like to sit down and comfortably watch that, you can go to that room. The public hearing will be televised.

But we do need to keep the door clear, so you are going to have to move away from the door. You could open the door and stand outside, as well, as long as --

Okay. So the first order of business, I would like to ask each member of the Professional Licensure Committee to introduce themselves and state where they're from. So we will start with Jesse. Why don't we start with you?

(INTRODUCTION OF MEMBERS.)

MAJORITY CHAIRMAN HARHART: Thank you. I do

want to tell everybody I think that the cameras are going, so I would be very cautious; because you may be on camera and might make a motion or something that you don't want to be on camera.

So we are holding -- and I'm so glad to see everybody here, I truly am. You really have an interest in this issue. And we are holding this public hearing to take testimony on this House Bill 765, legislation which provides for licensure and independent practice for certified nurse practitioners.

I would like to recognize the prime sponsor of this legislation, Representative Jesse Topper, for his opening comments. Welcome, and thank you for coming.

Representative Topper, you may begin.

REPRESENTATIVE TOPPER: Thank you, Chairman Harhart, Chairman Readshaw, and members of this committee. I truly appreciate the opportunity to address you this morning at this informational hearing on House Bill 765, and I'll be very brief in my remarks; because you have a tremendous panel of testifiers who will be offering expert thoughts on both sides of this issue this morning, and those are the individuals you really need to hear from, not me.

But I simply want to provide some of my

reasoning behind introducing this bill. This legislation is very simply about accessibility and affordability to quality healthcare, and that's especially in our most rural and urban areas that we believe are currently underserved.

Now, a group such as the AARP, Rural Health Association, Federal Trade Commission, and the National Governors Association believe that this legislation will help the physician shortage in these areas.

Now, many times when governmental bodies encounter and identify a problem, the first instinct is to create new regulations, more bureaucracy, and at the same time, most of the time unintentionally, more barriers to actually addressing the problem that they identify.

I'm trying to address this problem of accessibility and affordability to healthcare in Pennsylvania by doing the opposite, removing what I feel, and I think many feel, are burdensome and unnecessary barriers to this accessible and affordable and high-quality healthcare.

What I'm not trying to do, I'm not trying to start a battle between healthcare professions. I'm not trying to break up some kind of a medical team, as I've heard stated over the past few months. In fact, I

believe that we have a member of that team that is currently being underutilized, undervalued, and if we can operate in a little bit of a different manner, could bring a lot more to that very team.

Those team members are our nurse practitioners. I believe that they have the ability to provide that kind of care that so many in our Commonwealth need; and hopefully they can provide that kind of care if some of those restrictions are lifted on their profession.

So I'm more than happy to work with both parties represented here today as we look to provide the best possible care that we can for my constituents, our residents here in Pennsylvania. So thank you once again for this opportunity; and I look forward, as each one of you do, in hearing from our panelists this morning.

Thank you.

MAJORITY CHAIRMAN HARHART: Thank you, Representative Topper. Okay. I guess we will start with the panel of physicians. There's quite a few of you. You know what I think I'll do? I'm going to have you introduce yourself with your titles. And I know you all have testimony. Are you all going to give individual testimony?

(NODDING IN THE AFFIRMATIVE.)

MAJORITY CHAIRMAN HARHART: So if you could just kind of summarize it and keep it a little short so that we have time for our committee to ask questions. So we will start with --

MR. OLSON: We're just introducing; is that correct or --

MAJORITY CHAIRMAN HARHART: Yeah. Introduce yourself with your title.

DR. OLSON: I'm Christopher D. Olson, D.O. I'm past President of the Pennsylvania Osteopathic Medical Association.

DR. KRESSLY: Sue Kressly, Pediatrician in Bucks County and President of the Pennsylvania Chapter of the American Academy of Pediatrics.

DR. PETON: Ann Peton, Director of the National Center for the Analysis of Healthcare Data.

DR. RIZZO: I'm Karen Rizzo, an Otolaryngologist in Lancaster and current President of the Pennsylvania Medical Society.

DR. BRIGANDI: I'm Mary Brigandi, D.O. I'm the Family Medicine Osteopathic Program Director.

DR. DAVIS: Nicole Davis. I'm a family physician and the President of the Pennsylvania Academy of Family Physicians.

MAJORITY CHAIRMAN HARHART: Thank you. You

may begin. Who will be the first? Dr. Rizzo?

DR. RIZZO: I will, Madam Chairman. Thank you for this opportunity. What I'd like to do is set the stage for our point of view, and then the individual panel members here will focus on certain points. So I'm going to provide the overview.

And again, I'm Dr. Karen Rizzo. I'm the current President of the Pennsylvania Medical Society and a practicing ear, nose, and throat or otolaryngologist in Lancaster.

So on behalf of PA Med and the physicians, residents, and medical students we represent, thank you for the opportunity to present our position on House Bill 765, legislation which would allow nurse practitioners in Pennsylvania to practice independently.

In Pennsylvania, nurse practitioners are currently required to collaborate with physicians in order to diagnosis, treat, and prescribe to patients. Collaboration is defined as a process in which a nurse practitioner works with one or more physicians to deliver healthcare services within the scope of that nurse practitioner's expertise.

This relationship established in state law requires three components: First, immediate availability of a licensed physician; second, a

predetermined plan for emergency care; and third, a physician available to a nurse practitioner on a regularly-scheduled basis for referrals, clinical consultations and cosigning of records when necessary.

Linking nurse practitioners with physicians and defining their complementary relationship ensures that every patient has a physician involved in the management of their care, an assurance which is critical when that care requires a more highly trained professional.

Collaboration also guarantees that nurse practitioners have immediate access to a physician when, not if, complex medical issues arise; and they do arise routinely.

Despite these common-sense safeguards, supporters of House Bill 765 claim that the collaborative agreement is nothing more than a business contract which impedes their ability to care for patients. Nothing could be further from the truth. The collaborative agreement is a framework to ensure that patients get the best possible care.

We believe very strongly that the quality of care patients receive begins with the education and training of their providers. While most people have a general sense of what it takes to become a physician,

relatively few fully understand the process of medical education and training or how it compares to the nurse practitioner's preparation.

After completing an academically rigorous undergraduate course load in order to gain acceptance to medical school, a primary care physician must complete four years of medical school, followed by three years of supervised clinical training.

Whether you see a physician in Pennsylvania or in California or any other state in this country, they're training is all identical. Throughout their education and training, a primary care physician acquires over 16,000 hours of direct patient care supervised by an attending physician before they are permitted to treat one patient independently.

In stark contrast, the average nurse practitioner completes only one-and-a-half to three years of postgraduate education. That includes 500 to 720 hours of patient care experience. So there is a wide variation in the educational standards of nurse practitioner programs, which continue to evolve.

A growing number of masters of nursing programs can be completed part time and/or almost entirely on-line, with some programs providing nursing students with clinical learning experience through

simulated patient labs using patient actors.

Perhaps most critical, however, is the fact that nurse practitioners lack a postgraduate clinical training requirement comparable to a physician's residency and the necessary exposure that experience provides to treating real patients in a supervised clinical environment.

Such limitations in nurse practitioner training may explain why a study published in the American Journal of Nurse Practitioners in 2007 found that only 10 percent of nurse practitioners surveyed felt very well prepared for actual practice after completing a Master's level nursing program.

The majority of respondents, 51 percent, reported that their nurse practitioner programs had made them only somewhat or minimally prepared to practice. The contrast we are making between the education and training of a physician versus that of a nurse practitioner is not meant to devalue the expertise of these practitioners or the critical role that they play.

However, the depth and breadth of nurse practitioning training does not sufficiently prepare them for the wide array of challenges that regularly confront an independent practitioner.

Today, you will hear claims that nurse

practitioner independent practice will improve access to care, particularly in rural areas of the state. The evidence fails to support this assumption. Nothing in Pennsylvania law requires that nurse practitioners practice in the same geographic location as their collaborating physician.

And in the event that a nurse practitioner wanting to practice in rural PA is having difficulty finding a collaborating physician, PA Med would be very willing to assist them and facilitate such important work.

A majority of states across the country continue to require nurse practitioners to have physician collaboration or supervision in order to practice.

Moreover, states where nurse practitioners have gained the authority to diagnose and treat patients independently, continue to struggle with access problems. So you may be wondering, what is preventing providers from going into rural areas to practice?

The answer is simple. The factors that impact the ability of physicians to practice in rural communities also affects nurse practitioners. The fixed cost of establishing a rural medical practice, the maze of burdensome federal and state laws and regulations,

and relatively low patient populations are just a few of the reasons access problems exist in rural areas, not to mention practitioners face the additional clinical challenges associated with practicing in a community where medical infrastructure and a network of support are often lacking.

We contend that such isolation calls for rural practitioners to have more expertise and an even broader skill set in order to provide comprehensive patient care.

Proponents of House Bill 765 also argue that this legislation will result in reduced healthcare costs, higher patient satisfaction, and the same, if not better, outcomes when compared to physicians.

The extensive review of published research on this topic looked at over 4,000 relevant studies identifying only 26 that met their criteria for methodological quality.

When the level of nurses' clinical autonomy in these studies was considered, authors observed that the majority of support had contact with physicians. Authors concluded that current evidence assessing the substitution of physicians by nurses is substantially limited by methodological deficiencies.

They recommend more methodologically

rigorous research on health outcomes and costs before changes in the way primary healthcare is delivered or implemented.

A number of published peer-reviewed studies and reports have also directly contradicted claims of cost savings and superior quality of care provided by nurse practitioners.

For example, nurse practitioners have been found to order more diagnostic imaging tests than physicians, make more unnecessary and poorer quality referrals of patients to specialists and are far more likely to prescribe drugs to patients.

Two of the nation's largest professional liability programs for nurse practitioners strongly recommend that they actively consult and collaborate with physicians to mitigate risk and enhance quality of care and patient safety.

With the complexity of our healthcare system ever increasing, patients need both physicians and nurse practitioners coordinating care and sharing information for the benefit of the team. The team-based model of healthcare delivery as epitomized by the patient-centered medical home concept brings the best of each provider's training to the care of patients and the cure of disease.

Research has repeatedly shown that interprofessional collaboration and a highly functioning healthcare team leads to increased efficiency and reduced costs, while providing improved quality and comprehensive patient-centered care.

So at the end of the day, simply increasing the number of physicians or expanding the role of nonphysician practitioners will not solve our access to care problems in rural and underserved communities; rather, policies and programs which specifically target those areas and directly address the barriers to practicing there have the most chance for success.

Increased opportunities for education loan forgiveness in exchange for service, the creation of additional primary-care residency slots, further utilization and integration of telemedicine and expansion of team-based care are just a few of the effective strategies that can help us meet our growing healthcare needs. But we will only succeed through collaboration, not further fragmentation.

The Pennsylvania Medical Society supports a physician-led, team-based approach to patient care, which emphasizes increased collaboration and an integration among healthcare providers rather than provider autonomy.

Eliminating the ties that currently exist between nurse practitioners and physicians is contrary to those proven concepts and would only serve to further fragment patient care by eliminating the healthcare team's most highly trained member, the physician.

Thank you for the opportunity to share my views with you. Next.

DR. DAVIS: Good morning, Chairwoman Harhart, Chairman Readshaw, and members of the Committee. Thank you for allowing me to testify today.

My name is Dr. Nicole Davis, and I am the President of the Pennsylvania Academy of Family Physicians, which represents more than 5500 family medicine physicians and residents and also students who are interested in family medicine.

As you know, our specialty cares for the patient over his or her entire life span. Our organization's membership includes doctors who deliver babies, provide pediatric and adolescent care and, of course, adult and geriatric care.

Respectfully, we oppose House Bill 765. Nurse practitioners do not have the same training as a physician. Physician training lasts at least seven years versus fewer than seven years of training for a nurse practitioner. Importantly, all physicians have at

least three years of residency training and want to practicing rigorous continuing education and board certification requirements.

Allow me to briefly take you on the journey of becoming a physician. During undergraduate education, a list of prerequisite courses must be completed before applying to medical school, ranging from biology to organic chemistry.

The Medical College Admission Test, commonly referred to as the MCAT, is taken as an undergraduate to assess problem solving and critical-thinking skills along with knowledge of natural, behavioral, and social science principles.

In 2014, there were 49,480 medical school applicants and only 20,343 acceptances, highlighting that fewer than half of those who applied for medical school are actually accepted. The mean undergraduate GPA was 3.69 among matriculants.

In addition to the institutional assessment of knowledge during medical school, the United States Medical Licensing Examination is completed as a three-step process for medical licensure.

Each step is taken as a separate exam at different points in training and includes a section completed with live, standardized patients and another

with computer-based simulations. Similarly, following completion of each clinical rotation during medical school, the student must pass a National Board of Medical Examiners subject exam in that particular area, in specialties ranging from family medicine to surgery.

Put simply, the average medical student in his or her clinical years can expect to take a national standardized subject exam every 6 to 8 weeks. Upon graduation, the medical student, now officially a doctor, by merit of having attained a medical degree, must still complete a residency in that particular area of medicine desired to practice, adding at least three years of additional training.

