Joint Informational Meeting

House Health Committee
House Professional Licensure Committee

Improving Access to Healthcare

March 7, 2024 at 1 p.m.
House Majority Caucus Room

1:00 p.m. Opening Remarks

- Rep. Frank Burns, Majority Chair, Professional Licensure Committee
- Rep. Carl Metzgar, Minority Chair, Professional Licensure Committee
- Rep. Dan Frankel, Majority Chair, Health Committee
- Rep. Kathy Rapp, Minority Chair, Health Committee

1:15 p.m. Panel One

- Janice Miller, DNP, CRNP, FAANP
  President-elect, Pennsylvania Coalition of Nurse Practitioners
- Emily McGahey, DM, MSN, CNM, FACNM
  Vice president and legislative co-chair, Pennsylvania Association of Certified Nurse Midwives
- Dan Warner
  Pennsylvania Psychological Association
- Hans T. Zuckerman, DO
  Pennsylvania Osteopathic Medical Association
- David Csikos, MD
  Pennsylvania Medical Society

2:15 p.m. Panel Two

- David Csikos, MD
  Pennsylvania Medical Society
- Nicole Stallings
  President and CEO, Hospital Association of Pennsylvania
- Eric Kiehl, APR
  Director of Policy and Partnerships, Pennsylvania Association of Community Health Centers

3:00 p.m. Closing Remarks

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Pennsylvania Coalition of Nurse Practitioners

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Testimony by Janice Miller, DNP, CRNP, FAANP
President Elect, Pennsylvania Coalition of Nurse Practitioners
Pennsylvania Professional Licensure and Health Committees Hearing
March 7, 2024

Good afternoon, Chairman Burns and Chairman Frankel, Chairwoman Rapp, Chairman Metzgar, and members of the Professional Licensure and Health Committees.

Thank you for the opportunity to provide testimony.

We're here today because of a crisis that cannot be ignored. Too many Pennsylvanians lack access to health care providers, especially primary care physicians. We must act now.

A Mental Health Story

I'd like to begin with a short patient story. A woman in her mid-thirties came to see me in the primary care office. She had moved to Pennsylvania from Boston. The patient took several medications prescribed by a psychiatrist in Boston. The psychiatrist in Boston stated that since she moved, she needed to establish with a psychiatrist and have her medications prescribed and managed by a psychiatrist in Pennsylvania. The patient couldn't find a psychiatrist locally that accepted her insurance or, even if she were paying cash…several hundred dollars…which she was willing to pay… that had an appointment available for three months. Without her medications she was making mistakes at work, arguing with coworkers that had always been supportive and now feared she would lose the job for which she moved to Pennsylvania. She cried in the office and said, "My life is falling apart, and I can't find anyone who can help me get my medicines and maintain the good life I've built here".

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This didn't occur in a rural, remote setting. This occurred at an urban, academic medical center. If she could not find help in this setting, how likely do you think a patient is to find a psychiatrist in a timely manner in a rural community?

Accessing mental health care helps avert behaviors that result in family upheaval, substance use, violence, and crime.

Graduate programs are training more psychiatric mental health nurse practitioners because the supply is desperately needed…because patients and families are desperate. But if these psychiatric/mental health nurse practitioners can't find a collaborator, it's all for naught.

Women's Health Care

Having a women's health nurse practitioner in a community is valuable on many levels. Lack of prenatal care is directly related to preterm birth and low birth weight which result in lengthy hospital stays for babies.

Over 100,000 women in Pennsylvania live in maternity deserts…more than 100 miles from women's health care. 100,000 women. For a visual, think of Heinz Field, or Lincoln Financial Field. Each of those stadiums holds 60,000 people. Neither alone could house all the women in maternity deserts in Pennsylvania.

Think about how frequently you hear about a baby being born…in your family, or that of your colleagues, church members, neighbors. Losing even one of those moms to a pregnancy related death would be unacceptable. Yet Pennsylvania's maternal death rate is more than twice the national average. (32/100,000 vs 82/100,000)

Allowing full practice authority for nurse practitioners will improve access to prenatal care where moms who are at high risk can be identified and plans implemented to lower maternal death rates. We all agree that not one maternal death is acceptable, let alone twice the national average.

Primary Care

Granting nurse practitioners Full Practice Authority will impact the astounding workforce shortage in primary care and improve access in underserved areas.

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Patients constantly face long wait times for new patient appointments as well as follow up care all across the state in urban, suburban and rural areas.

For decades, nurse practitioners have safely managed patients. In primary care, everyone's goal is to manage health problems before they become complex illnesses. This improves the quality of life for people and families, enabling them to continue to have productive lives in the workforce, their communities and society. Nurse practitioners are also skilled at managing chronic illness care.

11% of the population has diabetes and thus at high risk for life changing, disabling complications such as stroke, heart attack and foot amputation…. These are mostly avoidable or minimized if managed well in a primary care setting.

Nurse Practitioner Education and Licensing

I'd like to pivot for a moment and describe preparation for practice as an NP.

Almost all NP students have been nurses for a length of time and bring tremendous practical experience to the graduate track they choose. NPs earn a master's or doctoral degree and are trained to focus on a specific population, perhaps pediatrics or psychiatric/mental health or adult/gerontology or women's health. All of the clinical classes and clinical training are focused on the health problems experienced by those populations. Colleges of Nursing must demonstrate that their graduate NP programs meet the requirements of national certifying agencies. Colleges of nursing and NP Programs are accredited by the American Association of Colleges of Nursing, similar to how medical schools are accredited by the American Association of Medical Colleges.

After completing a rigorous graduate program, every NP in the country must take the following steps:

To be eligible to register for the national certification exam, students must include with their application to test:

- A copy of their RN license
- An official transcript from their graduate program demonstrating the standard and required courses for the population specific certification exam.
- The official transcript must show conferral of a master's or doctoral degree with a GPA of 3.0 or higher

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- The college of nursing's Graduate Chair or Dean must sign documents attesting that the student has met the criteria to sit for the national certification exam

In Pennsylvania to obtain a CRNP license, a nurse practitioner must provide the following to the State Board of Nursing:

- Transcripts from their graduate college that demonstrate specific required graduate courses that led to a master's or doctoral degree.
- Documentation by the Graduate Chair or Dean that the student successfully completed an Advanced Pharmacology Course with a grade of B or better.
- Evidence of successfully passing the national certification exam
- Proof of professional liability insurance; and
- To maintain licensing and certification, there are continuing education and continuing pharmacology education credit hours required.

Compliance with these exacting criteria and numerous safety nets are already in place before an NP enters practice.

Collaborative Agreements

Currently, nurse practitioners in Pennsylvania cannot prescribe medicines without a written, signed, collaborative agreement with two physicians on file in Harrisburg. Let's be clear, these agreements are no more than costly, burdensome state mandated pieces of paper. It does nothing to compel the physician to see, sign off, or meet the nurse practitioner. Many NPs have never met their physician collaborators. One mental health NP who runs a clinic in suburban Pittsburgh has a collaborator who lives in Florida, has never visited the clinic, but is paid $2,000/month for signing the agreement.

HB 1825 removes the requirement for a written collaborative agreement after a nurse practitioner has completed 3 years and 3,600 hours of practice. This 3-year, 3,600-hour requirement makes HB1825 an even more stringent measure than has been passed in 27 other states, the District of Columbia and the Veterans Affairs (VA) Health

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System. We started this march toward Full Practice Authority in 2014 warning of the growing crisis in access to care. Ten years later, the situation has only worsened.

Nurse practitioners and patients have become stranded. This happens all the time in rural communities, but many community clinics led by nurse practitioners located in schools or community centers close because nurse practitioners are unable to establish or afford these administratively burdensome collaborative agreements.

In larger healthcare systems, physicians are often “assigned” as collaborating physicians, which places regulatory burdens on these organizations who have to pay employees to conduct the process and file the agreements in Harrisburg. This further delays a nurse practitioner’s entry to practice if they change location or organization. It also wastes valuable time for patients to achieve access care and for revenue streams to be established. Even in organizations, it’s not unusual for the nurse practitioner to never meet the collaborating physician.

Nurse practitioners with Full Practice Authority will have the agility to help the community clinic or healthcare organization immediately, even on a part time basis until they or another nurse practitioner fills the vacancy.

Safety, Quality and Patient Satisfaction

27 states, the District of Columbia and the VA health system grant Full Practice Authority to NPs. There are over 150 studies documenting high patient satisfaction, safety and high quality of care provided by nurse practitioners. The first of these studies was reported in the Journal of the American Medical Association 23 years ago. I have brought with me a compilation of those studies. The list continues to grow.

It was recently asserted that NPs do not represent a cost savings because we order more tests and drive-up healthcare costs. However, the 2015 analysis of Medicare claims concludes that when clumped together, NPs and Physician Assistants ordered 3 more X-rays per 1,000 visits than physicians in patients 66 and older and fewer X - rays for some conditions that were not delineated.

