

About the Author:

A little background, I am a voter and physician who completed an emergency medicine residency program and have held a Louisiana medical license and practiced since the early 1990s. I am not originally from Louisiana and could have practiced anywhere in the country, but I chose Louisiana. Why? I went into medicine to help people and felt I could have a big impact in Louisiana given the challenges they had (consistently ranked 49th or 50th in health), and continue to have, in health. That is what brought me to Louisiana in 90's. That is what has kept me practicing in Louisiana and inspired me to spend the time to step away from medicine to take the time to research this topic and write this informational paper to you, to address many points of concern that were discussed in the April 22, 2021 Health & Welfare Committee hearing, and offer some suggestions that could help improve the main concern that **everyone seems to agree on:**

Providing safe health care to those in need, particularly the poor, underserved, rural patients.

What has kept me in Louisiana are the amazing people of this great state. Working with others, we have developed and implemented processes that improve care, make care more accessible, reduce costs and improve outcomes and metrics.

I have worked as an emergency physician in various parts of the state as a staff physician, as a medical director, and as Chair of the Department of Emergency Medicine. I have been recognized nationally for the process improvements made that led to transformational changes in the manner that emergency departments operate. I have worked alongside physicians, nurse practitioners, physician assistants, nurses, and many other dedicated health care workers.

During the COVID-19 related public health emergency, I have provided in person and telehealth care to patients in numerous states. I have neither billed a single patient, nor has any patient been billed by anyone or any company, health care company or other entity, for the professional services I provided to them since March 2020. I have neither accepted nor collected a single dollar for the health care I have provided in the past year+. You read that right, I have provided these services for free. I have not made a single dollar for my services as a medical doctor. I believe this gives me credibility when I say I went into medicine to help people and that my priority is to help people in need.

I am currently working to form a non-profit organization, whose goal will be to assist people in need from man-made and natural disasters including as the COVID-19 pandemic and the crisis we have in rural healthcare. Our organization will be able to provide, or arrange for, medical services, including specialists, to residents in the rural areas of our state that have decreased access to care whether due to physician or non-physician shortages, distance, or financial reasons. This service would allow the doctor to remotely listen to the patients' heart and lungs, examine their ears, throat and do most everything that is done in person in order to make an accurate diagnosis; something that can be and has been done for years. The non-profit will accept/treat Medicare, Medicaid, private insurance, uninsured. For some time I have heard there

are not enough doctors in this location or that location. This can no longer be used as an excuse and through this non-profit, I hope to make my goal a reality. My goal is address the workforce shortage and increase access to healthcare by making physicians available to anyone who needs it regardless of who they are or where they live. We hope to be able to provide care “Anytime/Anywhere” 24/7/365.

This work is the product of numerous conversations with physicians, nurse practitioners, patients, the public, legislators and others and a considerable amount of time reading articles, comments and searching for data related to the many topics. I appreciate the opportunity to submit this information to you in hopes of providing useful and valuable information that will help you come to the best decision for the people of Louisiana. Should you wish to discuss any of the information or inquire about working with our non-profit to deliver needed services to the community you serve, do not hesitate to contact me.

I have intentionally not provided my name as I wish to avoid the appearance of being anti-NP, anti-MD, anti-LSNB, anti-LSMBE, offending anyone, trying to get publicity for myself, or trying to take advantage of the crisis that our fellow Louisiana residents are facing. My concern is that some may be doing this very thing. My primary concern is to help the people in need that do not have access to quality, safe, and effective healthcare. If necessary and requested, I will reveal my identity and speak publically if it will help the people of our state, assuming there is a genuine interest in making things better and allowing me to participate in constructive and meaningful discussions. I thank you for taking the time to read and consider my report and pray that the legislature does the right thing that will protect the health and safety of all of our citizens.

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It is important to address some of the points raised during the April 22, 2021 House Health & Welfare Committee (H&W) proceedings.

POINT #1

It was stated/suggested that if H.B. 495 passes, it will not affect anything other than not having to pay. i.e. “it is education, laws and state nursing board” that “keep me in my lane”

I Respectfully DISAGREE.

The Collaborative Practice Agreement (CPA) requirement is current Louisiana law. It is unclear if the NP, who made the comment of Point #1, realized this fact. The CPA can not only help keep NPs in their lane but also become better NPs. I believe **the law was written in by the legislators with the intention of protecting the public and allow for a physician led team approach to healthcare.** Removing the requirement for all ARNPs to have a CPA and a collaborating physician (CP) will remove an important safety feature.

Rep. Hughes stated during the hearing that “collaboration is good thing.” I agree. Having the CPA is a good thing too, a great tool. From what was heard in the hearing testimony, the issue seems to be that the CPA tool is not being used in a manner to improve care or promote physician engagement and that is a bad thing. Just because it is not currently being used as it should by many nurse practitioners (NPs) and CPs does not mean we should eliminate it or all the possible benefits it can bring to NPs and more importantly, the public. Do not throw the baby out with the bathwater.

Instead, the CPA and its language needs to be fixed. It is unclear if this is the responsibility of the legislature. It seems most logical that doctors and nurse practitioners work together through their respective regulatory boards i.e. the Louisiana State Board of Medical Examiners (LSBME) and the Louisiana State Nursing Board (LSNB), to assure that there are specific requirements that address the many legitimate concerns that were raised by both NPs and doctors. Specific guidelines and requirements need to be made clear such as:

- 1) The number of charts that will be routinely reviewed by the Collaborating Physician and a minimum number of hour(s) that the NP and collaborating physician must communicate each month to discuss the chart review, specific cases, or diseases that the NP may benefit from and allow the NP to ask any questions.
- 2) The fee (if any) that will be charged for the services of the Collaborative Physician’s Services and how it is based i.e. flat fee amount, dollar amount per chart reviewed, combination, etc. These should be published to allow other NPs and CPs see what the averages are to make it more competitive and allow transparency. The regulatory board could provide a guide of minimum and maximum charges allowed for CPAs and any deviation would need a waiver.
- 3) Identifying and requiring the NP and CP to list metrics that will be measured and tracked for quality control and improvement (and that can be compared to other NPs

- to give comparisons). These could be adjusted for the specifics of the particular practice setting and patient population.
- 4) Any other services provided including but not limited to: assigning reading assignments, education, on-site or in-person visits and supervision if agreed, anything that promotes the exchange of useful knowledge, makes NP better prepared, and improves patient care, etc.
 - 5) If collaborating physicians are exploiting NPs (as may be alleged) financially and not providing services to NP, these persons need to be reported and disciplined. This is consistent with existing statute Title 46, PROFESSIONAL AND OCCUPATIONAL STANDARDS Part XLV. Medical Professions Subpart 3. Practice Chapter 79. Physician Collaboration with Advanced Practice Registered Nurses, Subchapter C. Standards of Practice §7915. Responsibilities, Compensation Arrangements, C. that states:

“..A collaborating physician shall be mindful that a CPA is not an option for an APRN; rather, it is a requirement of state law. Any attempt to exploit such requirement by way of compensation arrangements for performing no professional services, merely serving as a CP under a CPA, or for an amount that is not consistent with the FMV of the services provided to an APRN under a CPA shall be viewed as unprofessional conduct.”