Last, but certainly not least, completion of residency is followed by the requirement to complete a board certification examination in the physician specialty. If we total these standardized exams, the average individual will need to successfully complete twelve standardized examinations before being allowed to practice independently, with no less than eleven years of training following high school.

Please know, nurse practitioners are our physician members' colleagues and an important part of a healthcare team. We unequivocally value their work.

However, there is no symmetry to their

education and that of a physician. We believe in a physician-led, patient-centered medical home model of care in which nurse practitioners, physician assistants, and all the members of the healthcare team work together to ensure the best patient care. At the end of the day, patients are truly who we care about most.

Thank you for the opportunity to testify, and I look forward to your questions.

MAJORITY CHAIRMAN HARHART: Thank you very much.

DR. BRIGANDI: Good morning, everyone, and the members of the Committee. It's an honor to be here. My name is Dr. Brigandi, as I mentioned before. I am currently the Reading Family Medicine Osteopathic Program Director in Reading, Pennsylvania.

I have had the privilege of teaching family medicine residents and medical students for over eleven years. I'm here to tell you my story, a story that helps me define quite well why I support nurse practitioners to remain in a collaborative role with physicians rather than be allowed to practice independently.

Prior to going to medical school, I was a registered nurse. I eventually went to graduate school at the University of Pennsylvania and finished my

Master's of Science in nursing there. The program was an adult nurse practitioner program and, at the time, considered the second best program in the country next to Yale's program.

My clinical training in graduate school consisted of a six-month internship in an office practice with another nurse practitioner supervising me. I certainly realized that it was not enough training for me to even consider practicing independently.

After graduate school, I began working as a nurse practitioner in the VA Medical Clinic in Philadelphia. During that time, I took care of many challenging medical patients with the guidance of the internal medicine physicians who worked with me side by side. They were from the University of Pennsylvania.

I was so grateful to have them there to collaborate with on the many difficult and challenging patients in the practice. But in my years there, I felt a gap in my knowledge, one that I knew that I could not be fulfilled unless I went to medical school. I really felt that I was not giving my patients the overall best care, because I did not have enough education at the time to do so.

I left my position at the VA Medical Clinic in good standing, took my premed courses and applied and

was accepted to medical school at the Philadelphia College of Osteopathic Medicine. It was a difficult process, and I consider myself very grateful for the opportunity I was afforded.

Despite my many years as a nurse, then a nurse practitioner, I was still very much challenged by the difficult curriculum I faced in medical school. It was very clear to me from the beginning how much more I needed to learn there.

I became aware very quickly of the depth and breadth of knowledge needed to become a physician. The complexities of disease and the human body, pathology, pharmacology, physiology, anatomy, histology, all rigorously studied in medical school.

Because I am a teacher now of both family medicine residents and medical students, they challenge me every day in the office and in the hospital. This reminds me that not a week goes by that I don't have to look up something or to learn something new, even after practicing medicine for the past 16 years. That includes my residency training.

I can recount spending up to two days straight in the hospital working during my residency. My training was rigorous and comprehensive, but still there is more to learn even now. The training has

allowed me to pick up subtle clues to illness in my patients.

About three weeks ago, I had a young woman come in to the office having difficult breathing. She had a strong family history of asthma, and I gave her a breathing treatment in my office. However, I noticed afterwards she was still working very hard to breathe.

This was concerning to me, and I sent her for a test to check for a clot in her lung; and sure enough, she had one. If she had gone home without me making this critical decision, she could have died from this.

It is because of my knowledge and extensive clinical training that I am able to make these decisions. Sometimes it is just a subtle clue that gives you all the answers.

I also remember a prior case of a nurse practitioner that was sued in a malpractice case. She saw a patient with a dark mole under the patient's nailbed. She assured the patient that it was just a mole and nothing to worry about. The mole turned out to be malignant Melanoma, a deadly skin cancer. The patient died from this disease.

When I told my fellow residents the details about the mole underneath the patient's nailbed, they

immediately knew what it was. This is why comprehensive education and extensive clinical training can make a difference, a difference sometimes in the life or death of a patient.

I want to end by saying I have great respect for all nurses. This is not about the criticism of the nursing profession. It is a great one. It is about patient care and what would be in the best interest for our patients and citizens in Pennsylvania.

Thank you so much for allowing me to speak today.

DR. KRESSLY: Good morning, and thank you for the opportunity to testify here today. I'm Sue Kressly. I'm a pediatrician in Bucks County, and I've been in practice for more than 25 years.

You already have my submitted written testimony, and I would really like to illustrate what this looks like in clinical practice, not just words on a piece of paper.

So I was in a practice that worked very collaboratively with nurse practitioners for 15 years, and part of the medical home team that we worked with with our nurse practitioners included some physician oversight. We looked at their charts; we reviewed charts with them regularly; we cosigned charts, and we

learned and we helped to train them and elevate their ability and skill sets in the office; but we also had some protocols in place that we felt were important for the safety of our patients.

And I'm here representing not only 2200 pediatricians and pediatric residents across the state, but I'm here really on behalf of the children in the Pennsylvania Commonwealth, including your children, my children, and our grandchildren; and I am soon to be a grandmother so I can say that.

But really this is all about doing what's right for the patient. And so as an example and an illustration of how this looks, there was a protocol in our office where we always had to have children -- if they were seen for a well visit by a nurse practitioner, they had to, the next time, be seen by a physician; and that was in no means to demean what the nurse practitioners can pick up, but we'll talk a little bit about the breadth and depth of our education.

It makes us look at things with a pessimistic optimism and look with a more critical eye and pick up some critical issues, and that was really very instrumental in some our patients getting early care for subtle illnesses and disease processes.

But to illustrate further, we also had a

protocol that any child under the age of six months who presented with constipation had to be discussed with the physician in charge. And that seems relatively silly to most people around the table. Constipation, it happens to all of us. We should be able to handle that, a mother should be able to handle that at home. And so a nurse practitioner came to me and said I'm here because I have to because it's part of protocol to tell you about this patient. And I asked her to tell me a little more, and I said let's go see the patient together.

And in the process of examining this baby who presented with constipation who was five months old, I started to notice that when I did an exam and used a tongue depressor -- we all gag when someone uses a tongue depressor -- that this infant's gag reflex was just a little bit diminished. And then I got out my reflex hammer and I checked the reflexes, which we don't do routinely on a five-month-old.

And then I pulled the nurse practitioner outside of the room; and she said, why did you do that? And the answer was because I suspected infant botulism. If you know anything about infant botulism, it is a progressive paralysis that, if identified early, can be life-saving; and that baby was in the intensive care unit on a ventilator for two months.

Now, why did I think about infant botulism and my nurse practitioner colleague didn't? In part, because I had spent many months in the intensive care unit in training following a child with infant botulism and seeing how it progressed from innocent looking constipation to life-threatening respiratory failure and out the other side. Why else? Because I had spent a month of pediatric infectious disease training with Sarah Long, who's the world-renowned expert on botulism in Philadelphia.

Why else? Because I had spent time with neurologists, and I understood the difference between how nerves and muscles work together and can lead to constipation that looks seemingly innocent but can be a small clue to a bigger problem.

In another case, I was taking care of -- I was covering a nurse practitioner in the same practice, and they came to me and said, I have this child who I think is dehydrated; they've been vomiting; and I'm trying to decide whether I need to send them to the emergency room or give them IV fluids or whether we think we can do this with just water and Pedialyte and oral rehydration.

And so I said, well, you know, what are your clues? Let talk about it. And then I said, let's go --

she actually asked me. She said, can you just eyeball this kid with me? And I said, absolutely. And in that collaborative agreement, we walked in the room together and we talked and looked at the patient. And as soon as I got a couple feet from the patient, I smelled acetone on that child's breath, which smells like nail polish remover, if you know what acetone is.

And the nurse practitioner had really gone through the protocols for vomiting and diarrhea because most of what happens when children vomit is gastroenteritis. We've all had kids who have been vomiting. But that clue, that subtle clue to me, was that this was a child who had new-onset diabetes and they were in trouble; and they were in trouble because the acetone was acid building up because they were having difficulty.

And so what made me think of that was because I had spent months following a pediatric endocrinologist around in my training and understood how diabetes presents from the beginning, how quickly they can get sick, how they can end up being in the pediatric floor while I follow them for a couple of days into the ICU. And if that child had gone and gotten home and just given oral hydration, they could have potentially died. If we had just given that child IV fluids in the

office, for those of the physicians in the room and probably some of the nurse practitioners who have seen this, you could get swelling of your brain that could actually have killed your child.

But it was my breadth and depth of education and working with the nurse practitioners that led to the safest and best outcome for children. And in medicine, we are told initially our first premise is first do no harm.

So I'm asking the Committee to consider that when we make any changes to the scope of practice, we should be held to the same standard, which is first do no harm. And if we should look at the real way to address in an evidence-based way if we're having access to healthcare issues, we fully support nurse practitioners being part of the medical home team and we enjoy collaboration; and we think together as a team; it's physician led, we can give the best and safest outcome and care for our kids.

Thank you so much.

MAJORITY CHAIRMAN HARHART: Thank you.

DR. PETON: Good morning. I have been asked by the Pennsylvania Medical Society to provide fact-based and independent insight on research that our National Center for the Analysis of Healthcare Data has

been conducting on national healthcare workforce trends and the impact analysis of those trends.

My center was created in 2007 to fill the gap that existed in quality healthcare workforce data for physicians, nurse practitioners, and fifteen other providers across the country. And until then, and up until that point, virtually all research and all policy decisions had been made at the federal, state, and local levels were based upon membership association data, such as the AMA master file and other provider-based member data or data that they created through creation of surveys.

As the founder of the center, I knew that with my over 20 years of personal experience working out of three different governors' offices and other state agencies, that there had to be a better data that would exist through the state regulatory licensure boards.

The center currently has the only individual provider practice-based data for 15 different providers from every state, based upon state licensure and the NPI and some other data sources that we integrate into it.

We normalize this data by pulling out the retired, inactive, and those individuals that have multiple state practice licenses. Our unique data allows us to compare providers into practice patterns

both at the interstate and at the intrastate levels.

Therefore, we were asked to provide our insight on the provider practice patterns of other states that have passed similar scope or practice laws and the impact of those laws on access to care and patient health outcomes.

We recently analyzed the practice patterns of all states' primary-care workforce, and that includes the primary-care physicians, the nurse practitioners, and physicians' assistants from 2008 to 2014 and found that there were only nine states that had a net primary care migration into rule. Those are Rhode Island, Iowa, Utah, New York, Missouri, New Hampshire, North Dakota, New Mexico, and Oregon.

States such as Arizona, which has had an independent nursing practice law in place for decades, have seen increases in both nurse practitioners and physician supplies relative to the rural practice densities.

In recent years, the number of nurse practitioners in Arizona has increased by 65 percent. However, 96 percent of that growth has occurred in urban Arizona. Today, only five percent of the nurse practitioners in Arizona are practicing in rural areas, similar to nine percent of the physicians.

Another state, Washington, has also seen a significant shift, with a 42-percent increase in the number of physicians practicing in rural areas, compared to the 16-percent increase by rural nurse practitioners.

There are many reasons for maldistribution. That's what we study. There doesn't appear to be, though, a correlation between states with independent nursing practice and an increase in primary care access in rural communities.

Physicians and nurse practitioners migrate to similar geographic areas, regardless, following migration patterns of the population into those other states. There would be no reason to conclude that this scenario will play out any differently in Pennsylvania if Pennsylvania adopted independent licensure for nurse practitioners.

The current migration patterns for nurse practitioners and primary-care physicians in Pennsylvania are similarly towards urban areas of the state. And looking at the trends nationwide, it does not appear that independent licensure of nurses would change that.

Improving access to care, especially in rurals, is complicated and requires all concerned parties, the healthcare training institutions,

healthcare provider organizations, state and policymakers to stay focused on the measurable patient health outcomes.

I appreciate and thank you for the opportunity to speak on behalf of PA Med, and look forward to your questions.

MAJORITY CHAIRMAN HARHART: Thank you.

DR. OLSON: Thank you, Chairman Harhart, and members of the House Professional Licensing Committee. I am Christopher D. Olson, DO, board certified Osteopathic family physician from Lewisburg.

I have been a member of an organization that, independent of hospitals and other large organizations, has had small practices in rural communities from Hershey to Williamsport.

And I thank you for the opportunity to present the views of the Pennsylvania Osteopathic Medical Association regarding House Bill 765, which greatly expands the scope of practice of certified nurse practitioners.

House Bill 765 would authorize certified nurse practitioners to diagnose, treat, and prescribe medication without the oversight or cosignature of an osteopathic or allopathic physician; thus, it would effectively allow CNPs the same authority and clinical

autonomy as physicians without the same amount of education and training.

They would also be recognized as providers under healthcare plans and be reimbursed directly for those services. While removing physicians' involvement from the equation, this bill does not include commensurate increases in education, training, or competency demonstration requirements for CNPs.

It also does not require CNPs to carry a level of liability insurance equal to that of primary-care physicians. We fear that the passage of this bill will put the health and safety of Pennsylvania patients at risk.

While CNPs provide safe and essential basic and preventative healthcare to patients, POMA does not believe their education and training are sufficient to handle autonomous decision making in regards to patient tests and diagnoses.