The study also clearly states that NPs may be more cautious in caring for sicker, older patients. Of course...everyone is more cautious with older patients who have less

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margin for illness severity. I have a copy of that article here if anyone would like to review the data.

Collaborative agreements were waived in Pennsylvania during the totality of the pandemic to rapidly enable nurse practitioners to treat patients where needed. No one challenged our abilities in the midst of the crisis. We're no less capable now than we were when so many people were near death.

I've been a nurse practitioner in primary care since 1996. I've been blessed throughout my career to work with tremendous physicians. I've never had a physician, pharmacist, specialist, social worker or physical therapist for over two decades tell me they couldn't collaborate with me because we didn't have a signed regulatory collaborative agreement. And I've never declined to collaborate at their request for that reason either. It's a false narrative to suggest that collaborative agreements are the way to force doctors and nurse practitioners to collaborate. It's simply not true. Everyone collaborates, each and every day because every healthcare professional has the same goals…. meeting the patients' needs, properly managing their health conditions and ensuring their access to care.

Looking Ahead

Pennsylvania is now losing nurse practitioners to surrounding states that have Full Practice Authority. They surround us…Maryland, Delaware, New York. A recent grad told me he had no reason to stay in Pennsylvania when he could get on 95 South and be in Delaware in 45 minutes and practice without encumbering regulations. We don't want to lose the intellectual capital we've developed here in Pennsylvania.

Dire predictions abound concerning the future primary care workforce, but let me assure you, the workforce shortage is already a crisis. That's why we're here today. 88% of nurse practitioners focus on primary care and can be found throughout the state. Many nurse practitioners would prefer to stay in their communities and serve their neighbors yet are forced to practice elsewhere or pay costly sums that preclude maintaining a practice.

Pennsylvania will need numerous initiatives across many sectors to solve the problem of access to care. Several pieces of legislation will likely help but over a longer period of time and with significant state budgetary impacts. Full Practice authority for

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Pennsylvania's 18,000 NPs is the easiest and most proven initiative that can rapidly impact access to care. And it adds no cost to the state.

Many advancements have occurred that were never thought possible ten years ago such as 3 D printers, and cars that park themselves. Yet, access to health care has not improved for patients. Access is still in the dark ages in Pennsylvania. It's time to move ahead. Help us help your constituents. They are desperate and you have the power to make these advances happen, quickly and without additional cost.

We urge you to pass HB 1825, so Pennsylvania patients no longer have to wait. Thank you for serving our wonderful state and for your attention.

Name: Emily C. McGahey DM, MSN, CNM, FACNM

Regarding: Joint Informational Meeting on Improving Access to Healthcare — PA Professional Licensure Committee, Chairs Frank Burns (Dem.) and Carl Metzgar (Rep.); and House Health Committee, Chair Dan Frankel (Dem.) and Kathy Rapp (Rep.)

Date: 3.7.24

Introduction

My name is Emily McGahey, I am the vice president and legislative chair of the Pennsylvania Association of Certified Nurse-Midwives—which represents over 500 certified nurse-midwives currently licensed in the Commonwealth and I am a licensed and practicing midwife as the Clinical Director at The Midwife Center in Pittsburgh—and I am grateful for the opportunity to highlight the current concerns around maternity care access in Pennsylvania. During this testimony I will explain the critical role that CNMs are already playing in maternal healthcare in the state, and how you as legislators and all of us as stakeholders can partner to ensure that midwifery continues to be available and accessible to communities that are in dire need of high-quality healthcare.

Let me begin by explaining what a certified nurse-midwife is. We are licensed sexual and reproductive healthcare providers who have received accredited midwifery education, a master's or doctoral degree, national certification by the American Midwifery Certification Board (AMCB), and state licensure.

Pennsylvania nurse-midwives work in settings that include one of the 5 freestanding birth centers in the state, large academic institutions, rural community hospitals, community clinics, private GYN practices, and patients' homes. In 2022, midwives delivered 16% of the babies in Pennsylvania. In addition to providing perinatal care, we also function as primary care and GYN providers across the lifespan, as well as researchers, scholars, program directors, and global healthcare leaders.

Issues

Maternal mortality:
The United States has been in a maternal mortality crisis since before the pandemic. Right now in our country around 700 hundred women die each year during pregnancy or in the year after giving birth. For each one of these maternal deaths, close to 100 people have experienced a severe health problem from being pregnant and/or giving birth.

According to the CDC, Black Americans are approximately 3 times more likely to die before, during, or after birth compared to women of other races. Pennsylvania is no exception to this crisis, with our Black citizens dying or suffering harm at significantly greater rates compared to white families. For example, Allegheny County ranks among the worst in the country in terms of outcomes in the first year of life for both Black moms and babies. The reason for this ongoing

disparity, as demonstrated in the research, points to systemic racism and implicit bias of health care providers.

It is also important to spotlight a critical conclusion of the PA Maternal Mortality Review Committee: a rising number of perinatal deaths are due to opioid overdose. Acknowledging that many Pennsylvania mothers are dying as a result of substance use disorder, we also want to highlight a report from the Center for Rural Pennsylvania, which shows that there exists a lack of MAT providers in the eastern and central portions of our state, with an even more significant lack of providers along the northern and southern areas of the state.

These outcomes discussed above are compounded by other critical access issues facing maternity care—maternity care deserts and a declining obstetric workforce.

Maternity Care Deserts:
Recently more attention has been given to the critical issue of maternity care deserts in our country. Maternity care deserts are defined as counties where there is a complete lack of maternity care resources. This means absolutely no functioning maternity-care providers providing hospital, birth center, or community practices (either midwife or obstetrician). According to a recent March of Dimes report, 7.6% of Pennsylvania counties are classified as maternity care deserts.

Areas of our country where there is low or no access affect up to 6.9 million women and almost 500,000 births across the United States. In our state, 15.6% of birthing people receive inadequate prenatal care compared to 14.8% of women in the general population. Nearly a quarter of all Pennsylvania counties do not have access to the full array of maternity care, affecting close to 200,000 families who need care a year. Our geographic size and large rural areas also present unique problems for families, as distance to maternity care has been shown as a critical access issue affecting outcomes for mothers and babies, with families living farther from birthing hospitals suffering worse outcomes. In our state, 12.4% of women had no birthing facility within 30 minutes of their home, compared to 9.7% of women in the general US population. One study found that from 2004 to 2014 9% of rural counties lost hospital-based obstetric services, and we know that this problem has only intensified in the last decade.

Obstetric workforce:
The United States currently does not have the number of maternity care providers working in our system that is needed to provide safe care to families, and this inadequacy is likely to worsen over the next ten years. The Bureau of Health Workforce published a report in March 2021 showing that through 2030 the number of OB-GYN physicians in our country is expected to decrease by 7%, while demand is projected to increase by 4%. This is a demand for over 5,170 FTEs in 2030 without the number of physicians to fill those demands. The American Congress of Obstetrics and Gynecologists also published a report highlighting the fact that fewer and fewer OB-GYNs remain in maternity care and at the bedside attending birth. The lack of available maternity care providers over the next decade is very likely to continue to contribute to poor maternal/fetal outcomes and the rising number of maternity care deserts in the U.S.

Solutions

Midwives in the U.S. and in Pennsylvania are poised and ready to assist with the current access issues facing families in our country.

An abundance of research has shown that midwifery is affordable, accessible, and sustainable, and that midwifery-led models of care demonstrate a reduced risk of poor outcomes for mother and babies, ranging from fewer cesarean births to lower rates of preterm birth and low-birth weight infants. Birth centers are an option for combating lack of maternity care access, especially in rural communities with a lack of hospital labor and delivery services, and with over 400 freestanding birth centers in the U.S., data has shown that they have over 40 years of demonstrated safety in the U.S. A Center for Medicare and Medicaid Innovation project demonstrated the benefits of the birth center model with midwifery-led care, which includes lower rates of preterm birth, delivery of low-birthweight infants, and Cesarean birth across racial and geographic demographics, as well as an over-$2000 cost savings per mother-baby dyad, compared to those cared for in maternity care homes or who experienced in-group prenatal care models. Patients who received midwifery care reported increased trust and satisfaction with their providers' listening to and addressing their concerns, compared with standard care. Increasing access to integrated freestanding birth centers is a realistic option for increasing access to high-quality accessible maternity care.

While the OB-GYN workforce is declining, growing the midwifery workforce has the potential to assist the ever-growing needs of our communities. Currently, the U.S. has approximately 4 midwives employed per 1,000 live births. While midwives currently attend less than 10% of all births in the U.S., they attend over 30% of deliveries in rural hospitals. With over 3.7 million live births a year, at least 22,000 midwives are needed in the midwifery workforce to meet the World Health Organization's goal of a minimum of 6 midwives per 1,000 live births. Currently, there are about 14,000 midwives in the U.S., including those not in clinical practice, resulting in a gap of at least 8200 midwives. Even at 6 midwives per 1000 births, the U.S. will have a smaller midwifery workforce than other high-income countries with better outcomes.