Both the Louisiana State Board of Medical Examiners and the Louisiana State Nursing Board must educate their members of these rules and should a physician be guilty of breaking the law, the Louisiana State Board of Medical Examiners must proceed with appropriate disciplinary action.

We do not know if this perception of collaborative physicians not providing education, chart review and other valuable and needed services for a NP to learn and become a safer and better provider, as was reported by a handful of NPs during the April 22, 2021 hearing, is limited to only a small handful of cases or whether it is widespread. More data is needed to determine if it occurs and to what extent. We do not know what percentage of NPs experience this problem or whether in fact it is a problem at all. Before any definitive conclusions or decisions are made, we owe it to NPs, MDs and especially the public and the safety of the public to find out if it is a widespread problem, isolated problem, or a misperception.

It would also be important to get data to see how many NPs currently practice directly under the supervision of a physician in comparison to NPs that practice independently under a CPA. It is unclear how many NPs would be affected by changing the CPA requirement. What percentage of NPs practice in a subspecialty already under the direct supervision of a physician and what percentage practice alone without direct supervision? Remember the CPA only requires supervision in the form of collaboration and not necessarily direct supervision.

As Rep. Cox so passionately expressed, “nurses and doctors need to come together.” Our legislators understand that our patients benefit when each member of the physician led team brings his or her education, skills, training, experience, and special skill set to the patient. As was stated numerous times, this is not about physicians against nurse practitioners or vice versa, it is about patient care. The medical community must take ownership and fix this. Legislatures understand that the path to independence and **a Better System is through Education, Not Legislation.**

POINT #2

How many NPs would be negatively affected by changing the CPA requirement?

It is hard to say because we do not have complete and unbiased data to know how many NPs work in various settings i.e. clinics or specialty practices under direct MD supervision vs. independently with CPA. There are potentially more NPs that could be negatively impacted by changing the law. It would be prudent to collect and review this data before making any permanent decision. We do not know what percentage of NPs work under the direct supervision of physician or in physician and medical practices that would not be affected in any way. These NPs currently pay no CPA fee, yet receive valuable supervision, quality review and education and continued training by working with physicians, often the proper way a constructive and beneficial CPA should be used by all NPs. If the CPA requirement is removed, these benefits may not occur and NPs could suffer, ultimately hurting patients.

POINT #3

It is unsafe to allow a freshly graduated NP to care for the public without direct physician supervision.

Depending on whom one asks, the answer may vary. But if one uses common sense and good judgment and look at the facts, the answer is clear, most, if not all, would **AGREE with Point #3.**

The difference between the education, training, and patient care experiences is significant between a physician who completes medical school and a residency program and a NP who completes NP school.

By the time a physician finishes college, medical school, and a residency program and before he or she is even allowed to sit for specialty certification, the medical doctor has spent about 11 years and had approximately 9,000 to 16,000 hours of clinical time interviewing, examining, and treating patients, often with direct supervision by specialists in the specialty they choose to practice.

In addition, there are 4000-6000 hours of classroom teaching, lectures, and conferences. Most of this is didactic lectures with back, and forth interaction with the medical students asking questions and professors providing real life experiences and addresses specific questions. These professors are paid staff members of the medical school's faculty who are reviewed by the medical school and its students through regular evaluations to make sure they meet the standards to provide quality lectures and produce well educated medical students who can become effective doctors who practice safe and quality medicine. If successful, the physician then practices in his or her specialty. Should the MD wish to practice in a different specialty, the MD would have to return and do a residency in that different specialty that would take 2 years or more, and thousands of clinical hours, depending on the specialty.

In contrast, a NP must complete 4 years of college and 2 ½ years (6 ½ years total) of NP school that includes, not in addition to, 500 required "clinical" hours. To specialize, the NP may be required to do additional clinical time. If the CPA is no longer a requirement, the NP could see patients after only 500 hours of "clinical" hours and it is unclear the quality of these hours when compared to a medical student and resident. Are the NPs an integral part of the care team when doing their "clinical hours" or are they simply observing? The experience and quality of learning differs significantly. I am told by a NP, it could be either and that there is no distinction between the two; they both count towards the required minimum 500 clinical hours to graduate. It is my understanding there is no record of the specifics of the hours documenting if the time was spent integrally involved, observing or how many patients were seen.

When a medical student completes medical school, he or she has completed thousands of clinical hours but is not allowed to practice independently. This does not count any of the approximate 10,000 hours of integral involvement of being the primary treating physician during residency.

Another important difference is medical schools and residency programs have physicians and other experts in their areas of expertise on their staff that have been vetted and available to provide supervision, information and guidance to the student and doctor in training. The medical school and residency programs have "slots" that students and MDs still in residency fill. NP schools must "create" their own slots. **NPs do not have a residency or anything that comes close to comparing with a residency program, which is the most important part of medical training prior to one practicing independently.** It is my understanding that NP students must arrange preceptors on their own.

According to a Google search and numerous other websites, there seems to be a considerable difference between the qualifications i.e. GPA, admission rates required in admission to medical school vs. NP school.¹²³ A few points to understand:

¹<https://www.shemmassianconsulting.com/blog/average-gpa-and-mcat-score-for-every-medical-school>

² <https://www.nursingprocess.org/gpa-to-get-into-nurse-practitioner-school.html>

³ <https://thriveap.com/blog/fnp-acceptance-rates-schools-south> (Retrieved May 4, 2021)

- 1) NP average grade point average (GPA) is unknown, as no listing of NP schools with their average GPA of admitted students was found as was with medical schools, but say many require 3.0 minimum (could be lower at others)
- 2) Medical school GPA are 3.64 science, 3.79 non-science and 3.71 average.
- 3) Seems many NP schools will accept if meet criteria and decline if they don't, although at least one NP School (WVWC) will still provisionally admit i.e. report of 96% and 100% admission rate
- 4) Medical schools will decline many students with higher GPAs that are "qualified"
- 5) Hard to find overall admission rate but numerous NP schools (at least in south, will accept most or all applicants who meet criteria)
- 6) Medical schools accept 41% of all applicants, and 41% of all interviewees (Google).
- 7) It is unclear whether NP schools interview applicants, and if so, how many do? This often helps determine the appropriateness of the candidate as a health care provider and if they are suited for health care.
- 8) NP students have a much lower threshold to meet for admission to a NP school than a US medical school. Many NP schools seem to simply be trying to make sure they fill up the slots (accept 80%+, 90%+, 100% of applicants) whereas, medical schools reject the majority of their applicants.
- 9) Medical schools not only have higher GPA criteria but take into consideration many other criteria to see if the applicant is better qualified than just anyone who meets a specific criteria as GPA or degree such as letters of recommendation, extracurricular activities, volunteer work, and interviewing of the candidates. Many very capable applicants who would likely be outstanding medical doctors are not accepted to medical school because schools wish to produce only the best doctors who will represent their schools the best, and provide the best care for their graduates' (MDs') patients.