It is important to remember the extensive education and training that our state requires for our physicians. Osteopathic physicians complete four years of postbaccalaureate osteopathic medical school, which includes two years of didactic study, two years of clinical rotations performed in community hospitals, major medical centers, and doctors' offices.

This is followed by three to seven years of postgraduate medical education based on the requirements of their specialty, where DOs develop advanced knowledge and clinical skills related to the wide variety of patient conditions; and I appreciate the other speakers here being very, very specific about some of those examples.

Physicians, DOs, and MDs have the extensive medical education and comprehensive training that prepare them to understand medical treatment of diseases, complex care management and safe prescribing practice.

In comparison, registered nurse practitioners who hold a two-year Master's degree in current board certification in a particular clinical specialty will automatically be deemed to be licensed as independent CNPs

Board certification in clinical specialties and independent practice rights for CNPs will allow them to practice in specialty areas as well as primary care without a medical degree, DO or MD and without a physician's specialty residency.

While we value the contributions of CNPs to the healthcare delivery system, granting independent practice to CNPs is an unnecessary risk to patients'

safety.

A physician-led, team-based practice model is proven to be effective in treating patients and lowering healthcare costs. POMA supports this model which maintains physician involvement in patient care.

It is imperative that Pennsylvania's patients have the access to the most highly trained healthcare professionals, the physicians, in order to safeguard their care.

We urge you to protect the safety of Pennsylvania's patients by opposing House Bill 765. And thank you again for allowing the Pennsylvania Osteopathic Medical Association to present our opposition to this bill today.

MAJORITY CHAIRMAN HARHART: Thank you, Doctor Olson. Before we open to questions, I would like to recognize Representative Joe Emrick from Northampton County. Welcome.

Panel; Committee? Gary Day. Representative Day. I'm sorry.

REPRESENTATIVE DAY: Thank you, Madam Chair. I want to thank you for your testimony today. I want to just say right off the bat that I don't support this legislation right now, but we always like to keep an open mind and hear all testimony before we make our

final decision.

And you all have explained very eloquently the strength of collaboration for patient outcomes. I want to make a statement, and then I'll ask two questions to keep it going quickly for everybody here today, if you could address the questions.

The problem with the medical-team story is that many members that I serve with here hear anecdotes from people they know in the profession or they experience it themselves, that this medical-team approach is not occurring.

So I think that's what drives -- I don't want to speak to the motive of this legislation, but drives many members to be at least open to the idea; because they don't see that medical-team approach.

For instance, I can report to my committee, I've had a nurse practitioner as my primary care physician for the last ten years and have not seen the doctor ever. Now, whether she goes out of the room and collaborates with them, you know, that could be happening; but I don't see that from my position.

So that creates a position where I don't see where I'm benefitting from that. Maybe we have friends and neighbors who are in the medical team and report these things as well. So I wanted to tell you that.

The two questions: Is there a level of experience that a nurse practitioner could achieve that you would say, now that person has now served with me for 15 years, I think then after a certain period of time they would be able to now be at that level of, you know, a starting-out doctor?

The second question is: Is it reasonable for us to codify and require that this team approach occurs so that I do see it when I go to my family physician? So those are my two questions.

Thank you, Madam Chair.

DR. KRESSLY: So I'll take the first question. I honestly believe that there is no length of time being in an office setting that can substitute for the breadth of the experience, seeing the continuum disease process through the hospital, from the presentation, through the, you know, ups and downs of a critically-ill disease process.

And so having limited exposure in the office in a 20-minute or 30-minute or 45-minute setting doesn't replace a 12-hour shift watching someone who you've had to watch the disease process and understand it.

So as much as you would like to think 20 years of apprenticeship would count, without the background of it having been in that breadth of -- and

with specialty input, I don't think that quantity is the same as having the breadth of the quality of experience.

DR. RIZZO: And I'd just like to comment about the team concept, because so many nurse practitioners are involved with teams, not just in office settings but in hospitals and in healthcare systems. So there is a conversation that goes on when they round on patients like in a hospital setting, that they do report to their supervising physician about the care of that patient and the changes that they think are necessary; and that may not happen in front of the patient, you know, at the bedside.

And in regards, though, to the office setting, I think what Sue says is accurate, that, you know, there's no testing established either that would, I think, really document the experience and knowledge that comes from firsthand clinical exposure to things that are complicated.

And you may not see complicated things in an office setting. So that's another, I think, deficiency of assuming that, you know, that apprentice, as she related to, is adequate enough.

DR. OLSON: I'd like to just add on that the team-approach idea, I think we would all be foolish to not admit that there are cases where the team approach

doesn't actually happen. But I think your experience of not having seen the physician doesn't mean that the team approach didn't work. It very often does happen behind the scenes, and you don't know that it's happening.

And certainly the team approach does work, as testified by some of my colleagues here, in many ways; and I do believe that most of the nurse practitioners practicing in this state are truly in a team and cooperative agreement.

And I think if we're talking in terms of rural practices, to put somebody out there in a rural practice independently without some kind of contact, what's going to happen is, when they find they have a problem, they're going to call a physician. But is it going to be on time or not?

And if they have some kind of a good agreement with a physician, a good working relationship with a physician, it's much more likely that they're going to have a better outcome for our patients.

DR. KRESSLY: I have one more thing to add, and that is that you are a part of the healthcare team. And so as a patient, I would say that maybe we don't all do a good job of explaining what our roles are in the team and that's one of the reasons we now have the badges where it says clearly who you are, because

patients were confused.

But I would say that the practice should have some sort of literature on their website about how they function as a team, and we should all do a better job of educating our consumers and our patients to ask, you know, where do I fit in this team healthcare and who are all the people involved in my care?

You have a right, and I would actually say an obligation, to ask the question: Is a physician overseeing your notes? Do we talk about my care? Do you have protocols you follow, because a physician of the -- leader of the team directed those protocols?

DR. DAVIS: In response to the first question, last year, our organization hired a nurse practitioner who was just finishing nurse practitioner school; and this year we hired one who has been in practice for over 20 years; and I definitely see the difference in their breadth of knowledge, in their ease in dealing with patients; but I don't think that would -- it doesn't -- you have to have the training. You have to have the extensive training in medical school. It doesn't replace that.

REPRESENTATIVE DAY: Anybody want to comment on whether we should require and codify the team approach so that it's in law?

DR. OLSON: I don't think we need any more laws.

REPRESENTATIVE DAY: Thank you, Madam Chair. That ends my questions. Thank you.

MAJORITY CHAIRMAN HARHART: Thank you, Representative Day. Okay. I'm looking at the time; so, members, when you ask your question, ask it to the person you want an answer from on the panel, instead of having everyone answer; because I want to make sure we have enough time, also, for the second panel. Okay?

Representative Knowles.

REPRESENTATIVE KNOWLES: Thank you, Madam Chair. And thank you for testifying today.

My experience in terms of the team approach is much different than my colleague from the Lehigh Valley who gave me a ride down, and maybe when I finish I'll be looking for a ride back.

About a year ago, my wife had open-heart surgery in the Lehigh Valley Hospital; and what I learned about healthcare was the team approach. I learned of the importance of the surgeon, the cardiologist, the nurse practitioner, the physician's assistant, the lab people, even the people that clean the room. I mean, it was just amazing to me. And I had a good experience and everything turned out well.

But what would -- and I'm really torn on this issue. I've been lobbied by both sides, and I'm really torn on this issue. Just two questions real quick. Number one, in terms of the latitude that a nurse practitioner gets, is the -- and in terms of the latitude with day-to-day contact, do you as physicians -- is there more latitude if it's a great nurse practitioner as compared to a good practitioner?

Is it as much latitude as you would give a physician's assistant? Just how much oversight is there in terms of your day-to-day contact?

DR. RIZZO: I think that varies on the circumstance involved and the experience of the individual. And, you know, the interaction between the physician and their nurse practitioner takes time to evaluate their knowledge, their appropriateness, the way, you know, they can diagnose. Are they accurate in what they're evaluating?

So until you develop, I think, a sense of trust, that takes time; so I think the variation in that, the hope is that you develop that trust over time and you give them more latitude, understanding that if there's a problem, you know, they have access to you in a timely fashion.

But I don't think you can say specifically

that everyone is treated the same, because there's too much variation on it; and you have to evaluate that patient's ability to interpret the information and then, you know, what they do with it clinically. So that all takes time.

REPRESENTATIVE KNOWLES: A quick follow-up. Are there cases where a great a nurse practitioner may do something and say, oh, Doc, by the way, I wanted you to know that I did this? I mean, are there things that they do on their own that don't require your direct oversight or direct contact with you?

DR. KRESSLY: Yes, but within the context of the team-based meeting where we talk collaboratively about how do you handle a patient like this or if you come across this, this is what you do next time or protocols written in the office that they can follow. So there is absolutely room for decision making and latitude.

But again, initial nurse practitioners in my office, we looked at every chart and cosigned and had conversations for a while and then we picked certain diagnoses like 6-month-olds and constipation, which we fought for the safety of children.

And so it really depends on -- it's a moving ball. And just like every patient is different, every

situation is different and calls for collaboration and working together as a team.

DR. RIZZO: Yeah. I mean, trust is imperative in this situation. There has to be a level of trust that gets established over time, so --

REPRESENTATIVE KNOWLES: Thank you. Thank you, Madam Chair.

MAJORITY CHAIRMAN HARHART: Representative Mustio.

REPRESENTATIVE MUSTIO: Thank you, Chair. And I'd like to, I guess, ask these questions and read these statements to Dr. Rizzo, if I can do that.

I've been on this committee since I was first elected in 2003, and this isn't the first time that we've had to act like Solomon. And it's not the first time that we've had issues similar to this, and I pulled some of the old pieces of correspondence from the medical society to this committee and to members of the General Assembly; and I'd just like to get your comment on some of these statements.

An insufficient number of in-state residency slots may not be preparing enough future doctors to take care of Pennsylvania's growing healthcare needs. The maldistribution of primary-care physicians in rural and urban medically-underserved areas is only expected to

worsen as our population ages.

In order to ensure that all Pennsylvanians have access to quality, affordable healthcare, it is imperative that we take the necessary steps now to strengthen our physician workforce in the near future.

Our state ranks fourth per capita in a number of undergraduate medical students and fifth in the number of primary-care residents, which is an asset. However, we rank 37th in retention of physicians we educate and train, a painfully reviewing discrepancy.

And I thought this was interesting. And the reason I'm asking these, I'm trying to get back to Representative Topper's, I think, real reason for the legislation and the way he enunciated it.

A University of Pennsylvania study found just one in three primary-care physicians in Pennsylvania were accepting new Medicaid patients. As the PA Medical Society asserted in April of 2014, because many providers opt not to participate in Medicaid due to its slow reimbursement rates, it is expected that patients with Medicaid would experience more difficulty in getting a primary-care appointment.

Given that 6 00,000 Pennsylvanians are now eligible for Medicaid coverage through Healthy PA, which has certainly changed, how will that status quo change

here in PA? So that's really, I think, what we might be referring to here. If you could address that.

And then how should the legislature -- how should we then, right, when we're looking at perhaps not enough funding for getting physicians' loans reimbursed when -- your chart was a good comparison to us in other states. If that's not going to happen from a budgetary standpoint, right? And we have all these people that are in need that really don't have anywhere to go, other than maybe relying on a parent hoping that they're guessing right when they go to the pharmacy, right, and get something off the shelf.

Is it not the next best step to do something? All of the members here, as I think Lorraine -- is Lorraine in the room? All of the members here rely on our nurse practitioner, Lorraine. Right?

And maybe after the hearing we should go down and ask her how her relationship is with her collaborative agreement with her physician. But I know she's kept me going on some of these tough budget days. Enough for me.

If you could address those concerns.

DR. RIZZO: Sure. Certainly retaining the talent that we educate in the state is a major concern for us. But the ability to do that, I think, the state

legislature does have the power to influence; and that's why we continue to push for medical student debt loan forgiveness. There have been changes recently that make that option, I think, more appealing to certain residents coming out compared to what other states are doing around us; so that is a step in the right direction, but continuing to improve that so that people do want to stay is certainly on the table. Increasing the amount of residency slots in our training programs, that's also, I think, a very doable thing. All right?

The use of telemedicine is another opportunity. The technology continues to improve. Utilizing that in a way that improves access to care, especially in rural areas, makes a lot of sense. And I know PA Med is in the process of putting together legislation that we hope will be adopted and serve as a foundation for developing that technology, again, in a patient-safe way.

So right there are three opportunities that I think, if encouraged and utilized, will make a difference. But going back to, you know, is there a better second choice? Again, fragmenting the team, we all feel does not benefit anyone in any way. The team-based approach helps.

Maintaining the team does not defer from the

ability of a nurse practitioner to go to a rural area or to work in an inner-city clinic, as long as the opportunity for that individual still exists to have some supervision, to be able to collaborate with someone when they're not sure about something. It facilitates that process. It doesn't detract from it.

REPRESENTATIVE MUSTIO: Under the current setup, how is the nurse practitioner compensated? I don't know. I don't know the answer to that. How is the nurse -- under the bill, I think it says they can get -- they will be licensed and will be able to draw directly from the health insurance company.