The midwifery model of care focuses on the whole person, including environmental and social challenges. Research shows us, for example, that care provided by racially concordant providers is an important factor in improving patient outcomes. Through our work with the Health Equity and Anti-Racism (HEAR) committee established in 2020, Pennsylvania midwives have been active in acknowledging the presence of racism and implicit bias in maternity care, and have been actively working to grow more Black midwives and other midwives of color through outreach and scholarship opportunities. The committee was recently the recipient of a $200,000 grant to provide scholarships to ease the financial burden of Black midwife students in Pennsylvania.

Midwifery education is less expensive than medical school, and midwives can be educated and certified at a higher rate than our physician colleagues, while maintaining safety and high levels of quality of care. OB-GYNs and certified midwives already enjoy collegial relationships throughout the Commonwealth, as described in the *ACOG/ACNM Joint Statement of Practice Relations between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified*

Midwives. Educating more midwives would allow our physician colleagues to focus on more acute levels of care, such as complex GYN care/surgeries and high-risk pregnancies.

Midwives and their connection with families have been demonstrated to improve outcomes for families affected by substance use. Pregnancy is an opportunity to reach people affected by substances and help them get healthy for their babies and themselves. Midwives have been recognized federally as appropriate providers of MAT with midwives in other states already participating in prescription of MAT, and increasing the number of MAT providers in PA will increase access to this critical service.

Continuing to integrate midwives into the health system and working on policies to increase the midwifery workforce should be a critical focus for all stakeholders who desire to change the tide on lack of access and poor outcomes for families in our state.

Conclusion

Currently, Pennsylvania ranks 39th out of 50 states and Washington, D.C., on a recent scale measuring midwifery integration. We believe that our citizens deserve better, with midwives more fully integrated into the care of mothers and babies in our state. The PACNM has worked for the last 5 years on legislation to improve our statutory language to fully integrate midwives into Pennsylvania health systems, in an effort to allow midwives to be active participants in improving maternal and neonatal outcomes and access to high-quality maternity care. Our goal is for our legislation to be brought before you for consideration this year.

I hope that today's testimony will encourage you all to continue to think of midwifery as a critical part of the solution for improving the health of families in the Commonwealth. Thank you to the chairs of both the Health committee and House Professional Licensure, all the committee members, and all present stakeholders here today for your time and attention to this important issue.

TESTIMONY BEFORE THE HOUSE HEALTH COMMITTEE AND THE HOUSE PROFESSIONAL LICENSURE COMMITTEE
BY THE PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

MARCH 7, 2024

Chairman Frankel, Chairwomen Rapp, Chairman Burns, Chairman Metzger and Members of the House Health Committee and House Professional Licensure Committee:

On behalf of the Pennsylvania Psychological Association, I would like to thank you for the opportunity to speak to you about the access issues to mental healthcare in the Commonwealth.

I am Dr. Dan Warner, a licensed psychologist in Pennsylvania. I hold a Master of Science in Clinical Psychopharmacology (MSCP), which puts me on the path to addressing the state's critical shortage of mental health professionals qualified to prescribe psychotropic medications. I completed the first of several steps to become a prescribing psychologist, namely: a doctoral degree in psychology, my license as a psychologist, and completing the aforementioned post-doctoral masters degree. Should HB 1000 pass, I would need supervised experience before applying for my prescribing certificate.

Although I am not currently licensed to prescribe medication, I leverage my extensive training and expertise in psychopharmacology to collaborate with prescribing clinicians and provide consultation to individuals having trouble accessing high-quality mental health care.

Recognizing this need, non-psychiatric physicians and other primary care providers frequently refer complex behavioral health cases to me for consultation regarding psychotropic medication options. This growing demand underscores the significant gap in timely access to psychiatric care, with wait times often exceeding six months.

The nation faces a growing mental health crisis, with a significant shortage of psychiatric specialists to address the increasing demand (Merritt Hawkins Report, 2018). This shortage impacts all communities, regardless of urban, suburban, or rural setting.

Pennsylvania exemplifies this national trend. While urban areas like Philadelphia and rural areas like Potter County have the highest Health Professional Shortage Area (HPSA) scores, even suburban counties like Westmoreland and Chester face moderate scores, indicating insufficient access to psychiatric care. A recent survey by the Pennsylvania Psychological Association (PPA) found that over 41% of clients seeking psychiatric care wait four or more weeks for appointments, highlighting the dire need for additional resources (Malowney et al., 2015; Warner, 2022). These findings, along with the Pennsylvania Psychiatric Shortage Map (Map 1), clearly demonstrate that the state's current psychiatric capacity falls short of meeting the population's needs.

The critical need for expanded mental health access is well-documented. A 2020 Pennsylvania Joint Government Commission Report highlighted the existing prescriber shortage, with a projected doubling by 2030 (June 2020). The COVID-19 pandemic further strained the system,

leading to an increase in psychiatrist retirements and leaving many regions of the state with limited psychiatric coverage.

Examples include a middle-aged professional facing severe and debilitating binge eating, requiring medication management to address her acute symptoms, and a chronically suicidal young person with treatment resistant depression, needing help finding the right medication regimen.

These scenarios represent the harsh realities of Pennsylvania's mental health access crisis. Adults and children in acute crisis are often unable to receive necessary treatment from primary care professionals, potentially leading to hospitalization, over-utilization of emergency room services, or even police interaction.

Non-psychiatric physicians and prescribers recognize my expertise in complex behavioral health cases, which often require specialized attention and time commitments well beyond the capacity of busy primary care providers. While primary care prescribers provide general care across physical and mental conditions, prescribing psychologists possess focused training on a limited formulary and mental health. Our approach integrates psychological, emotional, social, and biological interventions often unavailable to primary care providers. With a full toolkit for evaluation, treatment, and management, prescribing psychologists can prescribe psychotropic medications, de-prescribe when necessary, and implement tailored behavioral interventions.

Additionally, limited psychiatrist availability necessitates reserving their expertise for ***medically complex cases***. Therefore, prescribing psychologists fill the void, offering much-needed support for individuals struggling with acute or persistent issues beyond the capabilities of primary care prescribers. Researchers have found that prescribing psychologists in other states were more likely to see rural clients, and clients on Medicaid, than non-prescribers (Linda & McGrath, 2017).

While telehealth expands access to care, it cannot fully resolve the shortage of psychiatrists in Pennsylvania. This shortage results in insufficient care, regardless of delivery method. Other states face similar challenges, limiting our ability to rely solely on interstate telepsychiatry solutions.

We strongly support the passage of the Collaborative Care and Primary Care Behavioral Health Care Model bills. If HB 1000 also passes, prescribing psychologists could be integrated into these models, further enhancing access to high-quality mental healthcare.

House Bill 1000 presents a practical solution by authorizing appropriately trained psychologists to become qualified and safe prescribers. A recent Pennsylvania Psychological Association survey demonstrated that over 800 psychologists in the state are highly likely to pursue the required training and preceptorship (Gavazzi, Warner & Wycoff, 2023). Furthermore, research from New Mexico and Louisiana demonstrates a reduction in mental health-related mortality within several years of implementing similar legislation, suggesting potential benefits for Pennsylvanians (Choudry & Plemmons, 2021). Additionally, a recent study associates expanded

scope of practice for psychologists with improved access to pediatric mental health, both in terms of addressing unmet needs and medication access (Hughes, et al., 2024).

Leveraging their extensive clinical experience and specialized education through the Master's in Clinical and School Psychology (MSCP) program with additional supervision, psychologists are uniquely qualified to address the mental health crisis. House Bill 1000's expansion of mental health care access would significantly improve the lives of countless Pennsylvanians.

Once again, I would like to thank you for the opportunity to speak to you today about the access issues to mental healthcare in the Commonwealth.

Respectfully submitted,

Dan Warner, Ph.D.

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Hans T. Zuckerman, D.O.
Pennsylvania Osteopathic Medical Association (POMA)

Written Testimony

Joint Legislative Hearing on Access to Care
Pennsylvania House Professional Licensure Committee and House Health Committee

March 7, 2024

Introduction
The Pennsylvania Osteopathic Medical Association (POMA) submits these written comments to the Honorable members of the Professional Licensure Committee and Health Committee of the Pennsylvania House of Representatives in response to the joint committee legislative hearing on access to care in the Commonwealth.

There are shortages of healthcare providers across the board, throughout Pennsylvania and the country. Direct care workers, registered nurses, licensed practical nurses, mental health counselors, physicians, dentists, and many others. Throughout the Commonwealth, healthcare teams work together to provide access to quality patient care. POMA represents Osteopathic physicians in Pennsylvania, or DOs, who are trained and educated to provide physician medical care in all specialties. POMA would like to share with the Committees the work Osteopathic physicians are doing in the state to train, educate and retain practicing high-quality Osteopathic physicians.