There is also significant variation between the clinical experiences any one NP student may have at one NP school, as compared to another NP student at a different NP school. There can be significant differences in:

- 1) The knowledge base and teaching style of the preceptor
- 2) The ability to get a preceptor that the NP student wants
- 3) The ability of the NP student to get a rotation in a particular area of medicine
- 4) The number of patients one might see when in contact with different self-selected preceptors

- 5) The amount of “teaching” that the preceptor gives you. Many of them are practicing providers who do not have full time academic positions and do not give the same time to teach. In comparison, if a residency does not provide enough teaching or there is not proper supervision, it can lose its accreditation.

***There seems to be a lack of a minimal standard of uniformity and consistency to ensure proper education of NP students and a concern that NP school graduates are not properly prepared to safely care for patients without significant additional training.**

There is also a significant difference in the lectures and teaching between medical students and NP students. Speaking with NP graduates, it appears that one can graduate from a NP school and be eligible to become certified with very few didactic lectures. Much of all “learning is independent and done online” without real time interaction with a professor. It is unclear if those who prepare the online courses are vetted and evaluated by a recognized national accreditation body or if they are subject to methodical evaluations by the school or students.

Unlike medical schools where students at every medical school get a certain in-person, or real time, core of the same information for uniformity and to meet a minimal standard regardless of where one attends medical school, there appears to be a wide variation between what one student gets at one NP school and another. One example is what a NP explained. During her entire NP education of 2.5 years, there was only one semester where clinical exam occurred in person under the supervision of a school “professor” and there was 4-6 times during that semester that it took place in person lasting 1 ½ hours each time.

The same discrepancy appears to be true with clinical hours in medical school and NP school. Not only are the attending physicians in medical school vetted and evaluated and designated by the medical school to be qualified and able to provide direct supervision and teaching to medical students, but also there is a core group of rotations that all medical students go through to be certain that every medical school graduate receives a minimum exposure to a certain number of particular specialties and patients i.e. medicine, surgery, OB/GYN, pediatrics, psychiatry, etc.

In contrast, NP students’ clinical experience can vary widely. It is possible that some graduates receive little or no exposure to certain specialties and may get little to no direct formal teaching from the preceptors. It is unclear what process, if any, that NP schools have to evaluate the quality of the preceptors, or the quantity of patients and the type of patients i.e. pediatric, elderly, respiratory, surgical, medical, etc. Again, great variation.

When complete, a **doctor can have 10, 20 or 30 times more Clinical Hours of Medical Training than a NP Graduate** may have. This is the reason why many believe medicine should be physician led. This is not a knock or put down on NPs or other members of the care teams. They are an integral part of the healthcare team. **The problem is NOT with NPs, the problem is with independent practice without physician supervision (oversight) that would place the**

public's health and safety at risk, which is what would happen if H.B. 495 passes. It is not about NPs or MDs, it's about the public and the health and safety of the public.

The “minimal” clinical experience NPs have when they complete their studies should scare anyone. As a physician, I remember graduating from medical school and became officially a medical doctor (MD). If any state was foolish enough to allow me or any other newly graduated MDs to practice medicine without supervision, they should have been impeached. As a doctor, I knew it would have been unsafe to practice unsupervised medicine at the point.

Even though as a medical school graduate, I had at least 5-10 times more clinical hours than most every NP graduate, more didactic lectures, more high quality paid medical teaching staff professors who spent quality time teaching, I knew enough to know it was not safe for the public to practice unsupervised. The medical boards and the state legislatures also knew that a doctor fresh out of medical school was not prepared to practice unsupervised medicine. One must ask, **if a medical school graduate with more education and 5-10X more clinical hours than a NP graduate cannot safely practice unsupervised medicine, why would anyone believe a NP with only a fraction of the education and clinical hours can?**

It is unfair to expect anyone, NP or MD, to be able to practice independently in a safe manner with only a few thousand “integrally involved” clinical hours, let alone only 500 or 1,000. Medicine is complicated and there is a lot to know. It takes time. One never knows everything. We continue to learn throughout our careers. But there is a certain basic minimum that one must know before knowing enough to practice safely. The point is **You Don't Know What You Don't Know!** What scares me is that NPs don't know what they don't know. The very fact that some believe that a NP graduate can safely care for a patient unsupervised by a physician tells me that they have not had enough clinical experience or do not understand enough about medicine to appreciate how little they know about the complex world of medicine. To be fair, there are many NPs who have practiced for years, understand this point and will admit that it would have been unsafe for them to practice unsupervised by a physician for the first few years of practicing.

Legislatures in over half of the 50 states, including Louisiana, understand this and is the reason why they continue to require NPs to practice under the supervision of physicians through CPAs. Even other states that have relaxed rulings still have physician supervision requirements for a certain amount of time. They understand the value and importance of physician led health care. Although not ideal and potentially harmful, many states with provider shortages and access issues are taking a chance. Since we do not know what will happen with unsupervised NP care without physician oversight, no one truly knows. It has been stated that there are “absolutely no studies that show nurse practitioner safety and efficacy when practicing independently.”⁴ Before anyone assumes any study is believable, it is important to read it and consider the design of the study, who did it, who do they work for, what if any financial conflicts

⁴ <https://www.physicianspractice.com/view/effects-nurse-practitioners-replacing-physicians>

may exist, other studies done by the investigators and the quality of those studies, if it was a prospective or retrospective study, if there were enough data points i.e. patients, diagnoses, outcomes, the strength of the study, whether the study is comparable to one's particular situation, etc. The point is there are studies sometime cited as proof that are flawed and unreliable and one should be cautious assuming just because it is a study, it is worth any value. Of course if a study can withstand critical thinking and well thought out and legitimate scrutiny, it is worth consideration.

In 2020, Florida and California passed legislation to relax scope-of-practice laws for nurse practitioners (NPs)⁵

- 1) Florida's new law went into effect July 1 and allowed NPs to practice independently, after completing 3000 hours of practice supervised by a physician in the past 5 years.
- 2) The bill in California, which will take effect in January 2023, requires NPs to work under the supervision of a physician for 3 years before practicing independently

During the April 22, 2021 hearing, NPs testified that by changing the law, nothing in their practice will change. Two points, #1 this is not true because it will remove the CPA requirement that can protect the health and safety of the public. #2 if it will not change their practice, then what is the rush? Is it simply a financial issue? Temporarily suspend CPA costs or place a temporary limit on the fee charged. It is a valuable service when used appropriately and should be paid as it helps NPs provide better care and become better providers which in turns results in better patient outcomes and health. This is not about NPs or MDs, it should be about patients' health and safety.