Under the current setup with a collaborative agreement, are they compensated by the physician or the patient or -- I don't know how that works.

DR. KRESSLY: So it depends. If you're an employed nurse practitioner, you get paid by your employer just like their employed physicians in the group, but the billing is done directly through the insurance company.

And so there are -- the payers of nurse practitioners can get paid and bill the exact same services that we do. There's incident to billing and then there's credentialing; so sometimes nurse practitioners, especially under Medicare, are paid at 85

percent of a physician rate. But in other situations, they're billing the same charges at being supervised by a physician and it's the same cost of care.

REPRESENTATIVE MUSTIO: So under the current -- and this is my last question, Chair. Under the current scenario, nurse practitioner A is in a rural setting in Pennsylvania and she has a collaborative agreement with a physician; someone goes in to see her for treatment, does she get paid directly by that patient, by the health insurance company, or does she have to go through the doctor and then he also tacks on something because he collaborated?

DR. KRESSLY: The service to the patient gets billed directly to the insurance company. How the business that she's agreed to, if it's her own business with a collaborating physician, then that's up to their private business arrangement; but it's paid the same way directly from the payor that physicians are.

REPRESENTATIVE MUSTIO: To the nurse. Thank you.

DR. KRESSLY: Yeah.

MAJORITY CHAIRMAN HARHART: Thank you, Representative Mustio. Representative Kortz.

REPRESENTATIVE KORTZ: Thank you, Madam Chair; and thank you all for being here today and your

testimony.

First let me state for the record that I highly respect both medical professions that are here today. My sister's a nurse. So I really appreciate what you do for the people of Pennsylvania.

That being said, to the facts. Dr. Rizzo, I just wanted to clarify the amount of training, if I could. Medical doctor, graduate school four years. Nurse practitioner can have up to four years. Years of residency, three years; can be as high as seven, depending on the specialty, I believe. And there's zero years of required residency for nurse practitioners; is that correct?

DR. RIZZO: Correct. They don't have a residency.

REPRESENTATIVE KORTZ: And then direct patient care, very telling; up to 16,000 hours for the medical doctor, up to 720 hours for the nurse practitioners; is that correct?

DR. RIZZO: Correct.

REPRESENTATIVE KORTZ: So there's a big discrepancy in the amount of training that's being given.

Dr. Brigandi, to your point, I appreciate you sharing the story with us because that great

discrepancy can lead to tragic results.

DR. BRIGANDI: Yeah. Thank you very much.

REPRESENTATIVE KORTZ: Madam Chair, one follow-up question, if I could, for the prime sponsor? Representative Topper, I assume, you being from Bedford County where my sister lives, that this legislation was brought forth because there's a lack of medical doctors in that area. It's a rural area.

Does your legislation specifically state that this will only be applicable in rural settings?

REPRESENTATIVE TOPPER: No. No. And we believe, and I'm not alone in my belief, that it will help. But also we're talking about underserved areas not just being rural areas. You'll notice some of the cosponsors are from our most urban areas as well.

So I think underserved, as Representative Mustio said, especially in relation to how many Medicaid patients there are who just simply can't get into doctors' offices anymore, whether there's physicians there or not; if they're not taking the patients, then they're not getting care.

REPRESENTATIVE KORTZ: Understood. Thank you, Madam Chair. Appreciate it.

MAJORITY CHAIRMAN HARHART: Thank you, Representative Kortz. Representative Gillespie.

REPRESENTATIVE GILLESPIE: Thank you, Madam Chairman. Thank you for your testimony. Thanks for being here today. Dr. Rizzo -- and before I ask the question, I just want to preface it. Before I got elected, I had 34 years in healthcare, predominantly as an emergency-services provider, but the last 12 years as a hospital administrator and was responsibile for pushing a pencil and trying to balance a budget during some very trying times.

One thing that caught my eye and ear during your testimony, I believe on page 3 you talked about two of the nation's largest professional liability programs for nurse practitioners and strongly recommended they actively consult and collaborate with the physician.

I can remember a time, again, just before I took office, where our malpractice insurance at a small community hospital was about a half million dollars a year. Within a few-month period, that same premium went to $2-and-a-half million a year.

Now, for a small community hospital where the positive bottom line, difference between a good year and a bad year can be a hundred thousand dollars, you can imagine how devastating that was.

I know you're a physician and not an insurance expert, but what would you -- and again,

knowing what the professional liability issue has been in Pennsylvania, we've done some corrections with change of venue as far as filing torts and litigation, you know. Malpractice and punitive damages is a discussion for another day, but certainly something needs to be addressed here in Pennsylvania as it's been done in other states in the country.

Again, realizing you're a physician and not an insurance expert, but certainly seeing these things as part of your practice and running your costs, how would this affect the professional liability insurance for the Commonwealth if something like this was to take place?

DR. RIZZO: Well, I think the two companies that cover a majority of nurse practitioners are clearly seeing an increase in malpractice exposure; and it's coming from the same two reasons that are most prevalent for other providers, and that's a delay in diagnosis and errors in prescribing medications.

And I believe since 2011, from some of the information that was shared with us, that these increases have been substantial in the amount of claims being brought, processed, and paid out. So, obviously, over time, this will increase premiums. There's nothing else that can happen. So you will see an increase in

premiums for the coverage.

REPRESENTATIVE GILLESPIE: Okay. Madam Chairman, if I may, one more question?

MAJORITY CHAIRMAN HARHART: Yes.

REPRESENTATIVE GILLESPIE: Thank you. Earlier in your testimony, you talked about PA Med is willing and able to help facilitate the collaborative arrangement, particularly in the rural areas as we've heard about.

And, again, considering that could be a driving or motivating factor for the introduction and ultimate passage of this legislation, could you just maybe give an example of how you would help enhance or form these collaborative agreements so that the rural areas or the areas that are not currently served would be served?

DR. RIZZO: Right. If there are nurse practitioners that are having difficulty getting a collaborative agreement with a physician, we would be happy -- they need to contact us, and we would be happy to facilitate making an arrangement for a physician to serve in that capacity with them.

And as far as costs going to the nurse practitioner, you know, the potential, as it is for a lot, is that there's no cost. But if there was some

cost to cover, you know, time and the amount of energy needed for that physician to supervise and collaborate, then that would be, you know, an arrangement, I think, that could be facilitated by our intervention, making sure it's reasonable. Okay?

REPRESENTATIVE GILLESPIE: Very good. Thank you. Thank you, Madam Chair.

MAJORITY CHAIRMAN HARHART: Chairman Readshaw.

MINORITY CHAIRMAN READSHAW: Thank you, Madam Chairman. I want to thank all the doctors being on the panel today. Their testimony is very enlightening. And obviously the common theme -- one of the common themes that we're hearing is about and concerning education and training. And, Dr. Kressly, I want to thank you for your practical diagnostic experiences. They're enlightening, also.

My question is this: On page 7 of the legislation, and I don't know whom to address this to, it goes into the explanation of methadone treatment. So is anybody aware of how this House Bill 765 would change the current methadone treatment and the associated risks?

DR. BRIGANDI: I'm not sure I can completely answer that question, but I can tell you --

MINORITY CHAIRMAN READSHAW: Okay. You may -- if I can be helpful, perhaps you can describe the process for the methadone treatment now.

DR. BRIGANDI: I mean, you know, it depends on how you're using methadone, if you're using it for addiction versus you're using it for chronic pain. So there's two reasons.

However, prescribing it is a risky process because of the long half life of the medication. And it can be variable and if you're not familiar and you don't have experience prescribing it, then, you know, it can result in deaths; and that's happened, you know, unfortunately.

So that's really something that personally I've only prescribed on a few occasions for patients that were already on it for addiction or if they were prescribed it by a pain specialist for chronic pain, I've kept them on it and continued to prescribe it.

MINORITY CHAIRMAN READSHAW: But currently the doctor prescribes the methadone treatment; is that accurate?

DR. BRIGANDI: As I understand, yes.

MINORITY CHAIRMAN READSHAW: Okay. So under this legislation, unless I'm inaccurate, the nurse practitioners would be allowed to prescribe the

methadone treatment. That's what I was getting to. Is that accurate?

DR. OLSON: That's the way I read it.

MINORITY CHAIRMAN READSHAW: Okay.

DR. BRIGANDI: That, to me, is a very risky thing to do, you know, because of what I just mentioned.

MINORITY CHAIRMAN READSHAW: Okay. Well, that's what I was concerned about and hear, in reading this, that the doctors would be taken out of the process and the nurse practitioners would be allowed to, obviously, evaluate and prescribe the methadone treatment. That's what I was leading to, so -- Okay. Thank you very much.

DR. BRIGANDI: You're welcome.

MAJORITY CHAIRMAN HARHART: Thank you, Mr. Chairman. Representative Toepel.

REPRESENTATIVE TOEPEL: Thank you, Madam Chair; and thank you for your testimony. I had a quick question about the collaborative agreements. Are there any standards for those agreements?

Does the PMA or anyone have any standards, or are they each unique to the agreement between the physician and the nurse practitioner? Under what circumstances do they need to consult a physician, and how much interaction is required?

DR. RIZZO: Well, the three principles that I mentioned in my testimony are important for every collaborative agreement. So aside from that, it depends on what kind of practice you have and, you know, what kind of patients you're seeing. And that's what you develop over time with the experience you have with that nurse practitioner.

So you would have to be available. If there's an emergency, they have to know what to do, you know. There's a process. Those three principles are critical. But the day-to-day interaction that you want to be told about more specifically, I think comes with time and evaluating their experience.

REPRESENTATIVE TOEPEL: But it would be unique to each relationship. It's not like there's a standard that governs all collaborative agreements.

DR. KRESSLY: There are boiler-plate places to start, similar to a lot of other things. There has to be a signed agreement between the physician leader of the team and the collaborative agreement.

And the American Academy of Pediatrics have sort of an outline that practices can use to employ nurse practitioners or work with them, which has those three outlines in them. But it is written -- it's like any other contractual arrangement, the specifics are

unique to the situation.

REPRESENTATIVE TOEPEL: Thank you.

MAJORITY CHAIRMAN HARHART: Okay. Thank you. Thank you all for your testimony. You may now be excused after you've been grilled there. But I do thank you very much for your testimony and for being here, and it's very good. Thank you.

And as this panel moves out, will the next panel please move in? Excuse me. We have the rest of the panel here. Are they here and are they ready to be seated? Because we'd like to begin, please. Everybody there? Okay.

Okay. I am going to do the same. We'll have you all introduce yourself, along with your title, if you don't mind. And you can start at either end. It doesn't matter. So if you'd please introduce yourselves.

MR. HOGAN: Good morning. My name is David Hogan, and I'm appearing today as a private citizen, a patient of a nurse practitioner.

MR. JAEP: Good morning. My name is Kyle Jaep. I'm a JD candidate at Duke University School of Law; and I coauthored the report, The Value of Full Practice Authority for Pennsylvania's Nurse Practitioners.

MS. COUNTS: I'm Mona Counts. I keep trying to retire as a rural nurse practitioner. I'm a Professor Emeritus from Penn State University. I'm also the past president of the American Academy of Nurse Practitioners.

MS. GRAY: Hi, I'm Kathy Gray. I'm a family nurse practitioner. I'm also the President of the Lehigh Valley Nurse Practitioner Association and assistant professor at Georgetown University.

MR. YOUNG: I'm Mike Young, President of Pinnacle Health here in Harrisburg.

MR. VALDEZ: Good morning. I'm Brian Valdez, Law and Policy Manager for the National Nursing Centers Consortium.

MAJORITY CHAIRMAN HARHART: Okay. Thank you. You may begin. And as I said to the doctors, if you can, please, I know you're all going to be testifying, if you can just keep it a little short, summarize it, I would appreciate it; because we are limited to time. Okay?

MS. COUNTS: I know they took up time.

MAJORITY CHAIRMAN HARHART: I know. Well, you'll get yours. Thank you.

MS. COUNTS: Madam Chair, Chairman, members of the Committee, thank you very much for the

opportunity. You've got the testimony, and I would like to share some of the things.

I also didn't say when I introduced myself, I am a commissioner for the American Academy of Nurse Practitioners Certification Requirement. And what I would like to point out to you is that nurse practitioners, in order to be licensed in the state of Pennsylvania, must be nationally certified.

The national certification exams are given all across the country; and as such, there are requirements of their educational background that they have to do in order to sit for that certifying exam.

That includes that they have to be RNs, which means that they have been educated in healthcare for four years prior to even coming to a nurse practitioner program.

Secondly, it means they have to have numbers of clinical hours as nurse practitioners. What it does not identify is the number of hours that they have had as a nurse. So they have continued to have clinical experience not just specifically in their nurse practitioner program.

So that we clarify that real clearly, that many are experienced nurses that come back and be nurse practitioners. If not, most of them work while they're

coming back to be nurse practitioners. One of the things that was questioned was the safeguards, and we already have in place the safeguards.

We have, one, the required national certification, which is standard across the country. We have licensure within the state of Pennsylvania. That brings in the Board of Nursing. And the Board of Nursing's sole mission is protection of the public and the safety of the public.