Osteopathic Medicine is National Leader in Pennsylvania and GROWING!
The foundation of the Osteopathic approach is managing the full health of a patient, one that considers the whole person: body, mind, and spirit. This philosophy continues to guide all aspects of medical education and training for the nation's workforce of osteopathic physicians (DOs).

Pennsylvania is a national leader in educating and providing access to care, ranked third nationally with 11,117 practicing DOs. In 2023, more than half of the nation's DOs practice in the primary care specialties of family medicine, internal medicine, and pediatrics. ***The majority of DOs—62%—are under age 45,*** demonstrating that primary care remains a desirable specialty for physicians entering the workforce.

Pennsylvania's Colleges of Osteopathic Medicine (COMs)
POMA is home to three Colleges of Osteopathic Medicine (COMs), one in the southeast and two in western PA. The Philadelphia College of Osteopathic Medicine (PCOM) is located in Philadelphia with branch campuses in the State of Georgia. PCOM has been around for more than a century, and has trained highly competent, caring physicians, and other health practitioners, who practice a "whole person" approach—treating people, not just symptoms.

The Lake Erie College of Osteopathic Medicine (LECOM) is in Erie, Pennsylvania and has branch campuses at Seton Hill University in Greensburg, Pennsylvania and in the states of New York and Florida. Understanding the need for primary care physicians, LECOM introduced the Primary Care Scholars Program (PCSP) ensuring students receive three years of training that is the equivalent of four years of academic and clinical education whose focus is primary care. Additionally, LECOM offers certified physician assistants (PA-C) who are interested in expanding their education, and practicing independently, an accelerated pathway to earn a DO degree and license.

Duquesne University in Pittsburgh recently established a COM and is planning to enroll 85 students in its inaugural class in August 2024, with the plan to grow annual enrollment to 170 students per year beginning in 2026. Finally, there is discussion at Indiana University of Pennsylvania to develop a public College of Osteopathic Medicine in the Pennsylvania State-System of colleges and universities.

Physician Residency Slots Increase
Physicians, both DOs and MDs, after college graduation, receive 4 years of preclinical and clinical training to earn their medical degree, then at least an additional 3 years of residency training, before practicing independently. POMA believes this comprehensive medical training provides the skills necessary to lead the patient care team for the best interests of our patients. Increasing residency slots will increase the number of practicing physicians to provide the best care for our patients.

According to the Centers for Medicare & Medicaid Services, the federal government recently established policies to implement 1,000 new Medicare-funded physician residency slots, 200 slots per year over five years. In 2023, the first 200 residency slots were allocated to teaching hospitals in Health Professional Shortage Areas with 125 residency slots allocated for primary care and 20 slots allocated for psychiatry. Pennsylvania received 30 new residency slots through the allocation. It is also important to keep in mind that while in residency programs, resident physicians are also providing access to care while they train under the direction of an oversight physician. However, more policies like this are needed because they will increase physician supply.

Team Care Model
POMA believes that the team-based care model serves the best interests of patients. In this model, it's not the CRNP, RN, CNM, or the physician that is at the center. The ***patient*** is at the center of this model and the entire team works collaboratively to ensure the best quality care is provided. POMA further believes that physicians, who are the most educated and trained, lead the healthcare team. In terms of other healthcare providers who are permitted to make acts of medical diagnoses and prescribe, POMA believes they should do so only when working with a practicing physician. Healthcare teams led by physicians provide the safest and most comprehensive level of care to each patient.

Conclusion
It is POMA's hope that this written testimony has provided facts that support the leadership role Osteopathic medicine is taking towards providing access to quality physician care. If you have any questions or concerns POMA can help you with, please contact POMA staff member, Andy Sandusky at asandusky@poma.org.

Pennsylvania Medical Society

ADVOCATE. EDUCATE. NAVIGATE.

400 Winding Creek Blvd.
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Representative Frank Burns, *Chairman*
Representative Carl Walker Metzgar, *Chairman*
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501 N. 3rd Street,
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Representative Dan Frankel, Chairman
Representative Kathy L. Rapp, Chairman
House Health Committee
501 N. 3rd Street,
Harrisburg, PA 17120

Thank you, Chairman Burns and Metzgar and Chairman Frankel and Rapp and also to the members of the House Professional Licensure Committee and House Health Committee for having me here today. My name is Dr. David Csikos and I am an internist with over 40 years of clinical practice experience. For more than a decade, I served as the Chief of Internal Medicine and Director of the Critical Care Unit at the Chan Soon-Shiong Medical Center in Windber, Pennsylvania where I am now the Chief Medical Officer.

Receiving affordable, high-quality care should be a right all Pennsylvanians have and providing affordable access to the highest quality of care possible should be something we all strive for.

Geography, weather, availability of specialists, and transportation all play a role in preventing people from accessing high quality healthcare. However, we do have an effective tool that in many cases can help…that's telemedicine. Telemedicine can break down those barriers, especially for the thousands of Pennsylvanians living in rural and underserved areas. I recently conducted a pilot project that was funded by a grant received from the Pennsylvania Medical Society on advanced virtual care technology. The Chan Soon-Shiong Medical Center in Windber, a rural community, where I work, has a multi-faceted approach to virtual care. The original focus of the project was to virtually connect patients with their primary care physician to decrease emergency department utilization and hospitalization in our area. As a result of telemedicine, we have seen a positive change in our Community Based Palliative Care program. Twenty palliative care patients are currently using virtual care technology to complete their monthly appointments with technology that brings providers directly into their homes on 22-inch screens. While telemedicine is currently being used in the Commonwealth, we have a clear need for a statutory framework under which telemedicine can continue to evolve.

It's hard to believe but a large roadblock in access to patient care is noncompete clauses in physician's contracts. These clauses within an employment contract are designed to restrict a physician's ability to leave an employer and work for a competitor or other medical facility. This means if a physician were to leave their employer, they could be forced to work upwards of 25-50 miles away from any location owned and operated by their previous employer in order to fulfill the "noncompete" clause.

As part of these noncompete agreements, patients are not told where their provider is going to, and the provider is often prohibited from reaching out to their current patients to inform them of their move. Patients will be kept in the dark as to where their physician, who has cared for them and knows their condition best, is practicing. The patient's continuity of care will be broken. Any physician will tell you there is nothing more important than the physician and patient relationship, especially patients with chronic or life-threatening conditions. A foundation of trust is built between a patient and physician, often through major life moments.

PAMED has supported previous legislation on restrictive covenants that aims to prohibit their use in health care practitioner employment contracts, with limited exceptions. Previous legislative proposals allowed for the freedom of movement among employed health care practitioners while protecting health care employers in less densely populated areas who have more difficulty attracting and retaining practitioners. We encourage members of the legislature to work towards passing a measure to do just that.

In last year's state budget, the Primary Care Loan Repayment Program was included to expand access to care in Pennsylvania.

This program provides loan forgiveness for physicians and other health care workers who agree to practice for two years in rural or underserved communities in Pennsylvania and I encourage the legislature to include it for this year's state budget.
Not only will this program retain and recruit young physicians to work in Pennsylvania, but it will also attract them to work in the communities throughout the Commonwealth who have struggled with access to care.

The Pennsylvania Medical Society also looks forward to working with members of these committees to help overburdened Emergency Departments (ED) across our Commonwealth. While "boarding" in the ED is a decades long, unresolved problem, the COVID-19 pandemic brought it to becoming its own public health emergency. Our patients are finding themselves often receiving care in conditions they find less than sub-par, often because of issues that are well out of our control as physicians. This problem of boarding has many causes, some of which would be alleviated by working on, and passing, some of the proposals mentioned in my earlier testimony.

We all play an important role in effectively delivering health care. Whether it's certified nurse practitioners, pharmacists, psychologists, or even surgical technicians, there is a role to be played but the quality of health care is the most important part of our healthcare system. Access to high quality care is a right all Pennsylvanians should have and there are tactics, strategies and technologies that can help us provide that care as I've done in my rural community. While access to care is not a "one solution" problem, and some solutions may be out of your hands as legislators, these two committees can work towards helping us find a solution. By providing further funding for telemedicine and addressing systemic problems to where physicians can practice, it would provide substantial improvements in access to care for many Pennsylvanians.

Thank you again for the opportunity to appear before you. I would be happy to answer any questions you have.

Representative Frank Burns, *Chairman*
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The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

Statement of

The Hospital and Healthsystem Association of Pennsylvania

for the

Pennsylvania House of Representatives
Professional Licensure Committee
&
Health Committee

submitted by

Nicole Stallings, President and CEO

March 7, 2024

Thank you, Chairs Burns, Frankel, Metzgar, Rapp, and distinguished members of both committees. I appreciate this opportunity to underscore the urgent need for your intervention to ensure that all Pennsylvanians have access to the high-quality health care they need, when and where they need it.