Continue to practice and treat patients under while we improve the CPA process and gather data. Why should we change things if it will not change things? The point is it will change things and remove **an important feature that our legislature realized long ago and has respected and defended** when care and the safety and well being of our citizen was threatened.

There are other ways to increase access to quality care without removing the physician led healthcare that has been delivered to the public. This includes more physician care to MCD and rural patients. **I am happy to discuss with anyone, who is seriously interested in helping those in rural areas, how a non-profit initiated project can provide care to anyone who wishes to see a doctor.** There are options for MCD, uninsured and insured patients, often at no cost to the patient, and sometimes free. MDs, NPs and the medical communities need to work together to solve our state's health related problems.

Another important point to consider is whether NPs should be regulated by the Louisiana State Board of Medical Examiners. The common perception is that **nurses do not practice medicine, only doctors can practice medicine.** Doctors have practiced medicine for hundreds of years and

⁵ <https://www.medscape.com/viewarticle/943940> (Retrieved May 1, 2021)

organized medicine has evolved over more than 100 years. The first medical school in the United States started in 1765 while the first nurse practitioner school started in 1965. Perhaps that is one reason **why the curriculum of medical schools is so much more developed and the faculty is better vetted, provide more consistency and medical students are so much better prepared than NP graduates.** In fairness to NPs and NP school, medical schools and doctors have a 200 year head start over NP schools and NPs; it takes time. It takes time to develop a school that produces a consistent and uniform graduate class that possesses sufficient knowledge, to teach and prepare a person, who will be responsible for another's health, and have the knowledge and experience necessary to provide quality care. **If NPs are going to start practicing medicine, it would behoove the legislature and the public to have them regulated by the Louisiana State Board of Medical Examiners** as opposed to the state nursing board (or both). The LSBME are the experts overseeing anyone who evaluates, diagnoses and treats a patient i.e. the practice of medicine. **We should not experiment with patients just because they are poor and need help. We should not make a change that could harm patients until we have conclusive proof from unbiased, objective, well designed, prospective studies.** I applaud efforts to do research and try to fix problems facing our communities. But until there is sound proof based on research as described above, we need to **help these patients with established healthcare that has been practiced and has been accepted by the medical community and public for decades.**

POINT #4

During the past year, a CPA was not needed due to waivers brought on by the public health emergency (PHE) and “there were no bad outcomes”, and no increase in malpractice claims or complaints thus implying that it proves that unsupervised (no CPA requirements) and allowing full practice authority is safe and warranted.

I respectfully DISAGREE.

This line of reasoning does not prove anything. I was not provided any data to support the claim of Point #4 to review the data and determine who provided it and the reliability of the data. Assuming there were no increases in complaints or claims, there are many possible reasons to explain it other than concluding it was because NPs provide proper care without physician oversight:

- 1) Given the PHE, there was a large reduction in outpatient visits. The Commonwealth Fund reported a reduction of approximately 60%⁶ early in the pandemic. Assuming no other factors changed, one would expect a 60% decrease in complaints and claims. No one mentioned that this occurred.
- 2) Acquiring this data can be hard. It often does not show up in the National Data Bank as it is should.

⁶ <https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits> (Retrieved May 1, 2021)

- 3) Medical malpractice claims often are not immediately filed or known. It may take one or two years or more for a lawsuit to be filed after it is discovered that there was improper care.
- 4) Given the PHE and the “hero status” placed on physicians, nurses, and other health care workers, it is very possible that patients have a greater appreciation of all health care workers and are less likely to file a complaint or lawsuit.
- 5) It is unclear if any protection afforded to health care providers (physicians, NPs, etc.) prevent suits or raises the threshold for lawsuits
- 6) According to a recent Journal of Healthcare Risk Management article “**More claims naming PAs and APRNs** were paid on behalf of the hospital/practice (38% and 32%, respectively) compared with **physicians (8%, P < 0.001).**” That’s **300% relative increase** (32% vs. 8%).⁷

Broad statements that there were “NO” bad outcomes seem to be opinion and not based on facts. Bad outcomes occur on a regular basis. Persons making such statements tend to not be properly informed or do not fully understand what they are saying is often incorrect.

POINT #5

Because 8 of the top 10 Healthiest states have laws that allow NPs full authority, it shows/implies that NPs somehow causes the health of the state to improve.

This is a FALSE assumption or hard conclusion to make. To imply or assume this is the reason is **neither prudent nor correct.**

“According to Sophia L. Thomas, a licensed NP in Louisiana, and president of the American Association of Nurse Practitioners: eight of the top 10 healthiest states: Colorado, Connecticut, Hawaii, Iowa, Minnesota, Rhode Island, Vermont, and Washington, have full practice authority laws, which enables patients to directly access NP care without restrictions.”^{8,9}

While it is true that 8 of the top states do allow NPs full practice authority, what was not mentioned during the initial portion of the hearing was:

- 1) ALL 10 of the 10 **Healthiest** States happened to be in the **Top for Income** (4 in the top 10, 8 in the top 20 and 10 in the top 25).¹⁰ This could be a much more likely reason for the high health ratings.

⁷ <https://pubmed.ncbi.nlm.nih.gov/32362078/> (Retrieved May 4, 2021)

⁸ <https://www.nurse.com/blog/2019/09/10/np-shares-insight-full-practice-authority-laws/> (Retrieved May 1, 2021)

⁹ <https://thehill.com/blogs/congress-blog/healthcare/453380-nurse-practitioners-are-the-solution-to-health-care-provider> (Retrieved May 1, 2021)

¹⁰ https://en.wikipedia.org/wiki/List_of_U.S._states_and_territories_by_income (Retrieved May 1, 2021)

- 2) 9 of the 10 **Least Healthy** states are in the **Bottom 10 states for Income** (#41, #42, #43, #44, #45, #47, #48, #49 and #50), with the other #34 out of 50.¹¹
- 3) 8 of the top 10 **Healthiest States** happen to be amongst the top 20 states for number of **active Physicians** per 100,000 population.¹²
- 4) Of the top 10 healthiest states, 5 of them had some of the lowest proportions of NPs with per 100,000 population (25th, 29th, 33rd, 37th and 43rd)¹³
- 5) Of the lowest or **Least Healthy States**, half of them had some of the **Highest Proportion of NPs** for every 100,000 population.¹⁴
- 6) 6 of the top 10 **Healthiest States** were in the **Top 11 states in Education achievement** of all states.¹⁵

It would be premature and unwise to assume that the reason for these top 10 states having the healthiest populations according to the report is because NPs can practice with full authority. We do not know if this is true. One might just as easily state that the reason for the healthiest states is that 8 out of the top 10 are amongst the states with the highest number of active physicians. But while that statistic is accurate, it does not prove any correlation any more than the correlation that the NPs may have been attempting to make. The point of these statistics is not to attack NPs but to point out the information presented at the April 22, 2021 Health & Welfare Committee only gives part of the story. Perhaps NPs want it to be the cause and are allowing emotions to rule over hard evidence, sound scientific facts, and reliable statistical correlation. Many factors influence health. The number of proportion of physicians, number of NPs, education levels and income are all factors with income and education levels being two of the most important in determining one's health. When it comes to important decisions, one must not be emotional and base things on soundbites or incomplete information.