And the Board of Nursing in Pennsylvania is very efficient. All you need to do is read their bulletin occasionally and see who's been sanctioned. And a patient, a professional colleague, a professional from another profession, anyone can report somebody whose behavior, actions, are not to the standards of care, so that the checks and balances are already in there.

And I implore you to not look at just supervising. We are not in a supervising state. We are in a collaborative state. And as such, I could not practice without collaborating with others. And that collaboration includes physicians, pharmacists, physical therapists, multitudes of professionals, my other colleagues. I could not practice without them.

And when you look at clinical scenarios that

you see the classic comment as you call them, zebras, I think all of us have picked up a diagnosis that was missed by somebody else; and that is not a sole thing for any profession. We're all human. We all see many things. We all have the potential to miss something. So I use my colleagues when I have any questions.

I was in a practice in rural Greene County. Do you all know where that is? I didn't hear any of you say Greene County. The only time I ever locked my car doors was when zucchini was ripe. And I'm not kidding.

Nevertheless, I had over 6,000 patients when I turned the practice over to a community health center that was willing to help take it. I tried to retire; they found where I lived. So now we have cash or barter, so I'm getting trout instead of zucchini.

But, nevertheless, it is amazing; because I had to find transportation for folks to get to specialists. We had no public transportation. And people were charging folks to take them to specialty consults. I was the only thing in town. They had no other place to go, and they had nobody with them.

I had several collaborating physicians, as I shared with Representative Day; because if you're going to start a practice, there's no other practice in town; there's no place for them to go, and I started a

practice that's essentially a business.

If I'm required to have a collaborating physician and they get angry at me, you close the doors. So many times I would have two. And then when they would move, because the physicians would be coming in and then they wouldn't stay there because they paid back their loans and that kind of thing and move, so you'd have to find another one.

I was very fortunate. I have several physicians in adjacent counties that collaborate with me for the purposes of filing with the board. The real problem being is, I don't need that paper filed with the board. I need collaboration, but it doesn't need to be a paper filed with the board. Okay?

The other thing that I pointed out in my written testimony is primary-care NPs are more likely to provide care in a wider range of community settings like I did in Greene County. I know there's several others around the state. But you can't get too many of them.

I had the opportunity to develop educational programs at many universities across the country: Texas, Virginia, West Virginia; and I was part of the faculty that started the primary-care NP program at Penn State University that developed nurse practitioners for rural care.

And the reason we did that was so we could try to meet some of the needs of the residents of Pennsylvania. It was very interesting. We've had several stay, but several that are mobile have gone to states that have full practice authority, even though they were educated for Pennsylvania.

I've had students do rotations with me from Frontier University; and they have loved being in Pennsylvania, would have loved to have stayed here, and found out it was not a full practice state and went to a full practice state.

We're losing folks to Maryland; and if they're mobile, they'll move to the other of the 21. I think you can read all of our information. I don't want to bore you with reading it to you.

I would like to say that I am really concerned, when we went for full prescriptive authority -- I don't know how many of you were in the House at the time -- it was very interesting. Pennsylvania was second to last in the country to give nurse practitioners prescriptive authority. The only one behind us was Georgia.

I urge you to really truly look at full practice authority for nurse practitioners in Pennsylvania. Thank you.

MS. GRAY: Good morning, Chairwoman Harhart, Chairman Readshaw, and distinguished members of the Committee. As I said, my name is Kathy Gray; and I'm the president of the Lehigh Valley Nurse Practitioners Association and a supporter of House Bill 765.

A little bit about my background, I'm a board-certified family nurse practitioner. I spent four years getting a bachelor of science degree. And in that four years, I had many clinical hours in pediatrics, med/surg, community health; and I took all of the sciences.

I then went on to get a master's degree, which was another three years, took patho, physiology, pharmacology, epidemiology, all of the other science courses at an advanced-practice level, and also did clinical rotations in primary care.

For the past 16 years, I've been a member of the Pennsylvania Coalition of Nurse Practitioners; and I've cared for thousands of patients in Pennsylvania as a primary-care provider.

My scope of practice in family medicine is from newborns to geriatrics, and that is the practice that I'm board certified in. I also went on to get my doctorate degree; and I have my doctorate in nursing practice, which was another two-and-a-half to three

years. So as far as education, it was four years of undergrad, three years at the master's level and two-and-a-half years at the doctorate level.

So nurse practitioners provide a full range of evidence-based primary, acute, chronic and specialty healthcare. We order, interpret diagnostic labs; prescribe medication and other treatment modalities depending on the needs of our patient population.

In addition, a focus of our practice is of preventive healthcare. My colleagues and I are vital members of the community and directly contribute to the management of the healthcare needs of patients in Pennsylvania.

Nurse practitioners integrate the nursing model of care with a medical model of care to ensure best practice and clinical outcomes for our patient populations. So what is the nursing model? It's an approach to healthcare that focuses on the overall well-being of every patient. It is patient-centered and holistic, and also it is team-based.

Nursing started the team-base concept, and the medical profession has started to develop team-based care. We've always had team-based care.

So here is an example of how the two models of care complement each other: A patient came to me for a

second opinion regarding the management of his hypertension. He was on five different classes of medication for his blood pressure, and his blood pressure was still not at the recommended goal.

He was having side effects from all of the medications and very frustrated with the care he had been receiving. I listened to his story going all the way back to the time when he was first diagnosed with hypertension.

I obtained a thorough family history, ordered lab work to evaluate his kidney status, ordered a renal ultrasound, which was the key. The ultrasound revealed multiple cysts and an adrenal grand mass on his left kidney that had gone unnoticed before.

But I followed up with a CAT scan and referred him to a nephrologist and a surgeon. The surgeon removed the mass, and today he no longer suffers from hypertension. He's in excellent health, and this was a life-changing event for this patient.

There are many stories that nurse practitioners can tell you how they've saved lives and diagnosed and treated according to evidence-based practice.

When it comes to patient care, nurse practitioners and physicians are important partners.

Nurse practitioners collaborate every day with other providers, including primary-care physicians, specialty-care physicians, and other healthcare providers to ensure the best possible outcomes for our patients. It is part of our core training.

The problem is the red tape. Nurse practitioners in Pennsylvania are required to have a collaborative agreement, business contract, with two physicians in order to participate with many insurance companies and to prescribe medications.

This barrier prevents access to quality care and increases the cost to the care of the citizens of Pennsylvania. The requirement is redundant and unnecessary and it has directly impeded my ability to care for patients.

On three separate occasions, I had been called upon to take over a practice that was left without a primary-care physician, once due to a death and twice due to an extended illness. I was the only provider on site, yet I had to form business contracts with two physicians off-site in order to keep the doors open.

Thankfully, after a long search, I was able to find two physicians to sign the contracts. This takes time, and the state also has to process the

paperwork and prevented these patients from receiving care.

All this delay is mandatory, despite the fact that there is no requirement that the physician on the contract ever see the patients, review patient-care decisions or even set foot in the practice. Patients, experts, independent researchers and a growing number of states all agree full practice authority is an effective way to improve healthcare.

The results from other states paint a clear picture. Patient satisfaction and access to care is up, costs and wait times are down. So 21 other states and DC, have proven that collaborative agreements have nothing to do with collaboration.

In those states, nurse practitioners always work side by side with other providers, including physicians, specialists, pharmacists, and more, just as we always have and always will in Pennsylvania.

It is important to emphasize that supporting House Bill 765 and full practice authority will not change any of the requirements or safety protocols for nursing. We still will practice within our scope of training and education. It will simply allow nurse practitioners to fully utilize their training and education.

House Bill 765 has a direct positive impact on Pennsylvania families. There's no reason to doubt, evidenced from states that have already adopted full practice authority or the overwhelming research that proves that this reform benefits patients.

This bill will allow nurse practitioners to increase access to care for all of the citizens of our Commonwealth.

Thank you.

MR. YOUNG: Good morning. My name is Mike Young. I'm President and CEO of Pinnacle Health. I've been a CEO four times since 1988: the University of Buffalo, Emory University, and Lancaster General Hospital.

Currently, Pinnacle Health serves more than 500,000 patients per year in three locations across central Pennsylvania. We're proud to employee 50 nurse practitioners. They're a critical part of the Pinnacle Health team and our patients rely heavily on them.

I've heard a great deal of discussion today about who should lead the healthcare team. With all due respect, according to the Joint Commission and the Department of Health, the doctors and the nurse practitioners in this room, I, as CEO of Pinnacle Health, lead the team.

I have 6,000 employees, 850 physicians, 50 nurse practitioners, 120 pharmacists, 1500 nurses. Okay? The Pinnacle team needs Bill 765, so we can make primary care more accessible, make patients safer, and lower the cost of care.

I'm going to focus on three areas in my testimony: primary-care access, patient safety, and challenges for health systems. The bottom line is this: The bill is good for patients. It would reduce red tape and allow more patients to have access to proven, high-quality care.

What's good for patients is good for the health systems like Pinnacle. I'll give you an example. In 1981, I had my wisdom teeth taken out at Shadyside Hospital. I had a three-day length of stay. They used the same operating room for open-heart surgeries. That was the old way.

We had meetings like this in 1981 on outpatient surgery. In 1982, I built the first free-standing ambulatory surgery center in Pittsburgh, Pennsylvania. People, doctors, legislators, were fearful. They said patients would be put at risk.

Today, sixty percent of all surgeries are performed on an outpatient basis. That's the new way. Patients are healthier; healthcare's more efficient;

and, therefore, more people can access it.

I was able to take that step in Pittsburgh in 1982, because other states have led the way for Pennsylvania. And what the research showed and what my experience taught me is we could do that in Pennsylvania, too, and make healthcare more affordable and accessible. Most of all, I wanted to do what was best for the patients.

One of the questions of nurse practitioner licensure, the evidence is unanimous; nurse practitioners deliver a high-quality care, including the 21 states that already have laws like House Bill 765 in place.

This is supported by my experience at Lancaster General, at Pinnacle, and backed up by hundreds of studies. The most urgent and clear need to cut red tape for nurse practitioners comes from a field of primary care.

Nurse practitioners are well qualified to fill the growing gap in primary-care services. Over eighty percent of NPs are trained in primary-care roles. And because a hospital environment is inherently collaborative, House Bill 765 would have its greatest impact on primary-care access.

This is very important; because as we all

know, we have a tremendous primary-care shortage. It's especially bad in the rural areas where we operate. We know that when patients lack easy access to a primary-care visit, they wait. Small problems become big problems, and something that could have been caught early ends up as a trip to the emergency room. Today, as I sit here, Pinnacle Health has ten openings for primary-care physicians out of 150 slots. We can't fill them.

I was in Altoona Tuesday night at the Family Practice Residency trying to recruit graduates in July of next year; and two individuals showed up, two. I have ten slots, and I'm going to have thirteen retirements this year here in your community.

Those positions have been unfilled for months, and they're going to be unfilled through at least next July. The problem continues to get worse. The State Joint Government Committee recently predicted that Pennsylvania will need a thousand physicians in the next 15 years in order to just keep pace with demand.

Regarding safety, House Bill 765 would make patients safe. This is the most important question you must consider. Are nurse practitioners safe? And as a follow-up, would House Bill 765 keep patients safe? The unequivocal answer to both questions is, yes.

I say this based on 30 years CEO experience at Pinnacle Health and the other health systems where I serve, every piece of research ever conducted on the subjects and the experience of 21 states that already have a law like House Bill 765 in place.

More than 100 studies have compared care side by side between nurse practitioners and physicians. They all conclude that NPs have the same patient outcomes when compared to physicians.

Not a single study has ever found that nurse practitioners provide inferior services. That fact renders moot one of the most prevalent points in this debate, the misleading comparison between physician preparation and nurse practitioner preparation, where some have said if nurse practitioners want to be doctors they should go to medical school.

The implication is that the person with the most hours of training is always the best person for every job. Is it any surprise that physicians who must obtain thousands of hours of training in everything from surgery to advanced obstetrics are choosing specialty care? The two residents I spoke to have over $300,000 in debt and will not be going to rural areas.

Having overseen hundreds of physicians and nurse practitioners in my career, I can tell you that

simply looking at clinical hours is comparing apples to oranges. Decades of positive patient health outcomes prove that the education and training requirements for nurse practitioners prepare them well for their role.

When we look at how to run things in Pinnacle, we look at clinical results, thousands of them. Healthcare outcomes is what counts, not hours of training. Outcomes, outcomes, outcomes should be who serve patients.

There's strong evidence to show that the status quo, the collaborative agreement mandate, does significant harm to patients. Recently, research compared states that have laws like House Bill 765 in place to states like Pennsylvania that don't; and they found that there was a 50-percent potentially avoidable readmission rate among Medicare and Medicaid patients in states like Pennsylvania that reflects a huge burden on patients, the healthcare system, and on state and federal payers.

We run the largest accountable care organization in the state of Pennsylvania and our experience matches that exactly, where in rural communities where the primary-care base is overloaded, the use of emergency rooms in north central Pennsylvania is 50 percent higher than it is here in Harrisburg, 50

percent higher use of emergency room activity because of a shortage of access to primary care.

Challenges for hospitals is to explain how Bill 765 would help hospitals save money and be more efficient. So let me just finish by how the status quo is draining our resources. To do that, I want to draw a clear distinction between collaboration in the common understanding of the word and collaborative agreement. Collaboration means working together. Collaborative agreement is the state-mandated business contract that is a prerequisite for nurse practitioners to have a license, and you heard about the difficulty in doing that.