I'm Nicole Stallings, president and CEO of The Hospital and Healthsystem Association of Pennsylvania (HAP). HAP is privileged to represent more than 230 member organizations statewide. During 2022, HAP members cared for Pennsylvanians through more than 40 million outpatient appointments, 5.5 million emergency department (ED) visits, and 1.4 million discharges from inpatient treatment. To meet the needs of our communities, Pennsylvania's hospitals provided about $400 million in charity care. Hospitals also absorbed nearly $800 million in costs providing services at a loss to meet community needs—and that's not including billions in annual shortfalls from Medicare and Medicaid.

As you well know, health care is a continuum that includes an array of essential services. A single failing element stresses all other components. Multiple failures threaten to collapse the

entire system. We are not there yet, but the cracks are showing. We must act now, together, to safeguard Pennsylvanians' care.

The good news is that this is not a partisan issue. Each of you, the administration, every person in this room, and thousands of others who are not here today share the goal of making sure that every Pennsylvanian—no matter where they live, how old they are, or what their circumstances—can get high-quality health care when they need it.

As policymakers, you strive to ensure that Pennsylvania's communities have everything they need to keep people safe from harm; provide nutritious food and secure housing; and facilitate the interconnectedness that allows for our families, friends, and neighbors to live vibrantly. Thank you for these investments, which are fundamental to Pennsylvanians' health. We strongly encourage you to consistently prioritize social determinants of health as you weigh your personal policy positions on every issue. Transportation impacts health. Economic development impacts health. Education impacts health. Telecommunication impacts health. You get the point.

Ensuring access to care requires supporting all physical and behavioral health providers and services along the continuum.

Preventative and primary care in physical and mental health are necessary to keep people well. Traditional doctor, dentist, and optometrist/ophthalmologist offices; home-based programs; free and street clinics; school-based assessments; and early intervention services are just a few important ways to meet Pennsylvanians where they are.

When health concerns arise, community-based support can help address potential challenges before they turn into more serious medical conditions. Specialty care can diagnose, treat, and cure chronic disease. Timely acute care can attend to conditions before they become crises. Long-term, nursing, and home-based organizations can provide the right level of care at the right time and are fundamentally necessary for patients to be able to move seamlessly through all the services they need, when they need them.

It takes an array of connected providers to support communities. Hospitals are the anchors and the safety net at the end of the continuum. By choice, by mission, and by law, hospitals treat every person who arrives in our EDs, no matter their circumstances.

Our EDs are strained to the breaking point. In addition to unexpected injury or illness, some patients default to the ED for primary care when it is not otherwise available to them. Many patients' health conditions, which could be managed with primary and specialty care, remain untreated until they escalate into emergencies.

Some patients must wait in our EDs for days because too many acute care beds are occupied by patients who no longer need hospital services, but cannot be discharged as they wait—too often for months—for long-term, nursing, or community placements. An alarming number of patients stay in our EDs for weeks or longer because the essential behavioral health care they need is simply not available.

In too many communities, even the patients who experience unexpected injury or illness can arrive at the ED in even greater distress because—despite their best and often heroic efforts—emergency medical and transportation services are struggling to be able to respond as quickly as they know is necessary.

The growing crisis before us is that the commonwealth's health care continuum is losing its elasticity. We do not have enough programs, services, or providers to help Pennsylvanians avoid crisis. Then, we do not have enough programs, services, or providers to help patients effectively recover or manage their lives following a crisis. This is particularly true for those living with complex physical and behavioral health challenges.

I would like to highlight three specific ways in which you can take immediate action to stabilize the whole continuum of care, including hospitals:

- ✓ **Address Pennsylvania's health care workforce shortage, which is among the most persistent and severe in the nation.**

- ✓ **Update public payor reimbursement rates to reflect reality and shore up the continuum of care.**

- ✓ **Make it easier for Pennsylvanians to connect with health care providers.**

Address Pennsylvania's health care workforce shortage, which is among the most persistent and severe in the nation.

Pennsylvania is in a health care workforce emergency. The commonwealth has twice the number of primary care health professional shortage areas than the region's average and a third more than the national average. It is estimated that we will need at least 1,000 more primary care physicians within the next six years. A March of Dimes report identified 17 rural Pennsylvania counties as maternity care deserts or as having only moderate access to obstetric care. Mercer projects that by 2026, we will have the largest shortfall of registered nurses in the nation (20,345) and the third largest shortfalls of mental health professionals (6,330) and nursing support staff (277,711). Community- and home-based providers continuously struggle to find and train enough staff to meet their communities' needs.

These challenges have been years in the making and won't be solved overnight.

Hospitals are aggressively working to develop, recruit, and retain a robust and diverse workforce. Nearly all are increasing base pay, offering flexible work schedules, and providing tuition reimbursement and professional development in an effort to recruit and retain health care professionals. Many have implemented bonuses to recruit and retain staff and 39 percent are even providing childcare, which is significantly higher than the 6 percent of employers doing so nationwide. Nearly all Pennsylvania hospitals are working with four-year colleges/universities, community colleges, and high schools. More than half are also working with technical programs and community organizations.

One health system, for example, is developing a bilingual workforce by partnering with educators and Latino community organizations to provide English language and General Education Development classes along with training for health care careers. Others are working with local high schools to offer specialized training for health careers so that interested students can graduate with skills and job offers in hand—and then continue to receive support to advance their careers once they are hired. Others are focused on developing a workforce that reflects the diversity of its community by providing targeted support to students from underrepresented backgrounds and helping them address barriers as they train for and begin working—and advancing—in health care careers.

Hospitals are also innovating to better support patients and providers, advancing models such as team-based care, virtual nursing, hospital-at-home, and telehealth. For example, the number of licensed practical nurses in hospitals supporting patient care through team-based models has increased 68 percent statewide since 2020.

Despite these efforts, hospitals are consistently reporting double-digit vacancy rates among key positions. Because patient safety is the paramount concern, hospitals statewide are routinely delaying procedures when safe, closing beds as needed, and cutting back on service offerings to mitigate the realities of short staffing. While unfortunately necessary, these measures diminish access to the timely care we strive to provide.

Public Investments Needed

> While every component of the continuum is doing the best it can, most simply do not have the scale or flexibility needed to both innovate and continue providing services to their communities. Broadly growing the health care workforce across all necessary disciplines requires public policies and sustained investments.
>
> Health care provides good jobs that do essential work needed by every Pennsylvanian. Hospitals are only one segment of the continuum and, even so, are the top employers in 21 counties. Hospitals statewide employ more than a quarter of a million Pennsylvanians and pay more than $19.5 billion in wages. A helpful step to bolster this vital economic sector would be to expand the Pennsylvania Targeted Industry Program by including four-year pre-physician assistant programs and bachelor's degree programs in nursing, public health, and community health (House Bill 262).
>
> A strong health care workforce is also critical to the overall vitality of the commonwealth and our communities. People want to live and work in communities where they can access the health care they need. Employers rely on strong, local health care to maintain a healthy—and productive—workforce. It's easy to see how health care deserts can quickly become economic deserts. As the General Assembly and administration consider strategies to strengthen Pennsylvania's economy, we urge you recognize that health care access is vital to these efforts.

Nursing Education

Another significant opportunity for public policy to make a meaningful difference across the continuum is to address statewide shortages of nursing faculty and clinical education space. Many of Pennsylvania's nursing programs report that they are currently denying or wait-listing qualified applicants because they do not have the instructors or clinical resources to accommodate them.

The lack of educators is, in part, due to financial disincentives for practicing nurses to teach. On average, advanced practice nurses earn $120,000 at the bedside annually while master's level educators earn about $84,000 a year. HAP encourages the General Assembly to mitigate the earnings disparity between nurses who practice and those who educate, explore time-limited flexibility in credentialing requirements to teach nursing, and invest in clinical education infrastructure.

HAP also supports the development of a grant program to encourage more experienced nurses to serve as preceptors in a wide array of clinical settings, including Federally Qualified Health Centers (FQHC) and other rural care sites. Along these lines, Senate Bill 817 creates a primary care workforce initiative that provides grants to expand opportunities for medical, dental, and nursing students to complete clinical rotations at FQHCs.

Commonsense Improvements

Immediate, commonsense steps that you can take include:

- Fixing a discrepancy in current Pennsylvania law by clarifying that nursing education programs be certified by a U.S. Department of Education-accredited organization, which includes both regional and national accreditation agencies (House Bill 1403)

- Removing a redundant process by which the State Board of Nursing must currently review and approve applications for a student's ability to sit for the state licensure exam (House Bill 590)

- Authorizing, in limited instances and specific settings, trained nursing assistants to become "certified medication aides" (Senate Bill 668)

- Allowing required face-to-face interviews of direct care workers to be conducted using real-time, two-way video (House Bill 155)

- Increasing the number of and support for J1 visas to empower hospitals to recruit more international professionals

HAP also encourages you to consider opportunities to remove unnecessary barriers between well-qualified providers and patients, such as the reforms accomplished through House Bill 1825 and Senate Bill 25, which allow proven nurse practitioners who have safely cared for patients for at least three years or 3,600 hours to work without a formal physician collaboration agreement.