One must investigate and look into the many factors that can influence a certain situation to exist or particular outcome to occur. I point this out because during testimony, I heard legislators make the comment that "some care is better than no care. While this on the surface seems simple and reasonable, we must not rush to change until we understand the potential implications, many of which can be devastating, that could occur."

As physicians, we live by the motto "**Do No Harm.**" I heard a food analogy used. Something to the effect of steak or bread. I will use a similar analogy. If one is thirsty and wants a bottle of water or Gatorade but neither is readily available, yet someone offers you water from a well, do

¹¹ https://en.wikipedia.org/wiki/List_of_U.S._states_and_territories_by_income (Retrieved May 1, 2021)

¹² <https://www.beckershospitalreview.com/workforce/50-states-ranked-by-most-active-physicians-per-100-000-population.html> (Retrieved May 1, 2021)

¹³ <https://www.beckershospitalreview.com/hospital-physician-relationships/which-states-have-the-highest-concentration-of-nurse-practitioners.html> (Retrieved May 1, 2021)

¹⁴ <https://www.beckershospitalreview.com/hospital-physician-relationships/which-states-have-the-highest-concentration-of-nurse-practitioners.html> (Retrieved May 1, 2021)

¹⁵ https://en.wikipedia.org/wiki/List_of_U.S._states_and_territories_by_educational_attainment (retrieved May 2, 2021)

you drink it? Maybe? You are thirsty. Well water seems to be safe and good enough. Some water is better than no water at all, right?

If it turns out the water is not what we think and turns out not to be as good i.e. contaminated with a parasite or other organism that causes severe diarrhea and possibly death, the person (public) would be harmed by something that reasonably should have been better than doing “nothing.” Is something better than none in this case? I am concerned about our citizens because when I set emotions aside, I realize that even the best intentions do not always result in good outcomes. This does not mean we do not care or should not do something, it is just to emphasize that we must be prudent. The medical community needs to prudently act to fix the manner in which CPA are made and operate to assure improved access, quality, and not disproportionately harm those most at risk. Some may argue that “rationing health care by restricting access to physicians and substituting lesser trained practitioners is very much a question of social justice.”¹⁶ No one is suggesting that this is the reason for trying to pass H.B. 495, but one must consider the perception some may get, particularly when having no physician involvement/oversight has not been demonstrated in reliable, well designed, objective and unbiased studies.

POINT #6

By allowing full practice authority, a higher proportion of NPs will locate and practice in rural areas to meet the unmet need.

Available data seems to contradict Point #6. Whether a NP works in a state that does not allow independent practice of NPs (25+ states including Louisiana) or allows full practice authority of NPs, the majority of NPs locate in the big cities.¹⁷ **Only about 18% of NPs practice in the rural setting.**¹⁸ Interestingly, “states that protect physician-led care have more physicians and NPs serving them than do states without requirements for physician-led team-based medical care.”¹⁹ H.B. 495 passage would eliminate physician led team based medical care.

If the goal is to address a provider shortage in rural areas, although not ideal, a consideration could be made to allow a lesser supervised form of care to exist only in rural areas. This could increase the number of NPs who would be willing to go to rural areas as opposed to the small percentage of NPs who currently practice in rural areas. The downside would be that we would be condoning that it is OK to allow underserved, disadvantaged, and poor citizens to receive a lesser form of supervised care. This could be interpreted as discriminatory, or racially biased, as often a disproportionate number of minorities and poor live in rural areas. If we acknowledge that unsupervised care and no physician involvement is a lesser level of care or could cause harm

¹⁶ <https://www.physicianspractice.com/view/effects-nurse-practitioners-replacing-physicians>

¹⁷ <https://www.texmed.org/TexasMedicineDetail.aspx?id=52583> (Retrieved May 1, 2021)

¹⁸ <https://onlinenursing.duq.edu/blog/family-nurse-practitioners-meeting-health-needs-in-rural-> (Retrieved May 1, 2021)

¹⁹ <https://www.ama-assn.org/practice-management/scope-practice/independent-practice-nps-fails-solve-rural-access-problems> (Retrieved May 1, 2021)

to the public but want to allow NPs to practice unsupervised care in both rural and non-rural areas to avoid claims of discrimination for only rural areas, this would not help the problem of increasing the proportion of NPs in rural areas, as was stated earlier.²⁰²¹

In addition, many assume that a majority of NPs will in practice primary care, thus helping the shortage in primary care. According to a Primary Care Work Force Study done by the Oregon Center for Nursing Report:

“When considering the impact of the nurse practitioners in providing primary care in Oregon, policymakers may be tempted to rely on statistics that suggest 75 percent of the NP workforce is practicing in primary care. This is a gross overrepresentation and relying on a flawed estimated workforce could potentially leave patients and communities underserved. Careful analysis of multiple factors suggests only 25 percent of Oregon’s NP workforce are practicing in primary care”²²

Based on the above referenced sources, it appears that in at least one state only a small percentage of NPs practice primary care (25%) and nationwide it appears only a small percentage of NPs practice in rural areas (18%). Perhaps this is because NPs prefer to live in the city or non-rural areas and can make more income practicing in specialties and non-primary care.

Point#7

It was mentioned that the CPA was all about the money i.e. a mechanism for collaborative physicians to collect large fees while not providing services.

It is hard to know if this is true just based on anecdotal reports and without complete, demonstratable, and reliable data. It is important to get more information and data from all NPs with CPA and to see how many feel this to be the case and then to have the specifics of each case reviewed objectively by LSNB and LSBME.

It concerns me that the “only thing a collaborative physician does is collect a check” comment was made during testimony at the Health & Welfare Committee meeting. This comment makes it appear that all CPs are not providing valuable oversight, education, chart review services with recommendations for improvement etc. During the hearing, it was stated that collaborative physicians charged \$30,000-\$40,000 and even \$60,000 was mentioned. No evidence was provided demonstrating these amounts or the names of the alleged physicians involved, but these amounts seem much higher than the amounts typically mentioned. **\$500/month** was a figure that a couple persons I spoke with had mentioned.