NPs work with physicians every day at Pinnacle Health, but that collaboration has nothing to do with the collaborative agreement. For hospitals, the collaborative agreement is nothing but a nightmare. Every time I add a physician or a physician leaves or an NP comes or an NP goes, I have to track this down. Just remember that the Patient Safety Bill passed last year, where we have to do evaluations on every employee and every doctor and it costs us $500,000 in cash cost, not including the people in HR which have to track every one of our thousand physicians and 6,000 organizations. So we've added $500,000 this year because of that mandate,

so is Penn State, so is York, so is Lancaster.

So for hospitals, the collaboration agreement is nothing but a nightmare. It adds no value whatsoever to patient care. The mandate spent -- forces us to spend thousands of dollars on paperwork instead of patients. The red-tape affects our decision process on where we put practices, how we staff them; and primary care is a very, very difficult sector from a cost standpoint. It is very difficult to break even a primary-care office. That's why there's such a shortage.

So in conclusion, healthcare delivery models are changing, just as surgery's gone from inpatient to outpatient. This is driven by CMS and insurers. It's driven by the availability of new information technology.

All the latest healthcare trends, team-based care, accountable care organizations, everything about professionals working together to coordinate care. They are the core tenants of nurse practitioner training. They have been for decades. NPs have been ahead of the curve.

In conclusion, the mandate is outdated and redundant, just as dental surgery, hernia surgeries, arthroscopies being done in hospitals. It hurts

patients; it raises healthcare costs.

House Bill 765 would serve patients, taxpayers, and healthcare providers like Pinnacle Health.

MR. VALDEZ: Chairmen, members of the Committee, thank you for the opportunity to speak today. My name is Brian Valdez. I'm with the National Nursing Centers Consortium, and my purpose here today is just to make a couple quick points about Pennsylvania's nurse-managed health clinics and retail clinics and how full-practice authority would impact those clinics.

And the point I want to make is that Pennsylvania is one of the nation's leaders in the development of innovative nursing-care models, such as nurse-managed health centers and retail clinics.

There are thirty nurse-managed health centers around the state. That is the most in the country. And they provide health promotion, primary care, to low-income patients regardless of their ability to pay.

There's also 80 retail clinics. These are the clinics in CVS and Walgreens, and most of these clinics are also staffed by nurse practitioners. And then on top of that, there are also thirty nurse-practitioner-led, school-based health clinics,

which provide primary care, health promotion and disease prevention services to students and members of the surrounding community.

Granting full practice authority to nurse practitioners will help Pennsylvania maintain its position as a leader and innovator in nursing care and it will align Pennsylvania with the national trend toward greater use of nurse practitioners. It will also help these existing clinics accomplish their triple aim of increasing access, improving health outcomes, and decreasing costs.

I just want to make two quick points, one about access. So in terms of nurse-managed clinics and retail clinics, the point I want to make is that these clinics are serving patients that the state's primary-care physician workforce does not have the capacity to reach or is not currently reaching.

The Institute of Medicine stated that the nurse-practitioner-led, nurse-managed clinic is a vehicle for getting care to populations that would not otherwise receive needed services.

And a study by the Rand Corporation showed that sixty percent of retail-clinic patients also staffed by nurse practitioners are not connected to a primary-care provider, so they're seeing patients that

physicians aren't currently reaching.

We heard a lot about education; but the point I want to make about that is that you can have all the education in the world, but if the patient can't get to a provider, it doesn't make any difference.

We are not just seeing this in rural areas. In Philadelphia, where I'm from, a patient can go to a city-run health center and they'll have to wait more than a month to see a physician.

So isn't it better if a nurse practitioner with full-practice authority can get that patient care, can get that patient seen by a provider? The best way to care for that patient is to get them seen by a provider, and the best way to do that is to grant full-practice authority to nurse practitioners.

The second point I want to make is in terms of quality. There's also been a lot said about education. And my brother was trained as a primary-care physician in Pennsylvania, so I definitely know a little bit about the education he went through.

And we also heard talk about the patient-centered medical home and the patient-centered medical home team. And what I want to say about that is that there were four nurse-managed clinic practices that became nationally recognized by NCQA as patients enter

medical homes, and there were eight nurse-managed clinic practices that participated in Pennsylvania's chronic-care medical home demonstration project; and these were nurse practitioners who weren't part of a patient-centered medical home team; they were leading the team. And what the data showed is that their outcomes as part of the patient-center medical home were comparable to physicians; and that was data collected in Pennsylvania through the chronic-care demonstration project, and they also received national recognition by the NCQA.

They were one of the few nursed-managed clinic practices in the nation to receive that honor. So nurse practitioners are able to direct the patient-centered medical home, not just be a part of the team.

The data shows that the quality of their care is equivalent to physicians, and they know when it is necessary to refer to a physician or consult with a physician. It does not need to be mandated by a business collaborative agreement. It should be left up to the professional judgment of the provider.

And then in terms of cost, my colleagues will also address that the collaborative agreement requirement raises costs. This is particularly of a

concern for nurse-managed patients, because they are underserved; so any increase in cost -- and they are low income. Any increase in cost is really going to hurt their access.

I'll leave that to them to talk about that more. Thank you very much.

MR. HOGAN: Good morning, Chairman Harhart, Chairman Readshaw, distinguished members of the Committee. My name is David Hogan. I live here in Harrisburg. I'm honored to speak with you today about House Bill 765.

I'm one of the many private citizens who hopes to see Pennsylvania join the District of Columbia and 21 other states who have already adopted full-practice authority.

I am also pleased to share with you my experiences as a patient of a nurse practitioner. I hope that we will work together to make the kind of care that I'm receiving available to more Pennsylvanians.

Like many residents in the communities that you represent, I suffer from a wide range of medical concerns. Some of them are acute, some of them are longer-term, lifetime conditions, and I have my aches and pains from daily life.

Several years ago, I decided to make a

change in how I get my healthcare. I did some research. I looked at what was available, and I thought about the attributes of my primary caregiver in terms of the relationship with me and not the diseases that I suffer from.

I chose a nurse practitioner because I wanted a patient-centered holistic approach, and I also wanted the kind of attributes that the caring and decent people who choose this line of work happen to possess. Regardless of their training and experience, they chose to be nurses and take care of patients.

I believe a lot of the value offered by this approach comes from the extensive training they receive and, more importantly, how that attributes of nurse practitioners treat me and not my conditions. I'm not alone in my belief.

In recent years, experts in the National Institute of Medicine, the AARP, National Governors Association, Federal Trade Commission, and the National Conference of State Legislatures have all endorsed policies that ease the restrictions and expand healthcare access to millions of individuals across the nation.

I am very happy with my decision and the positive impact it's had on my health and the quality of

my life. My nurse practitioner makes me an active participant in my healthcare team and in healthcare decisions, and I have developed a level of trust based on the time she has spent knowing me as a whole person and not a set of prescriptions and conditions.

I particularly appreciate the collaborative approach that my nurse utilizes to ensure that I receive the best possible healthcare. We have brought in and worked with specialists from several fields, including physicians, other nurses, and nurse practitioners, for a number of issues.

Because of the atmosphere created by my nurse practitioner, I feel more like a full partner. I trust her in a way that I have not felt with several family physicians that I've seen in the past.

You can't imagine my shock and disappointment when I received a call from my nurse practitioner a few years ago telling me that she had to close her clinic. I asked her why, and she explained the costly mandates and the burdens that nurse practitioners face in Pennsylvania.

I didn't understand this. All I knew was that my nurse practitioner was the best caregiver that I had in many years, and I was losing her. Now, I was very fortunate. My nurse practitioner found another

position, and I'm still able to see her; but many of my neighbors and friends aren't that lucky and don't have that freedom of choice.

I've experienced how nurse practitioners provide proven high-quality care to patients. I'm living it. I am very concerned that some of my friends and neighbors and the constituents in your communities may not have access to the same type of quality healthcare unless we all act together to eliminate the legal obstacles to full-practice authority for nurse practitioners.

So many people in Pennsylvania are struggling to find an affordable source of quality healthcare, and too many of them won't have the good fortune that I've had in locating a nurse practitioner unless we remove these obstacles.

The changes being proposed are cost effective, bring a new set of resources to a heavily burdened healthcare system at a time that we really need them.

Our communities need the skills and health services that nurse practitioners provide. Simply put, HB 765 is the right thing to do for the residents of our state. We need to join the growing number of states who have taken the necessary steps to remove the roadblocks

separating residents and citizens from these certified professionals.

Chairs Harhart and Readshaw and distinguished members of the Committee, I implore you to join me in supporting HB 765. Let's work together to pass legislation that will undoubtedly improve our well-being and the quality of life offered in our communities.

Thank you for this opportunity to speak.

MR. JAEP: Good afternoon now. I guess it's afternoon here. Chairwoman Harhart, Chairman Readshaw, and members of the Committee, I appreciate you taking this opportunity to -- for me to have the opportunity to speak to you today.

Again, my name is Kyle Jaep. I'm a JD candidate at Duke University School of Law; and I coauthored the report that I provided to you, The Value of Full Practice Authority for Pennsylvania's Nurse Practitioners.

I prepared a few brief remarks; but in the interest of time, I'm going to weave in some brief responses to the previous panel, as well, just for time's sake; and I'd be happy to answer questions on anything after we finish here.

You've heard a lot of commentary on the

present state of things in Pennsylvania. A couple things, 35 percent of Pennsylvanians now live in underserved areas.

And as Mr. Valdez reported here, even in urban areas, the wait time is up to 21 days on average, up from nine days just five years ago, to see a primary-care provider.

This sets the stage for my report that I coauthored with fellow JD candidate, John Baily, and also a team of people, one of which was a supervisor and one of the top healthcare economists in the nation who is now -- she's teaching at Harvard, as well as a reviewer panel of economists out west in California. A team of economists reviewed this and gave their stamp of approval.

It delved into three areas, which is access, quality, and cost; so I'll briefly summarize what the findings were on that. And a lot of this stuff will be -- the things I say today will be in line with what you heard the self-proclaimed leader here, Mr. Young -- what he was saying. It's going to back up -- it was in line with what he is saying here.

So the first thing is access. Our analysis suggests that over 1,000 more nurse practitioners would be practicing in Pennsylvania today, that's a 13-percent

increase, if Pennsylvania had granted full-practice authority in the previous decade.

An increase of this size for primary-care access would help satisfy this growing unmet demand. And if I could just interject a little commentary, response, to the previous panel, they stated that there would be, I guess, little migration coming into rural areas based on their data. There is a plethora, an abundance of reports that say otherwise. A lot of them are based on the reports that we looked into, powerhouse policy. Think tanks like Rand will say otherwise, and they're based on a lot of different studies that say otherwise.

But with that said, migration isn't the only factor that would have contributed to increased access in rural areas. Just raising the level in general across all areas will do it as well. So just because someone doesn't migrate doesn't mean that you'll have -- you won't have first-comers into the profession that will go into the rural area. That's something that is just response, but -- yeah.

On that, I can go to quality. And, again, an abundance of reports in our research indicate that nurse practitioners provide comparable or even superior care to the physician counterparts in primary care.

Also, subjective measures like patient satisfaction are increased when under the care of a nurse practitioner. Adults and children enjoy this increase in subjective measures, but were all health outcomes. In states that have granted full-practice authority, they're also increased. Things like annual checkups go up in these states and avoidable emergency room admittance go down; and our report, what it did, just to give you a brief explanation before we get into the costs, which is I'm sure very interesting to everyone here, especially in light of the budget battle here.

Our report took data that was compiled and analyzed by these big powerhouse think tanks like Rand, distilled them to get the information that would be applicable to Pennsylvania, and then we applied them to Pennsylvania's demographics. So that's what we did.

So now with that, moving into cost. Pennsylvania, to set the stage, is among, was among, and probably still is because the last day -- the last date of available data for this was 2009. But in 2009, they were among the ten states that had the highest per capita expenditures, healthcare expenditures in the country. That means we were one of the ten worst states in terms of managing our expenditures for healthcare.

So this Rand study -- there's a Rand study, and they did a couple of them. They did a study on Massachusetts but also spoke to a broader national perspective, and they reported after looking at MEPS data, which is, again -- this data is data that was used for access as well. It's the medical expenditure panel survey, which is used by many reputable organizations.

They found that care from nurse practitioners is, on average, 20 percent less expensive for the same care with the same quality. Given this, and confining nurse practitioners to just acute care, if you were to grant full-practice authority just to the extent of acute care, which was six conditions, Pennsylvania would conservatively save $6.4 billion over ten years; and that's in total expenditures.

If reform expanded to two-fold, to actual full-practice authority in our minds, which means that nurse practitioners would be independent in giving general medical examinations and well-baby visits, that number goes to 12.7 billion over ten years.

And, again, these are rough numbers; but they paint a picture as to at least the order of magnitude we're talking about here. These savings directly translate to lower burdens on consumers, business, and public programs.

And to speak to Medicaid, again, just to underline, these are very -- these are rough estimates; but with Medicaid, we would love to drill down more with more time to research, and we're going to do this, to getting a more finely-tuned estimate.