Behavioral Health

There are specific challenges to Pennsylvania's behavioral health care delivery system. Several reports—including the Legislative, Budget and Finance Committee Community Mental Services Report (February 2021) and the Joint State Government Commission's Behavioral Health Care System Capacity in Pennsylvania and Its Impact of Hospital Emergency Departments and Patient Health Report (July 2020)—have found that, too often, people who need complex care cannot access it.

HAP supports Governor Shapiro's budget proposals to invest an additional $20 million in community-based mental health services and to make substantial strides forward to address low payment for essential providers within the intellectual disability and autism communities.

We also support legislation introduced by members of both parties and from both chambers to help strengthen the mental health delivery system, including:

- Making investments in developing additional behavioral health professionals and building capacity in behavioral health programs across the state (House Bill 849)

- Extending the reach of current providers by integrating mental health screening and services in primary care settings (House Bill 24 and Senate Bill 445)

- Supporting hospitals as they seek to transfer patients to appropriate care settings in a timely manner, allowing hospital-based providers to more quickly care for additional acute care patients (House Bill 22 and Senate Bill 606)

Retaining Providers

We need to ensure we are keeping providers in Pennsylvania. HAP supports expanding—not cutting—and updating student loan repayment programs for front-line nurses and primary care providers, with an emphasis on supporting rural areas. Ohio, New Jersey, and New York, for example, reimburse up to $120,000 while incentivizing work in underserved areas. Data shows that 80 percent of recipients stay in these communities.

It is also important to note that the medical liability climate in Pennsylvania is compounding the already serious provider shortage. A rule change by the Pennsylvania Supreme Court that took effect last year upended legal reforms that had stabilized liability for the past 20 years. Now, medical liability claims from anywhere in Pennsylvania can be moved to places like Philadelphia and Allegheny counties, which have documented histories of higher payouts. Case in point: Attorneys filed 544 cases in Philadelphia last year, a 33 percent increase from the average annual caseload in the three years before the pandemic.

This practice, known as "venue shopping," forces providers to travel hours (taking time away from patient care) for potentially erroneous proceedings and significantly increases insurance costs for rural practitioners, especially in highly needed specialties, such as obstetrics. Last week, one rural hospital testified before the House Health Facilities Subcommittee that it pays on the order of $75,000 per year per obstetrician in insurance costs, a sum that strains their already limited finances.

We cannot afford additional—and, for 20 years proven unnecessary—impediments to practicing medicine in the commonwealth. We urge you to revive the work done by all three branches years ago: please immediately reach out to the Governor and to the courts to address venue shopping.

Update public payor reimbursement rates to reflect reality and shore-up the continuum of care.

Hospitals nationwide are straining under the weight of severe financial challenges as they emerge from the largest, paradigm-shifting health crisis in more than a century. Workforce shortages, record inflation, rising drug costs, continued threats to programs like the 340B drug program, and supply chain disruptions have skyrocketed the cost of providing treatment, while payments from Medicare, Medicaid, and commercial insurers have not kept pace. At the same time, more patients are presenting with more advanced diseases, which requires more complex care.

According to the Pennsylvania Health Care Cost Containment Council, 39 percent of all Pennsylvania's general acute care hospitals operated at a loss in fiscal year 2022. Another 13 percent posted operating margins between 0 and 4 percent, which is not sufficient for long-term sustainability.

Rates Don't Cover Costs

> Studies show that Medicaid pays hospitals just 81 cents on the dollar for the cost of delivering care—a figure that was derived before the pandemic, workforce crisis, inflation, and other stressors—while Medicare pays 84 cents on the dollar. And while it's a dramatic oversimplification because there are many types of hospitals, on average, 50 percent of Pennsylvania's general acute care hospitals' net patient revenue comes from these sources.
>
> Let me say that again: On average, a hospital has an operating loss of 16 to 19 percent built into half its operating budget.
>
> That share is higher for rural hospitals and for some urban safety-net hospitals. As of fiscal year 2022, rehabilitation hospitals rely on public payors for about 72 percent of their revenues and hospitals that specialize in psychiatric or substance use treatment rely on public payors for 74 percent. This kind of structural deficit is unsustainable.

I offer hospital-specific data because that is my role, but we must acknowledge that—along with the workforce emergency—structural, chronic underfunding is among the largest threats to Pennsylvania's entire continuum of care.

In December, 33 provider organizations wrote a letter to Governor Shapiro asking for help in this year's budget. Home care, nursing care, care for people with developmental disabilities, and others all need reimbursement rates sufficient to be able to attract and retain high-quality caregivers and adjust to the realities of today's prices. As one example, the Living Independence for the Elderly (LIFE) program's public reimbursement has increased by less than 3 percent over the past 15 years. We all know that is nowhere near enough to accommodate the increase in labor, inflation, transportation, therapy support, and other costs over that period.

Health care is a continuum that includes a wide array of essential providers and services. A single failing element stresses all of the other components. Multiple failures threaten to collapse the entire system.

If we are not adequately supporting programs that allow healthy seniors to choose to live at home, then we are increasing dependence on nursing homes, which are not sufficiently funded to recruit and retain staff to keep their beds open, and so on.

Public Rate Activity Affects Private Payments

There is a crucial market dynamic that further increases the importance of rational rate setting in public fee-for-service payments. The reality is that the thresholds set in public programs become the de facto baseline expectations for managed care organization payments and have strong influence on negotiations by private companies.

And, while addressing fee-for-service rates is critical to the continuum, so is exploring alternatives to them.

Even before the current stressors, 33 rural Pennsylvania hospitals reduced services or closed completely within the last two decades. It is challenging, if not impossible, to achieve economies of scale and cover high fixed operating cost requirements when

there is low payment volume and disproportionate dependence on Medical Assistance payments.

Five years ago, five hospitals and five payors began working together to pilot a new rural health care payment mechanism and delivery model. Initially funded by the Center for Medicare & Medicaid Innovation, the Pennsylvania rural health model allows hospitals to step off the fee-for-service hamster wheel and focus on what their communities actually need. It provides participating hospitals with stable, predictable funding that empowers them to truly transform the care that they provide.

The model has grown to 18 hospitals and six payors. It has cared for more than one million covered lives. Participant hospitals are estimated to reach 10 percent of the state's population and contribute $2.4 billion in economic activity. This success demonstrates what state policymakers, hospital leaders, and committed payors can accomplish when incentives and priorities are aligned.

The rural health model was a pilot and much has been learned. The resounding message from the health care community is that Pennsylvania policymakers must act now and with great urgency to develop a path forward upon this year's conclusion of the program. HAP stands ready to provide both the leadership and support necessary to move this work forward.

Make it easier for Pennsylvanians to connect with health care providers.

To maintain an effective continuum of care, patients must be able to connect with and move between the providers and services they need. Effective health care meets people where they are and is delivered by caregivers who understand their concerns. Community-based, in-home, mobile, drop-in, street, crisis-intervention, and free care are literal lifelines to many Pennsylvanians. They must be considered essential components of the health care continuum.

Adequate Networks

The most effective way to connect Pennsylvanians with health care providers is to ensure that every Pennsylvanian has health insurance and that every insurer—public and private, physical and behavioral health—is held accountable for developing and

maintaining an adequate network. Both the array of covered services as well as number and diversity of providers are important for network adequacy.

Geographic 'care deserts' for specific services, long wait times to schedule basic appointments, and/or an inability to move between providers may possibly be early warning signs of network inadequacy. Payors must be negotiating contract terms that are sufficient to retain providers that are realistically available to the insured.

Many hospitals have added whole teams of professionals to coordinate patients' post-hospital health care. Even with these dedicated, knowledgeable resources, hospitals struggle to find timely placements for patients who need skilled nursing, rehabilitation, or other post-acute care. Discharge delays can be counterproductive to a patient's health; are frustrating for families; and are demoralizing to hospital staff. Discharge delays also impede hospitals' abilities to treat other patients who need care.

Telehealth

Telehealth has proven to be one valuable tool for eliminating barriers to specialty care; treating patients who cannot reach or have difficulty reaching in-person care (due to geographic distance, mobility restrictions, work obligations, or transportation limitations, for example); expediting scheduling; and increasing the number of patients who can be treated.

Many providers pride themselves in caring for members of their communities "where they are." Increasingly, patients expect their providers to be online and to offer telehealth for both physical and behavioral health appointments. Pennsylvania must ensure that payment cannot be denied simply because care is provided via telehealth. HAP supports Senate Bill 739, which accomplishes this goal.

For telehealth to be an effective option, broadband must be improved in rural communities. HAP supports the Pennsylvania Broadband Development Authority's work to deploy more than a billion dollars in federal aid and distribute funding for projects in underserved areas, including for community anchor facilities and access to devices for end-users.