²⁰ <https://www.texmed.org/TexasMedicineDetail.aspx?id=52583> (Retrieved May 1, 2021)

²¹ <https://onlinenursing.duq.edu/blog/family-nurse-practitioners-meeting-health-needs-in-rural-> (Retrieved May 1, 2021)

²² https://oregoncenterfornursing.org/wp-content/uploads/2020/03/2020_PrimaryCareWorkforceCrisis_Report_Web.pdf (Retrieved May 4, 2021)

“According to healthcare attorney Alex Krouse, who often works with nurse practitioners in setting up their own practices, NPs can expect to pay a physician anywhere from **\$5 to \$20 per chart reviewed. As a flat, annual fee.** He most commonly sees MDs paid anywhere from **five to fifteen thousand dollars per year.**”²³

We do not know if all CPA are dysfunctional as what was described on April 22, 2021 but we must find out and make sure it is corrected for the betterment of Louisiana. We need to push the LSNB and the LSBME to investigate, giving them time to collect and analyze the data, and determine if a problem exists. If a problem exists, measures need to be done to discipline those who violated existing rules and make changes to prevent it from happening in the future. If no inappropriate behavior is found, counseling those who allege inappropriateness should be done.

Many in the public and healthcare believe that physician involvement, whether direct physician care or physician led care, improves care and/or benefits patients. A patient survey found that 86% of respondents agree that patients with one or more chronic diseases benefit when a physician leads a primary health care team.²⁴ It is possible that the NPs that perceive no value from a CPA and involvement of a collaborative physician are not selecting the proper physicians to collaborate with or not including language in the CPA to ensure that they do receive value that benefits both them and their patients.

The issue of money and control or power was mentioned or implied during the Health and Welfare Committee testimony i.e. “...does nothing but collect a check.” It is interesting to learn that during an American Association of Nurse Practitioner (AANP) meeting, a slide was shown that listed AANP “Board Initiatives” which had two bullet points as follows:²⁵

- “Patients nationwide will have full and direct access to high-quality care and will choose NPs as their health care provider (emphasis added)”
- “NPs will have parity with physicians and other providers in reimbursement, payment, and government funding”

If NPs and the AANP are promoting elimination of the CPA, harming the public by removing the physician component requirement of law, to achieve greater financial reimbursement or receive taxpayer money, they are placing “collecting a check” ahead of what is in the public’s best interest. No one is making this claim but should this be the case, shame on them.

POINT #8

Nurse practitioners prescribe more antibiotics and opioids than physicians.

²³ <https://thriveap.com/blog/how-much-should-nps-expect-pay-collaborating-physician> (Retrieved May 2, 2021)

²⁴ <https://www.ama-assn.org/practice-management/scope-practice/independent-practice-nps-fails-solve-rural-access-problems> (Retrieved May 1, 2021)

²⁵ <https://www.texmed.org/TexasMedicineDetail.aspx?id=52583>

Point #8 was brought up at the hearing. It does appear that **Point #8 is supported by data.** (Particularly for opioids prescribing in states that allow independent prescribing authority for NPs)

Antibiotic stewardship interventions should target NPs and PAs given prescribing patterns. Antibiotics were more frequently prescribed during visits involving NP/PA visits compared with physician-only visits. NPs/Pas prescribed antibiotics over 40% more often than physicians in overall visits and about 13% more often for acute respiratory infection visits.²⁶

Opioid and other substance abuse is a serious problem in our state and country. Some have called it an opioid epidemic. A 2020 Journal of General Internal Medicine article addressed the prescribing patterns of various types of “providers.” It was stated:

“Among 222,689 primary care providers, 3.8% of MDs, 8.0% of NPs, and 9.8% of PAs met at least one definition of overprescribing. 1.3% of MDs, 6.3% of NPs, and 8.8% of PAs prescribed an opioid to at least 50% of patients. **NPs/PAs practicing in states with independent prescription authority were > 20 times more likely to overprescribe opioids than NPs/PAs in prescription-restricted states.**”²⁷

States considering allowing independent practice of NPs who are concerned about the opioid epidemic or are concerned about their citizens should take a good look at this difference in prescribing patterns of between NPs in independent vs. prescription restricted states. In the independent prescribing authority state for NPs (Connecticut), Heather Alfonso, an APRN “**wrote 8,705 prescriptions for opioids** and other Schedule II drugs in 2012 — the most prolific prescriber among all Connecticut practitioners, including pain specialists and other physicians, according to Medicare data compiled by ProPublica. She wrote more prescriptions for the opioid Exalgo than any other Medicare provider in the country, and was the seventh-highest prescriber nationally of Oxycontin, writing more than twice as many prescriptions for that narcotic as the next-highest prescriber in Connecticut. She also was the 10th-highest prescriber nationally of Avinza, a morphine product.”²⁸

If one is curious, advanced practice clinicians (NPs/PAs) **ordered imaging 47% more** than primary care physicians in episodes of care.²⁹

²⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047413/>

²⁷ <https://pubmed.ncbi.nlm.nih.gov/32333312/>

²⁸ <https://www.courant.com/health/hc-high-opioid-prescriber-20150220-story.html> (Retrieved May 4, 2021)

²⁹ <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1939374> (Retrieved May 4, 2021)

Some argue that NPs will reduce costs of healthcare. Even if we ignore potential care issues that could harm patients and ultimately end up costing patients and society more in the long run, it is unclear if costs will be reduced. While it is true that NPs tend to make less than a physician. The provider component is only a fraction of healthcare costs. Other factors such as blood tests, X-rays, CT scans and other imaging studies, referrals to consultant that a NP or MD orders, etc. often contribute much more to healthcare costs than the cost of the provider. When one factors in the costs of the additional imaging tests ordered by NPs or increased rate of referrals, it is unclear what the ramifications on care and overall costs at the population level will be.³⁰

It is interesting to learn that in an American Journal of Managed Care article, “90% (of nurse practitioners who responded to a survey) believed that it was acceptable to attend lunch and dinner events sponsored by the pharmaceutical industry. Almost half (48%) stated that they were more likely to prescribe a drug that was highlighted during a lunch or dinner event.”³¹ This does not prove NPs are easily influenced or lack the ability to make sound prescribing (or other health related) decisions, but **it may be worthwhile looking into it further as those responsible for the health, safety and well-being of the public must not be easily influenced by pharmaceutical sponsored lunches or dinners where biased studies might be presented (NP or non-NP)**

The Journal of Child and Adolescent Psychopharmacology reports Psychiatric NPs and non-psychiatric NPs appear to have significantly increased the proportion of prescribing psychotropic medications while physicians are prescribing at a lower rate. (50.9% increase and 28.6% increase respectively). By contrast, the proportion of psychotropic medications prescribed by psychiatrists and by non-psychiatric physicians declined.³²

The conclusion in the article was that “NPs, relative to physicians, have taken an increasing role in prescribing psychotropic medications for Medicaid-insured youths. The quality of NP prescribing practices deserves further attention.”³³

³⁰ <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1939374> (Retrieved May 4, 2021)

³¹ <https://pubmed.ncbi.nlm.nih.gov/21291293/> (Retrieved May 4, 2021)

³² <https://pubmed.ncbi.nlm.nih.gov/29641238/> (Retrieved May 4, 2021)

³³ <https://pubmed.ncbi.nlm.nih.gov/29641238/> (Retrieved May 4, 2021)

Proposed Solutions:

The following section is inspired by Rep. Ivey's comments. It was refreshing to hear a legislature challenge those in the audience to "**Bring Solutions.**" His comments were refreshing. I was unable to attend but was able to view the video online and am heeding his request.