But if we apply that 20-percent savings rate to what Pennsylvania spends on Medicaid for acute care, then you're looking at savings directly to the Pennsylvania government of $500 million over ten years. And if you expand it to general medical visits and well-baby visits, which they are trained and experienced in, then you're looking at upwards of a billion dollars in savings directly to Pennsylvania government over ten years.

So, in conclusion, we found that states that allow nurse practitioners to serve patients to the full extent of their authority, you'll see costs go down, access be increased, and quality maintained at a superior level.

And, you know, we don't have a dog in this fight, per se, but we couldn't help but come to the conclusion that Pennsylvania should move immediately to pass this bill and to grant full-practice authority, just as 21 other states have done with good results.

Thank you.

MAJORITY CHAIRMAN HARHART: Thank you. Okay. We do have questions from the members, and we'll start with Curt Sonney. Representative Sonney.

REPRESENTATIVE SONNEY: Thank you, Madam Chair. This is going to be for one of the practicing, or rather, trying-to-retire nurse practitioners.

MS. COUNTS: I keep trying.

REPRESENTATIVE SONNEY: If a new patient comes in to see you, or when a new patient comes in to see you and the first question out of their mouth is, you know, you're a nurse practitioner; what's the difference between you and a physician?

MS. COUNTS: I'd love to answer that. I come to healthcare from the background of nursing, and so I go after care. Medicine comes to healthcare from the medical model, and they go after cure.

Now, we do many of the same things; but my approach is looking at the care for the patient in the family, in the community, as well as management of the chronic disease and the acute illnesses and coordination of other services. And the physicians are trained, they want to cure everything. So I really need them when I get some really complicated patient, so I send them to them.

I don't know if that answers you totally.

But it's --

REPRESENTATIVE SONNEY: Well, it does; and it kind of leads into my next question. And I get that, Mr. Young, that in a hospital or within a system, you know, the team exists. In other words, all the professionals are bumping shoulders with each other all day long.

And so, you know, it is a total different atmosphere from the nurse practitioner that would be out in that rural area practicing on their own. So another follow-up question would be, If this bill became law and there was not the mandate for a collaborative agreement, do you believe that you would still seek out those collaborative agreements?

MS. COUNTS: I'd like to -- I think somebody said it; it's not a collaborative agreement. I still collaborate, absolutely; but I don't need a collaborative agreement, which is a legal contract.

REPRESENTATIVE SONNEY: And do you think that there's a real difference when you're dealing with a physician between having an actual contract and to define that agreement than just simply seeking it out? Because, you know, you kind of need it in a way.

MR. YOUNG: Maybe I can answer that question. The answer is absolutely. I have personal

knowledge of a physician who had a collaborative agreement in York County with a nurse practitioner for five years and never stepped foot in the office one time in five years. But it met the collaborative agreement methodology, but it provided for no collaboration. So it met a legal definition, but it did nothing to improve patient care.

And then, secondly, even in the rural areas -- and the question was asked in the last session, Will the billing go through insurance companies? The answer is, Insurance companies are there to evaluate what nurse practitioners do.

The health systems in that area, even the rural areas, we all have relationships; so every bit of care today is evaluated. We evaluate all 8,000 caregivers in our ACO, because that accountable care organization from York County to Corning, New York; because for the first time, we have electronic information and I see how many mortalities, how many morbidities, how many readmits, how many times they go to the ER.

For the first time in history in my 30-year career, we have that capacity to really evaluate everybody. So the reality is, nurse practitioners, even if they're by themselves in Huntingdon, Pennsylvania,

where we have a hospital where they cooperate because they have to refer to the pediatrician, they have to refer to the rheumatologist or --

REPRESENTATIVE SONNEY: But, you know, we're not really talking about on the collaborative agreement on -- we're not saying in the collaborative agreement -- today apparently does not say that this does not mean that the physician is a supervisor who must oversee, okay, look at records, you know, similar to a PA. That's not -- that doesn't exist today.

MS. COUNTS: Right. Right.

REPRESENTATIVE SONNEY: Okay? What exists today is the fact that you are not physicians. Okay? Granted, right?

MS. COUNTS: Right. We're not.

REPRESENTATIVE SONNEY: It's a different role, even though an important role, a very important role. But you're not physicians. And to remove this and allow you to operate independently in a rural area -- okay -- granted, you said that you would still seek out, you know, a contact with a physician, some type of -- even if it's a verbal agreement that, hey, you're going to be there, you know, should I need some collaboration. You know, what's wrong then with keeping it in line? In other words, making sure that you are

able to get that collaboration, whether it's in a contract form or not. You're still -- you know, you admitted that you would seek it out.

MS. COUNTS: Right.

REPRESENTATIVE SONNEY: So what's wrong with making sure that it stays in place?

MS. GRAY: Because it prevents access to care. So we need this collaborative agreement, in my case, when I took over for a physician who was deceased and it wasn't in a rural area, we could not find a physician to fill that clinic; so they asked me to fill in since I am board certified in family practice as a nurse practitioner.

So it took us awhile till we found two physicians who would collaborate. Not every doctor wants to be on that collaborative agreement. They just don't want to. And there are physicians in my health system that will not even work with nurse practitioners.

So it just depends on the physician. And would I -- I have a team of -- a network of specialists that I work with. Whether I practice in rural America or in an urban area, I will call on those physicians when I need them. I don't -- I am a primary-care provider, so I don't need a collaborative agreement with another primary-care provider. I'm fulfilling that

role. I am the PCP.

So I need specialty care to manage my patients that have complex disease processes like diabetes, heart failure; we comanage those patients together. So they see -- the specialists will see that patient maybe once every six months. I will see that patient every two months, whatever, you know. I'm just -- or three months.

So really what we need to do is collaborate in the true sense of the word collaboration, not with a written agreement in Harrisburg.

REPRESENTATIVE SONNEY: I still find it hard to understand why that agreement is such a stumbling block when it really doesn't appear that it is, only in some instances, some instances, especially when you're -- the more rural that you get.

MR. JAEP: And I just want to remind that -- you know, I have no experience directly with collaboration agreements. But, again, looking at the results of the states, -- I mean, we can discuss rationales; but that's not going to help understand things that haven't happened yet.

But, I mean, this has happened in 21 states. I mean, the results are pretty clear. I mean, just having educated myself over the past year on this, I

mean, we had to keep in mind that the results are clear that this does lead to increases in numbers of primary-care providers and decreased costs. You can argue about why, but --

REPRESENTATIVE SONNEY: The decreased costs were obviously because, you know, the reimbursement is less. We're an aging state, you know. Medicare plays a huge role in the healthcare delivery within this Commonwealth. And if you're going to receive 15 percent less, it only goes to show that there's going to be a 15-percent savings. But that's only if, you know, you took over the whole state and the physicians didn't exist anymore.

I know there's other members who want to ask questions. I thank you, Madam Chair.

MAJORITY CHAIRMAN HARHART: Thank you. Representative Knowles.

REPRESENTATIVE KNOWLES: It will be quick, Madam Chair. I thank you. Whoever put together the list of testifiers, I want to commend you; because I've been to a lot of hearings, and this is a great group of testifiers on both sides of the issue.

I think it was Representative Kortz who had asked a question regarding the residency in terms of docs. Okay? I mean, we look at a doc in residency and

then we look at a doc who's well experienced and he's out there in a family practice.

Has there been any thought -- and maybe the prime of the bill might be able to answer this question more than anybody -- has there been any talk about any type of a structured residency program in terms of tying it in with this bill?

MS. COUNTS: What we found, though, through the certification process and the background in nursing and in the -- instead of having only didactic education and then clinical practice, NPs are educated concurrently so that you see the didactic and the clinical practice at the same time.

So when you look at it, when we look at the certification process, a certificate has to meet the standards. And it's not an easy test. I know; I write the questions. I'm glad I'm not taking it. But so that they have the qualities that are necessary for safe beginning practice.

And even a physician coming out, when they first start practice, they're just starting practice as well; so it's true across any profession.

REPRESENTATIVE KNOWLES: Is it -- in other words, it just seems to me that the doctor route, there is a residency that takes place after they become

doctors.

MS. GRAY: Right. And there is a residency. But as Mona said, we integrate our clinical experience with the didactic, so we're doing our residency concurrently with our didactic education.

So physicians will go to school one year or two years and then they won't do any clinical. Then they do a couple of years of externship where they really can't get involved. They kind of look around to see what they're interested in and which field they'd like to specialize in and then they apply to specialize.

So we already -- I already knew that I wanted to be a family nurse practitioner, so I started off with that; and all my training and clinical has been in family practice.

REPRESENTATIVE KNOWLES: Thank you, Madam Chair.

MAJORITY CHAIRMAN HARHART: Representative Kortz.

REPRESENTATIVE KORTZ: Thank you, Madam Chair; and thank you for your testimony today. Comment and a question, Madam Chair; and I'd like to follow up with what Representative Sonney touched upon.

Two of the testifiers in this panel, Mr. Hogan, on page two at the top, you explained how you

appreciated the collaborative approach, including the physicians. Dr. Gray, on page two, second paragraph, you talk about when it comes to patient care and nurse practitioners and physicians are important partners; you must collaborate.

My concern is if House Bill 765 becomes law, you can basically practice medicine on your own. There is no real requirement to collaborate with that doctor. Just a comment. I'm very concerned about that; because if some nurse practitioners don't feel the need to collaborate, they won't. And then what safeguards are there for the patient? That's a comment.

My question's for Mr. Jaep. You make a very bold statement in saving 6.4 billion and as much as up to 12.7 billion. Tell me what Nevada, Arizona, and Oregon saved? Do you have those numbers?

MR. JAEP: Well, what they saved is difficult to say; because again, you're comparing it to what would have been; it's a hypothetical. So it's hard to say.

So in that case, what you have to look at is, in this case, Rand has given us a number and they've weeded through these MEPS data, which is costly prohibitive to go through. You actually have to go down to Washington, DC and get that; and that's why not many

of these studies have been done.

REPRESENTATIVE KORTZ: Okay. That's a very bold number you throw out there.

MR. JAEP: Right. So Rand is a big, reputable think tank; and they tell us that -- they did a study on Massachusetts, which was a 35-percent cost savings, and they mentioned that they also compiled a national average, which was 20 percent. So the only way we can figure out whether costs are down is through these measures like this; because you can't measure what would have -- it's hard to measure what would have been.

So you take the 20 percent and we applied that to -- we took Rand's formula and changed the 35 percent to 20 percent to be conservative. Who knows, Pennsylvania could be at the 35 percent. And I'm likely, you know, inclined to believe that it probably would be because of our expenditure history here.

So this is very conservative. And when you apply that to acute care, just acute care, nurse practitioners giving that, you get 6.4 billion. Again, may not be exactly on the nose, 6.4 billion; but we're talking about on order of magnitude; and, I mean, anything over a billion, I think, would catch the ears of a lot of policymakers. That's where we came from.

REPRESENTATIVE KORTZ: It would be a lot

more credible if somebody went back and looked at the states that have already converted and said here's the actual number. Then I could find it more reasonable.

MR. JAEP: Well, again, that's impossible. That's impossible.

REPRESENTATIVE KORTZ: Thank you. Thank you, Madam Chair.

MR. JAEP: Uh-huh.

MAJORITY CHAIRMAN HARHART: Representative Mentzer.

REPRESENTATIVE MENTZER: My question was for Mr. Jaep, but it was the same question that Representative Kortz asked. But let me just clarify this. You're telling me that of all the states that have passed a law similar to this, there has been no study done as to how much money it has saved that state? Is that what you're suggesting?

MR. JAEP: Well, to actually get -- so, for example, the studies that are done are on states that haven't passed yet. So we haven't come across one that said --

REPRESENTATIVE MENTZER: Okay. You answered my question. Thank you very much.

MR. JAEP: Right. Okay.

MR. YOUNG: But remember what I said in my

testimony, in north central Pennsylvania where there is a severe primary-care shortage, they use 50 percent more ER visits, significantly more readmissions to the hospital. Because the doctors' offices are full, the patient can't get in. There are a shortage of nurse practitioners, so I have firm ACO data that shows utilization is significantly higher per thousand of population. And if you multiply that across the 28 million people in Pennsylvania, it's a thousand to $1500 per enrollee per year, per year.

REPRESENTATIVE MENTZER: Madam Chair, may I just ask one question then? Why would it be so difficult for us to get this from the states who have already passed this law? Why would that data be so difficult to obtain?

If you can make that speculation in Pennsylvania, it would seem to me it would be very simple to get that information from a state that's already passed the law.

MR. YOUNG: I hear what you're saying. I'll go do some research. He's a poor law student trying to pay his tuition, and these are poor nurse practitioners.

MR. JAEP: I mean, hey, it's $12 an hour for an RA position.

MR. YOUNG: They don't have millions of

dollars of support behind them, but I'm on the board of the Hospital Association; we'll look at that.

MR. JAEP: I can also attempt to explain that. I mean, so I've looked at the trends of spending for the states and especially Pennsylvania, and they're all trending up. Everything's trending up.