Transportation

Transportation is vitally important to the health care continuum in two ways. The first is by connecting patients to the care they need in both routine and emergency situations. The second is by moving patients from one care setting to another when they cannot transport themselves.

The framework for providing non-emergency medical transportation can be extremely confusing between transit agencies, senior services, nursing providers, managed care organizations, and others. Patients frequently cancel or "no show" for appointments due to lack of transportation, often exacerbating their health challenges. Some patients are forced to spend extra (unnecessary, costly) days in the hospital while care coordinators strive to find and schedule available transportation to move them to a skilled nursing facility or home.

According to the Department of Health, Pennsylvania had more than 1,250 emergency medical services (EMS) agencies that responded to 2.4 million calls for service in 2021. These robust numbers belie the funding and workforce crisis in this essential component of the care continuum. More than 2,600 EMTs were part of 4,000 overall EMS certifications that were not renewed in 2021. The subsequently longer response times jeopardize both in-crisis Pennsylvanians and first responders.

HAP thanks the General Assembly for last year's action to increase ambulance payment rates and the Shapiro administration for allocating $1 million in tuition assistance to help recruit and retain EMS providers. We also support the Governor's budget proposal to increase the Fire and EMS Grant Program to $60 million.

Thank you, again, for including me in today's important discussion. While there is no "silver bullet," this testimony considers an array of interventions—some championed by Republicans, some by Democrats, some from this chamber, some from the Senate, and some put forth by the administration—that, taken together, can make important strides toward achieving our shared goal.

The hospital community is eager to work with you. Please call on us.

PENNSYLVANIA ASSOCIATION OF COMMUNITY HEALTH CENTERS

House Health Committee and Professional Licensure Committee Hearing

Joint Informational Meeting on Improving Access to Healthcare.

Eric Kiehl
Director of Policy & Partnership
Pennsylvania Association of Community Health Centers

March 7, 2024

Good afternoon, Representative Frankel, Representative Burns, Representative Rapp, Representative Metzgar and members of the House Health and House Professional Licensure Committees. We thank you for the opportunity to discuss how we can all work together to improve access to healthcare and how Community Health Centers work as part of the safety-net network to provide critical services to individuals across the Commonwealth who might otherwise have difficulty accessing care.

Thank you for the opportunity to provide an overview of the important role Community Health Centers play in Pennsylvania and some of the issues that must be considered and addressed as we work together to improve access to health care across Pennsylvania.

Background

In speaking on behalf of the Commonwealth's Community Health Centers, I will take a moment to provide context. The Pennsylvania Association of Community Health Centers, or PACHC, represents Community Health Centers (also known as federally qualified health centers or FQHCs) throughout Pennsylvania. Community Health Centers compose the largest network of primary care providers in both the state and the nation. These health centers are held to nearly 100 federal requirements to gain and maintain their status as Community Health Centers – some of which include minimum number of hours of operation, quality assurance standards, and locations in an underserved area. Community Health Centers improve health equity and offer access to quality primary medical, dental, behavioral health care, vision and other health-enhancing services for individuals and families. Health center services include primary medical care, behavioral health care, oral health care, prenatal care, cancer and other disease screenings, immunizations, pharmaceutical services, enrollment assistance, and many others.

Community Health Centers are open to all, including privately insured, Medicare, Medicaid, and the uninsured, and currently serve one in 13 Pennsylvanians. If a patient is uninsured, the cost of services provided by the health center is based on the patient's family size and income through a sliding fee discount program. Our average patient is working poor – an individual who is employed but their employer is unable to provide insurance, or it is too costly for the individual.

There are 53 community health center organizations serving Pennsylvanians, with more than 430 FQHC sites in 54 of the Commonwealth's counties operated by these non-profit community organizations. You will find Community Health Centers in both rural and urban underserved areas of the Commonwealth. In aggregate, Community Health Centers provide quality care to almost one million Pennsylvanians every year. Many of these individuals would have difficulty accessing health care without their local FQHC. Community Health Centers also often serve as the first line of surveillance and response to public health needs, especially for the most vulnerable.

The Health Center Program and model of care has a history exceeding 50 years and has enjoyed bipartisan support throughout that history. Multiple studies have validated that although Community Health Centers serve more individuals challenged by the social determinants of health, like poverty, and with complex medical conditions, they do so both effectively and cost efficiently. A recent study by George Washington University concluded that the health care system saved $1,760 annually for everyone who has a Community Health Center as their medical home. If we extrapolate that number times the 890,000 individuals served by Pennsylvania's Community Health Centers, these critical providers are saving the health care system—and consequently, the Commonwealth and taxpayers—**more than $1.74 billion dollars annually.**

Community Health Centers are only able to be located in rural and urban areas that are federally designated as Medically Underserved Areas (MUAs) or Health Professional Shortage Areas (HPSAs)—areas of highest need. Community Health Centers are successful in part because of the federal requirement that these non-profit community-based organizations have a patient majority board. That is, at least 51 percent of a Community Health

Center's governing board must be patients of the health center to keep the Community Health Center responsive to their community and community need.

Primary Care in Crisis

Primary care is in crisis. On Feb. 28, 2024, the Milbank Memorial Fund published their second annual Scorecard[i] that highlighted the systemic lack of support for primary care in the United States, which is harming people's health and weakening the US health system. Despite the overwhelming evidence that access to primary care improves population health, reduces health disparities, and saves health care dollars, support for primary care continues to dwindle. As a result, the average life expectancy in the United States continues to stagnate, and health disparities in preventive services and other basic primary care services persist. The primary care workforce is not growing fast enough to meet population needs.

The number of primary care physicians (PCPs) per capita has declined over time. While the rate of total clinicians in primary care, inclusive of nurse practitioners (NPs) and physician assistants (PAs), has grown over the past several years, it is still insufficient to meet the demands of overall population growth, a rapidly aging population with higher levels of chronic disease, and workforce losses during the pandemic. The number of trainees who enter and stay on the professional pathway to primary care practice is too low, and too few primary care residents have community-based training. In 2021, 37% of all physicians in training began their residencies in primary care, but many of them go on to specialize and don't ever practice primary care. More than half of residents with the potential to enter primary care subspecialized or became hospitalists instead. In 2020, only 15% of primary care residents spent most of their time training in outpatient settings where a majority of the US population receives their care. Fewer than 5% of primary care residents spent most of their training with the most underserved communities in the United States.

Pennsylvania's community health centers employ 509 physicians, 370 nurse practitioners and 130 physician assistants. These primary care practitioners account for 1.6 million patient visits a year. However, that's not nearly enough providers to cover the need. The recruitment of physicians, nurse practitioners, and physician assistants, along with mental health professionals, dentists, and other skilled health care professionals is key to caring for Pennsylvanians now and into the future.

Primary Health Care Practitioner Program

That is why it is imperative that the General Assembly support an increase in the Primary Health Care Practitioner Program (PHCPP). Programs like PHCPP become even more critical to ensure we have a viable health care workforce to meet the demand for health care services in the short- and long-term.

The PHCPP funding allows organizations across Pennsylvania to train and place clinicians in underserved communities, provide technical assistance to primary care clinicians and health care facilities across the state, and support the Commonwealth's network of safety-net providers. The line item also supports the state's Primary Care Loan Repayment Program, which offers funding for educational loan repayment to primary care clinicians practicing in underserved communities. This program acts as a financial incentive for the recruitment and retention of physicians, dentists, mental, and behavioral health professionals, and other primary care clinicians in areas that lack access to primary care. It also helps Pennsylvania health care employers compete with other states to secure clinicians to practice in the Commonwealth. This comprehensive programming supports clinicians serving hundreds of thousands of Pennsylvania patients in need of access to quality, affordable health care to help them get well and stay well.

Unfortunately, each year there is a delay in getting the funding to those clinicians due to a combination of the lengthy budget approval process and the arduous application process that is managed by the Pennsylvania

Department of Health[ii]. The following barriers impact access to and participation in the program, per the PHCPP Request for Application (RFA)[iii]:

1. In order to do business with the Commonwealth of Pennsylvania (Commonwealth) practitioners selected for an award are required to enroll in the Student Assistance Program (SAP) system. Applicants may enroll by selecting "Non-Procurement" at https://www.budget.pa.gov/Services/ForVendors/Pages/Vendor-Registration.aspx.
2. Grant funds will be distributed at the end of each year of the service commitment. The LRP will send approved Grant payments directly to the practitioner (not to the student loan lender).
3. State Taxability – Student loan repayments or the forgiveness of student loan debt received as an inducement to enter or as a result of employment in a certain profession or field are considered taxable compensation for Pennsylvania personal income tax purposes according to the Pennsylvania Department of Revenue. By comparison, recipients of loan repayment through the federal National Health Service Corps do not pay tax on their loan repayment dollars.