With this in mind, **I believe it is important to establish some basic "ground rules"** to keep in mind whole trying to come up with solutions:

- 1) Identify the problem
- 2) Be objective
- 3) Collect objective, unbiased data
- 4) Use objective, reliable, and unbiased data to guide decisions
- 5) Be passionate but resist letting emotions cloud one's good judgment
- 6) Come up with numerous possible solutions or improvements while assuring safety
- 7) Put aside our personal interests. Instead, place the best interests of the people suffering, that we claim we are attempting to help, ahead of our own personal interests. This goes for NPs, RNs, AAPN, LSMS, MDs, the nursing and medical boards, and members of our state's great legislature.
- 8) Work together as opposed to against one another.
- 9) Educate one another
- 10) Criticize the process, not the people
- 11) Improve the process.
- 12) Improve communication
- 13) Improve education
- 14) Use critical thinking to guide decisions
- 15) Have mechanism to correct or reverse bad decisions back to prior conditions
- 16) Re-evaluate and adjust as necessary
- 17) Be respectful
- 18) Remove inefficiencies that do not add value

The way I understand it, **the problem and many of the concerns are as follows:**

- 1) People, particularly those in rural areas, find it difficult to access quality healthcare in a timely manner
- 2) Shortages in healthcare "providers" i.e. physicians, nurse practitioners
- 3) Quality concerns
- 4) Misinformation
- 5) Costs of Collaborative Practice Agreements to NPs
- 6) CPA needing attention, it is not being used in a manner to improve quality, knowledge and health care delivered to the people in need as was intended
- 7) Limited unbiased, reliable, and objective data to make confident conclusions
- 8) Non-physicians practicing medicine
- 9) Who should regulate those who evaluate, diagnose, treat and prescribe medication

SUGGESTIONS to Improve

Since the hearing, I have spoken with numerous physicians, nurse practitioners, registered nurses, legislators, community leaders, patients, and the public. Based on these discussions and research done, I have identified numerous areas that could be addressed and that would result in improves that would help all of us in our respective positions and most importantly help patients, particularly those who are underserved, poor, and in need. The following is recommended/suggested:

- 1) **The Collaborative Practice Agreement (CPA) should not be eliminated. Doing so will not correct the access problem and may in fact harm those we are trying to help.** According to a NP who was asked, “It would not be fair” to the public. It would essentially allow someone who is not prepared or qualified to “practice medicine” without any involvement by a physician. This is dangerous and should scare anyone who understands the complexity of medicine and the minimal training a newly graduated NP possess relative to a physician. This is not a put-down on NPs, no one (including MDs) with only 500 hours of “clinical hours” is safe to evaluate, treat and prescribe medications to patients. A NP suggested that newly graduated NPs be under direct supervision by a physician for a minimum period of time (i.e. 3 years) until it is determined they are clinically able to work independent with a CPA. Whomever makes the determination that the NP is able to work independent should have some responsibility/liability if determination was negligently determined.

Eliminating the CPA could also harm NPs that have healthy CPAs in place where collaborating physicians (CPs) review charts for quality purposes and then provide quality improvement education through communication/education to the NP he/she works with. Items to improve and strengthen CPAs so that all NPs can benefit include:

- a. Require NP and CP to state on CPA the number of hours of education/communications they will have on monthly basis for education and quality improvement purposes.
- b. Clearly state on CPA the number (or percentage) of charts that will be reviewed by the CP each period (weekly, monthly, quarterly). It would be prudent to have more charts reviewed early in the relationship to identify any issues or areas that need addressing and adjust as seen fit i.e. after 6 months or 1 year. Any changes must be reported.
- c. Regular calls/discussions between NP and CP discussing the findings of the chart review and addressing any areas of concern or that need improving. There should always be efforts for continual improvement. Log should be kept of times, subject matter and length of calls to be submitted to the regulatory body
- d. The NP and/or MD should keep a log of the number of calls or communications that NP has with MD and submit to regulatory body for tracking purposes

- e. Outcome data (specific metrics determined by regulatory body) should be tracked and submitted on regular basis to regulatory body
 - f. Flexibility to vary according to the specifics of the particular situation i.e. need of NP, education, experience, etc. If much variance, it must be explained and approved by regulatory boards.
 - g. Education of their members by the LSNB and LSBME of the CPA changes, the importance of the various parts and of completing them
 - h. Review, initially and periodically, the CPAs and to verify that measures were followed and any metrics were tracked and outcomes. Use data for quality and education purposes for individual NPs and all NPs in general
 - i. Enforcement of the rules by the regulatory bodies
 - j. Publish the number of CPA and the average amount charges paid. This will help other NPs and CPs know amounts and help negotiate rates.
 - k. Create a database of all physicians willing to be CPs (with rates) to make easier for NPs who are looking for CPs
 - l. Have NPs evaluate CPs and submit to regulatory body for quality and tracking
 - m. Have CPs evaluate NPs and give to regulatory body for quality and tracking
- 2) The LSNB and LSBME must be engaged, review CPAs submitted and determine if “acceptable” in terms of quality measures, proposed communication times, metrics, rates charged, and outcomes to track, etc.
- 3) **The LSBME should regulate NPs and anyone else who evaluates, treats, prescribes medications i.e. practices medicine.** This makes the most sense. Given the LSBME has the most experience with those practicing medicine. While it is understood a NP is technically a nurse, and the LSBN oversees nurses, the practice of medicine is not a traditional nursing function. **Once the nurse begins to enter an area that involves the evaluation, treatment, prescribing medications, etc., they have crossed the threshold where nursing ends and the LSBME should control.** If this is a major obstacle, then joint regulatory authority is a consideration.
- 4) **The NP schools/education system needs to be overhauled.** When one understands the variation amongst NP schools and the drastic contrast from medical schools that are much more established, he/she begins to appreciate the need for supervision. One can easily make a strong argument for more supervision. While this may not have immediate impact, it needs to be looked at immediately. The sooner changes are made, the better NP students can learn and become more prepared for the careers. While it will not give them the same education or training as a MD, it will make them less disadvantaged when caring for patients. If NPs truly want to have the same knowledge, training and level, be treated like a physician, and practice medicine, they would have to graduate from medical school and complete an accredited residency training program. **There really is no short cut.**

It appears that many NP students are being put in suboptimal situations by their NP schools that are not conducive to a thorough, consistent, and uniform, quality educational experience. This may explain why there is so much variation between NPs who graduate from different NP schools. **In order make the educational system fairer to the NP students** and better assure uniformity and a better grasp and understanding of a core curriculum, and ultimately produce better qualified, better prepared graduate NP students, the following are suggested:

- a. Require applicants to have practiced as a clinical nurse prior to admission to any NP school i.e. minimum of 2-3 years. This will allow the NP student to get more from the rotations, which is important given the low number of required clinical hours to graduate.
- b. **Require more clinical hours prior to graduation i.e. 3000-4000.** This would better prepare the NP for patient care and should improve patient safety. This would partially close the large gap between clinical hours of a medical student, who has not yet begun a residency program, and a NP. Keep in mind, even with this requirement the NP graduate would still lag behind a physician who completed a residency by about 10,000 clinical hours (and the associated teaching by specialists and experts in their fields)
- c. Didactic classes. These can be in-person or virtually. In person preferred. If virtually, they should be in real time to allow the important back and forth question and answer, format that occurs and contributes to better learning. The classes can be recorded for those who cannot attend in real time, but this does not relieve the school of having real time classes.
- d. The professor/lecturers should be experts in their fields and paid as part of the NP school's regular faculty. The faculty member should be vetted by the NP school initially and evaluated periodically (by semester, annually) by the school. Students should also be able to provide evaluations based on: content, quality, effectiveness, relevancy, ability to understand, and/or other measures as deemed necessary
- e. Professors should be required to have and post "office hours" for students to meet with professors i.e. questions, etc.
- f. NP school should provide a list of qualified MDs and NPs that have been vetted and are willing to serve as preceptors.
 1. Better define what a clinical hour or clinical contact is to avoid confusion
 2. These preceptors should be paid and on faculty of the NP school. This will create an understanding and/or obligation that they will serve as preceptors.
 3. Preceptors must be willing to teach, not just be followed around.
 - a. Watch clinician
 - b. Spend time presenting patient to preceptors
 - c. Observe preceptor interviewing and examining patient after NP student has
 - d. Spend time discussing patients' evaluation, H&P, and treatment and the whys
 4. Preceptors should be in various specialties
 5. Limit the number of NP students that 1 preceptor can have at any given time to ensure enough time to teach each NP student effectively

6. NP students should not have to call around and find someone who is willing to allow them to precept with them. i.e. a sign up list, or online request, from a NP school supplied roster
 7. If students have difficulty matching with preceptors, it will be NP school's responsibility to ensure preceptor options are available to NP students
 8. NP student rotations with preceptors must meet a certain minimum number of patient contacts
 9. NP student should be required to rotate through various core rotations that all NP students in the country will rotate through (consistency)
 10. NP students will be required to complete evaluations on preceptors at end of rotation i.e. rate rotation based on number of contacts, quality of teaching, involvement in the patient care, accessibility of preceptor, if felt not enough/too much supervision, etc.
 11. School will re-evaluate preceptors on regular basis (quarterly, annually) to assure meeting needs of students and providing quality rotations
 12. NP school should offer resources such that any NP student can get additional help if needed i.e. additional teaching of performing physical exam, unsafe clinical situations, etc. Self-learning is good, but early on, students must not be left alone to learn "everything" on their own or find preceptors willing to be preceptors. While self-learning is important, particularly in one's medical career, requiring a NP student to have to read most/all subjects without formal teaching/lectures and ability to have back and forth real-time conversations, to better learn, or requiring NP students to find their own preceptors may result in inadequate clinical experiences, a sense of debt or awkwardness in asking for or expecting a quality clinical experience, and puts them at a disadvantage and sets them up for failure.
 13. Tracking the ages and conditions, and number of patients they participate (with clear definition of what that means) in the care of (P) or observe (O), for every preceptor or rotation the student participates in and clearly indicating which and submitting to NP school who will maintain on file for 5 years after graduation and for tracking reasons.
 14. Track any, and all, procedures performed and submit to NP school who will keep on file for 5 years after graduation
 15. Tracking will allow analysis, comparisons, and provide data that over time that can help NP schools to continually improve and evolve into more efficient and effect teaching institutions.
- 5) Implement a Telehealth Network. I am very familiar with telehealth.. Telehealth has many benefits:
- a. Relatively simple to implement
 - b. **NP/PA integrally involved** in care at the patient bedside
 - c. Non-physician providers (NPPs) benefited from service and **became better providers**
 - d. Great tool

- a. For improved patient care
 - b. Reduction of unnecessary tests
 - c. Education otherwise not available to the provider
 - e. **Immediate impact** to current problem. (fastest to make difference)
 - f. Physicians delivered to rural areas. Paraphrasing what was mentioned at the hearing **“meat is better than bread but bread is better than nothing,”** with telemedicine **patients can have the meat AND bread, they do not have to settle or feel that they are being offered anything less than what others may get in the city or in an academic setting.**
 - g. Immediately address the “shortage” of doctors in rural communities
 - h. Almost immediately double, triple, etc. the workforce of physicians (or non-physician providers) who would offer services in rural areas or our state
 - i. There are non-profits wanting and willing to help residents in rural areas and those in need
 - 1. Organizations do not want to eliminate NP or PA positions
 - 2. Compliments NPs, MDs, and other providers
 - 3. Works as part of a medical team
 - 4. Provides logistic support and network organization
 - j. Goal is to improve the **quantity AND quality**, not just the number, of providers and healthcare
 - k. Reduce incremental costs of care
 - l. Allows medical community (not legislature) to solve health issues
- 6) Provide incentives to have MDs (or NPs/PAs) locate to rural areas. We have to think outside the box.
- a. Monetary
 - 1. Lump Sum or Monthly
 - 2. Directly to physician (or NP/PA)
 - 1. Board certified & eligible physicians
 - 2. Resident physicians
 - 3. Directly supervised NPs/PAs
 - 3. To residency training programs
 - 1. Conditional of physicians rotating in rural hospitals
 - 2. Locating supervising attending physicians to rural sites for resident teaching (i.e. satellite residency)
 - b. **Money in kind**
 - 1. Forgive student debt if relocate to rural area (underserved)
 - 2. Provide office space/clinic at no cost
 - 3. Waive/reduce licensing fees if rural practice
 - c. Non-financial
 - 1. Immunity from lawsuits
 - 1. More likely to offer services

2. Increase workforce
 3. Poor outcomes often related to poor resources
 4. Puts public's best interest ahead of plaintiffs' attorneys
 5. Effective during PHEs in disaster settings
2. Workforce Task Force
 1. Made up of health care experts
 - a. Medical knowledge
 - b. Economic knowledge
 - c. Leadership
 - d. Track record of proven effectiveness
 2. Set goal and timeline to deliver recommendations
 3. Accountability Built in (Skin in the Game)
 4. Willingness to see past natural bias
 - d. Offer resident physicians rotation opportunities
 1. Assist with patients now
 2. Provides exposure and learning experience to doctors who are MDs and are still in training under supervision of physician specialists
 3. Provides more educated and higher clinical experienced health care providers to underserved areas
 4. Increase likelihood of permanently locating after training
 5. Likely require additional incentives