The question is, at what trajectory? So you're going to look at trajectories of spending. The problem is, there are so many other variables that affect the cost of healthcare in a state that to isolate it to this one thing, you have to look at measurable things, like what's the cost of care that a nurse practitioner would provide and how would that affect if you were to expand that? That's how you have to do it. You can't just say, okay, this is what it would be literally -- because there are so many variables in that state.

REPRESENTATIVE MENTZER: Thank you very much, Madam Chair.

MAJORITY CHAIRMAN HARHART: Representative Brown, do you have questions?

REPRESENTATIVE BROWN: I'll be quick. First, thank you very much for your testimony. And, you know, there's -- I have notes everywhere, I think, from both sides; and it is very interesting, the whole

subject matter. But I do have to say, you know, in many of the testifiers here, everything talked about was the quality of care and the importance of collaboration, which is common sense.

So the one question that I have is, if you were to remove the contract, the collaborative contract, is there wording or something that you would recommend in a legislative fix of some sort to increase collaboration that you believe would be more beneficial as compared to a so-called contract?

MS. COUNTS: I don't think there was any difference between a family-practice doctor practicing independently and a family nurse practitioner practicing independently on the checks and balances. Because it would be the same as a family-practice doc, if they didn't refer and collaborate, they could get in trouble with their board. And it's the same for the nurse practitioner. If I didn't collaborate and take care of the patient appropriately, then there's going to be some repercussions of that.

REPRESENTATIVE BROWN: And, Madam Chair, one more quick question. She's not looking, so I'm going to ask. Now, speaking of that, because even in your testimony you mentioned the fact that, you know, we all can make mistakes. And us as a legislative body, we can

make mistakes. We can hopefully fix them.

MS. COUNTS: Please.

REPRESENTATIVE BROWN: Yeah. And we try to fix them and amend the law; but, you know, unfortunately, as physicians, when you make a mistake, it is a mistake that is devastating to a life or a family member. So whether you're a doctor or a nurse practitioner, whatever it may be, that is my ultimate concern looking at any of this legislation.

And no one is perfect. But when you look at the fact of trying to maybe remove a so-called team, the more eyes the better, in looking at any issue. So it goes back to my first question of recommendations from the collaborative agreement.

But the second piece is, in the states that have passed this, and we talk about the reason why we lost doctors. We lost doctors because malpractice, because of liability, and they left the state. So if we go back to the real reason why we have a shortage, we're going back to the cost of doing healthcare and why doctors are not going into the practice any longer.

So when you look at that, the unintended consequences on malpractice or liability in the states that have passed this, do we have any stats on that?

MS. COUNTS: From what I understand, I don't

think there's any difference between -- the NSO is the one major insurance company that many folks use, and it's pretty standard across the country. It has not been changed per practice area.

I think the one issue that was brought up earlier is that there's more litigation, that there's more people, and there's more nurse practitioners. I mean, it's not -- for a while there, nurse practitioners had no litigation; but there weren't that many of us.

MR. YOUNG: But let me answer that. I have 30 years of paying claims. I've been a self-insured hospital since Shadyside in 1981, and the largest claim in Lancaster, where I was CEO for 18 years, was a primary-care case. You know, you heard about the fingernail cancer. Patient goes to a well-known doctor that many of you in this room know, great doctor, saw him three days in a row; had a headache. Fourth day goes to an ER. Fifth day comes to our ER. Half an hour later, he's in the ICU; and six hours later he's dead of encephalitis. It was a multimillion dollar settlement. We didn't have to pay, because by the time we got involved it was treated.

If you follow the discussion that we've had, that family doctor never should have treated the patient because he had a headache. He should have been referred

to a neurologist immediately that day.

The reality is, you all know, you can't see a neurologist. And so if you follow that philosophy, you shouldn't have family physicians or internists because there's always an expert.

I've sat in board rooms with many of the folks in the room, where OBs had these same discussions with family-practice leadership saying, family doctors should never be OBs or do OB. They don't have enough training; there's too much risk. The malpractice is so high.

I nearly lost my job in 1988 by mandating that the largest family-medicine residency in the state at Lancaster General be allowed to do OB. The board chairman called me up at 11:45, Hey, Boy, you have your job till tomorrow at least. Okay?

So I fought these battles on behalf of family medicine. And these questions are no different than we had 20, 25 years ago in OB, in endoscopy. Look at how many primary cares are doing endoscopies now.

Our busiest endoscopist is an osteopathic family physician; whereas 15 years ago, he wouldn't have been able to do that; and we had these same discussions. There is no GI evaluating his collaborative agreement, is he doing right on colonoscopies? It's a skill set

that he was trained to do, and he does them very well.

We look at his complication rate, and it's actually slightly better than the average gastroenterologist. So we have data available. If you don't collaborate, you go out of business. If you don't refer properly, you go out of business. The community knows. Most of us live in small medical communities. Everybody knows. And so there are bad hospital executives; there are bad doctors; there are bad nurses; there are bad nurse practitioners.

But this one law makes it so hard, this collaboration; you've heard their real-life examples; it makes it so hard to bring people here; and therefore, you wait for days and days to get into the primary-care office.

And when 13 more guys retire because they're already over 65 -- this is here in downtown Harrisburg; we're dead. There just aren't enough. And I've been to Lancaster; I've been to York; I've been to Reading; I've been to Altoona. The CEO gets in his car and drives there after business hours to recruit family docs. And how many showed up at York? One. How many in Lancaster? Three. Even if I get them all, that wouldn't even fill the current shortage.

So as I said, it's interesting that we've

had so many discussions, 20 years ago, about family medicine and internal medicine and now we're having the same one in nursing.

So I ask you to support this. It's going to help your neighbors.

MR. JAEP: And I just want to answer your direct question about the malpractice insurance. A study was done, and there is no rise in malpractice insurance, and that went to quality. It was done to measure quality in the state, so there was really no difference.

And just one last thing on the cost. That was a great -- it really was a great question about the method. But again, it does not diminish the validity in any way in my mind; because Rand, for example, predicted that even Massachusetts would have savings of between 4.64 billion and 8 billion.

So these are the numbers we're working with. These are big-time big wigs at these policy think tanks that are coming up with these numbers, and they are valid.

Thank you.

MS. GRAY: I'd just like to say one thing. I truly believe that in the next five years, maybe even sooner, that nurse practitioner providers will be the

primary-care providers in the state of Pennsylvania; because physicians are not going into primary care.

We are quality, safety. We're very -- our schooling, education, is excellent. We have to pass a state board exam in primary care. And I truly believe we'll be the primary-care providers in the state.

MAJORITY CHAIRMAN HARHART: I think -- Representative Gillespie, are you next for a question?

REPRESENTATIVE GILLESPIE: Thank you, Madam Chairwoman. And I'll be brief, because it's been a long day. And again, thank you, folks, for coming up and testifying as well.

And this can be for any of the certified registered nurse practitioners. From a clinical standpoint -- from a clinical standpoint, what does having a collaborative agreement with the physician prohibit you from doing, from a clinical standpoint?

MS. COUNTS: Getting licensed.

REPRESENTATIVE GILLESPIE: I'm sorry?

MS. COUNTS: I can't be licensed without one.

REPRESENTATIVE GILLESPIE: But what does it prevent you from doing clinically?

MS. GRAY: Prescribe medications. Some insurance companies require -- I cannot see my Medicaid

patients without a collaborative agreement. Even though I am their PCP, their primary-care provider, I need a physician's name on that insurance card; and the physician will never see that patient or may never see that patient. So my Medicaid patients would not have access to care.

REPRESENTATIVE GILLESPIE: Okay. But you could see other patients other than Medicare patients; is that what you're saying?

MS. GRAY: Well, depending on the insurance company. Medicare, but you're not licensed. Well, right, you're not licensed; so you really couldn't, yeah, and couldn't prescribe medications.

REPRESENTATIVE GILLESPIE: Okay. And we've heard a lot about rural access. We've heard about emergency room visits increase. Again, coming from a small community hospital, our emergency room was a family doctor in many cases, even with education and, you know, big posters in the clinic and being referred there, they still would come to the emergency room out of convenience.

But you heard Dr. Rizzo from the Pennsylvania Medical Society testify that she's willing to work with folks in these outlying areas to have access to the collaborative agreements.

Do you see that as an issue in any way at all?

MS. COUNTS: I think that it's going to be a nonissue, because I think you guys are going to vote right and remove this.

REPRESENTATIVE GILLESPIE: Well, given the history of the legislature in some cases, perhaps it may not go to -- I mean, seriously, with the affirmation that Dr. Rizzo gave concerning the working with to get these collaborative agreements in place so that there is access to care.

MS. COUNTS: I think that's kind of super unless there's something because there's some physicians that charge NPs a thousand dollars to collaborate. A month. I'm sorry. There's others that do it out of the kindness of their heart. There's others that we guilt them into doing it. I mean --

MR. YOUNG: I have 300 employed physicians, and the chief medical officer has to beg them to sign collaborative agreements; and about half the time I have to go and really beg them. So these are employed physicians where they're a hundred percent covered under our malpractice and they don't want to do it.

So now you're asking a private nurse practitioner to go get some private doctor. I think

there will be a limited number of private doctors who will do it, and it's an even smaller group who will do it for an amount of money that's affordable. You've heard numbers, a thousand dollars a month, $5,000 a year. It's a lot of money for nurse practitioners and clinics who don't have it.

REPRESENTATIVE GILLESPIE: Well, since you brought the issue up, Mr. Young, why are those physicians reluctant to do so?

MR. YOUNG: Because it's a hassle. They have to sign these agreements. The nurse leaves. They get another one. It's a lot of responsibility for them with absolutely no value.

REPRESENTATIVE GILLESPIE: Okay. So wouldn't there be a way that that could be streamlined so that it would be easier for the physician then to enter into those agreements?

MR. YOUNG: Yeah. You could do away with it.

REPRESENTATIVE GILLESPIE: Yeah. I said streamlined, not do away with it.

MS. COUNTS: No. I was going to reiterate the same thing, that it's just not needed; you know, it's just an extra burden. It's a barrier to practice; it's a barrier to access; and it's not cost effective

for the healthcare system.

REPRESENTATIVE GILLESPIE: Okay. No other examples as far as what would prohibit you from your scope of practice, other than the Medicare area that you cited?

MS. GRAY: No. I couldn't practice at all. I mean, I need to prescribe medication. I need a collaborating physician to prescribe. Their name is on my prescriptive license in Pennsylvania. So I wouldn't be able to practice.

In the case where the physician passed away, I had to wait a couple of weeks until I could find two physicians, and then I had to send it to the state. They had to approve it. I could not work. I could not work. Those patients did not have primary care until I got that letter from the state.

REPRESENTATIVE GILLESPIE: I have a lot more questions, Madam Chair, but I'm going to be respective of the time. And I thank you. Thank you, all.

MAJORITY CHAIRMAN HARHART: Representative Mustio.

REPRESENTATIVE MUSTIO: Thank you. I'm going to ask about the collaborative agreement, something different. And we are being watched, because I got an e-mail from a nurse practitioner and she said

the physician who she is in a collaborative agreement with has never stepped foot into the building that she operates in. And based on the heads nodding, that sounds -- that's probably pretty typical.

And she does pay a lot less per month than what you quoted earlier. But my concern is with doing away -- she said, but he is available by phone for consultation when she needs that. But that's because there's a written agreement, I assume, that says that?

MS. COUNTS: No. No. I think that any healthcare provider in any profession with a call from another professional asking for advice or asking to collaborate regarding some patient outcome will do so. So it is not required to put it in writing.

REPRESENTATIVE MUSTIO: So even the physicians at Pinnacle Health that don't want to sign the agreement still pick up the phone and answer it?

MS. COUNTS: If I had a patient today --

MR. YOUNG: Absolutely. We refer out 800 patients a day out of primary care to specialists every day, because the primary-care doctor doesn't feel he or she has the expertise to do that. So we coordinate 500 referrals to various specialties every day.

REPRESENTATIVE MUSTIO: I was really referring to the nurse practitioners.

MR. YOUNG: But same thing. Within those 500 referrals, we have about one-third nurse practitioners to doctors; so they're one-third of that 500.

REPRESENTATIVE MUSTIO: So at the end of the day, taking care of the patient trumps everything else? So whether that agreement's there or not?

MS. COUNTS: Yes.

(APPLAUSE.)

REPRESENTATIVE MUSTIO: Thank you.

MAJORITY CHAIRMAN HARHART: Thank you, Representative Mustio. Okay. I guess that concludes this hearing. I thank you all very much for coming. I thought everybody's -- both sides, their testimony was very good. I think we can all agree on, the bottom line is that the patient is the number one person here; and patient safety is, I think, the most important part in everybody's mind.

So I am going to say this meeting is now over. And I think the Committee will talk about this and look at some of the testimony and maybe if Representative Topper could sit down with any of you and maybe work out a little something that maybe might make the bill a little bit more compatible, we -- you know, you could do that as well. I'm sure he'd be willing to

do that.

So again, thank you very much and have a very nice day.

MS. COUNTS: Thank you.

(Whereupon, the hearing concluded at 12:40 p.m.)

CERTIFICATE

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the within proceedings and that this is a correct transcript of the same.

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Tracy L. Markle,
Court Reporter/Notary