Funding for Community Health Centers

Health Centers across Pennsylvania are continually faced with narrowing margins and increased costs throughout their organizations. In addition to covering the cost of caring for the uninsured and to make up for inadequate Medicaid reimbursement, Community Health Centers are facing additional unfunded costs for a myriad of services that are needed to comprehensively care for their patients. At the same time, attacks on the 340B program are decreasing saving through this program; inflation is increasing the costs of goods and services; and increasing workforce challenges are directly impacting the ability to provide care. When we are not there to provide care, the alternative is a much more costly emergency department visit and, often, hospital stay. There are also additional costs associated with telehealth services. Community health centers quickly embraced telehealth services at the beginning of the pandemic. The use of telehealth is now a critical part of part of the care being delivered in both rural and urban communities. Nowhere is telehealth more important than in the delivery of behavioral health services.

Throughout the pandemic and moving forward, Pennsylvania's Community Health Centers have taken care of Pennsylvania's most vulnerable populations and have filled in the gaps to serve as the state's public safety net for much of this population, across both rural and urban settings. The chart below highlights the unfunded costs Pennsylvania Community Health Centers encounter to just care for the uninsured population in Pennsylvania.

FQHC Patients	**Uninsured Patients**	**Average PPS Rate[iv]**	**Unfunded Care**
992,412	129,609	$216.46/Visit	$28,055,164
FQHC Visits	**Uninsured Visits**	**Average PPS Rate**	**Unfunded Care**
3,585,864	468,314	$216.46/Visit	$101,371,248

Pennsylvania's Community Health Centers need financial support to assist them in covering the costs of providing care to uninsured Pennsylvanians and to assist in covering many of the additional unfunded costs. These include Community Health Workers, transportation, care coordination, technology costs, etc. To date, community health centers have never received direct state funding through the state budget to support the unfunded care they provide. Pennsylvania is one of only four states that do not fund FQHCs.

Primary Care Preceptorship Program for Community Health Centers

PACHC supports SB 817, the FQHC Primary Care Workforce Initiative. Introduced by Senator Brooks, SB 817 is based off a key program initiative implemented in Ohio. The legislation seeks to ensure that Pennsylvania is

training and incentivizing primary care, dental, and behavioral health students to learn, live and work in Pennsylvania and serve our underserved populations with affordable, quality health care IN their local communities. The legislation helps to bridge the gap between Pennsylvania's state-based medical, dental, nursing, and other schools and Pennsylvania FQHCs by creating the infrastructure to allow them to offer preceptorships to students who are training for careers as primary care clinicians, dental providers, and behavioral health professionals.

Nurse Practitioners Full Practice Authority

PACHC supports HB 1825 and SB 25 to grant full practice authority to nurse practitioners (NPs), increasing access to care for the people of Pennsylvania. Community health centers across Pennsylvania employ more than 300 nurse practitioners who account for more than 750,000 patient visits per year and who contribute to our positive outcomes--quality of care that is validated by publicly available data. We are confident from our experience, and the experience of 29 other states where NPs already hold full practice authority, a formal collaborative agreement with a physician is not a prerequisite to these professionals providing quality care. It is becoming harder to find a supervising physician, which limits access to care.

Credentialing

PACHC also supports HB 1510, which would require health care practitioners and insurers to use the Council for Affordable Quality Healthcare (CAQH) system for credentialing, limit the credentialing period to 45 days for complete applications and streamline the process for health practitioners practicing in multiple locations. Community health centers routinely face delays with the credentialing process, particularly with the Medicaid Managed Care Organizations. When a health center can find and hire a practitioner, the credentialing process may take up to 6-12 months. During this time the practitioner may be providing care due to high patient need, but the community health center might not receive any reimbursement for the care provided. This puts the community health center at financial risk. We fully support a mandatory, centralized, standard credentialing system for all health care providers to ensure timely access to care and reimbursement for services provided.

> *Here's an example of the broken credentialing system from one community health center: The credentialing process for new providers takes an unreasonably long amount of time. Since 2020 we have experienced wait times of 6-12 months for our new providers which has hindered our ability to meet the increased demands of our community. We are currently losing a dentist who was hired immediately after residency because she feels she isn't able to practice her clinical skills enough to progress as a new dentist. Our organization struggles to find funding that supports the salaries of uncredentialed providers for 6 months. As the Chief Dental Officer of my organization, I have had to sacrifice my administrative time to compensate for lost productivity during the credentialing period. This has created further problems for my department within the organization. I understand there is a time-limit for insurers to complete a provider's credentialing. I've experienced MCO's going well beyond the time-limit, then retro-activating the credentialing to a time that is compliant. Since we are not informed about which plans will retro-activate credentialing we are left to assume none will.*

Mobile Units

In 2023, PACHC conducted a survey with support from our national association regarding Pennsylvania mobile units and identified that 15 of the 50 Pennsylvania FQHC organizations operate one or more mobile units. These mobile units offer a wide variety of services including preventative services, primary care, dental, enabling services, outreach and enrollment, immunizations, and pediatrics. Community health centers use mobile units to meet communities where they are by offering services at community events, schools, health fairs, homeless shelters and encampments, and low-income housing. Based on the survey, the average cost to operate per unit per month in Pennsylvania is $82,936.29. Additionally, hiring and training staff was identified as the greatest challenge to operating a mobile unit, further highlighting how the workforce shortage impacts access to care. Many health centers struggle to sustain their mobile units. If payers could offer value-based incentives for service

provided on mobile units or make eligibility for collecting payment more flexible, it would ease the overall financial burden of maintaining these very expensive units.

School-Based Health Clinics

There are 10 FQHC organizations operating one or more school-based health clinics (SBHC) in the commonwealth, accounting for nearly half of the 30 individual SBHC sites in Pennsylvania. School-based health clinics provide access for children to receive primary health care and other services where they are: in school. Research has shown that SBHCs increase access to health care, decrease emergency room use, and improve school attendance and academic achievement. In West Scranton Intermediate School, at the SBHC operated by The Wright Center for Community Health, parents can join their child's appointment via telehealth, thus eliminating transportation and time off work barriers to care. Community integration is foundational to FQHC operations; therefore, Community health centers are well-suited to operate school-based health clinics. Hannah Penn Center, an SBHC operated by Family First Health in York, has been an example of excellence in this space for 26+ years. Through generous funding from a variety of partners, Hannah Penn Center provides school physicals, immunizations, mobile dentistry, primary care, and care navigation while being fully integrated with the school culture and activities. Hannah Penn Center even employs a Health and Wellness Coach that is embedded in school activities and promotes wellness, health, and disease prevention across the school community.

SBHC services are valuable assets to ensuring access to care, however, they are expensive and difficult to sustain without adequate funding. For example, West Virginia funds 160 SBHCs, the majority of which are operated by FQHCs. West Virginia SBHCs provide care to more than 45,000 students and provide access to care to more than 85,000 students. With an investment in FQHCs to provide access to students and their families through SBHC, Pennsylvania could become a national leader in school-based health and ensure access to care for families who need it most.

Maternity Deserts

Many patients served by Pennsylvania community health centers face disparities in social determinants of health, including decreased access to care, financial instability, and limited social support. These barriers put many FQHC birthing people at risk for poor health outcomes. The maternal death rate in the United States in 2020 was 23.8 deaths per 100,000 live births, which was higher than in 2019.[v] In the Pennsylvania Maternal Mortality Review: 2021 Report, the pregnancy-associated mortality ratio across the state was 82 deaths per 100,000 live births.[3vi] For non-Hispanic black patients, this number was 163 deaths per 100,000 live births, which was two times higher than non-Hispanic white patients.[3]

One factor contributing to poor outcomes for birthing people is lack of accessible hospitals with maternity units. With rural hospitals closing across the state, and maternity units closing in urban hospitals, pregnant individuals are left to travel long distances for care. These closures have a negative downstream effect on prenatal care availability in Community health centers who often partner with hospitals to provide the full complement of maternal care. Community health centers are a safety net provider providing prenatal services to vulnerable populations, regardless of their ability to pay. Often, this includes patients who are uninsured and ineligible for Medicaid. Community health centers fill the gap to provide prenatal services for these patients, however, many Community health centers are not outfitted with the capability to provide anatomy scans. Patients end up having to be referred to outside organizations where the cost is prohibitive. Uninsured pregnant women should have presumptive eligibility for Medicaid throughout the course of pregnancy and for 12 months after to improve access to prenatal services and improve patient outcomes. Additionally, continued support of evidence-based programs such as Nurse Family Partnerships[vii] and Healthy Start[viii] is important to allow families access to prenatal and post-partum care through home visits.

Oral Health Access

According to 2023 federal shortage designations, Pennsylvania has 174 individual Dental Health Professional Shortage Areas (Dental HPSAs)[ix]. Pennsylvania ranks tenth among states for most people living in dental HPSAs in the country. A lack of dental providers, including dentists, dental hygienists and dental assistants, across the state necessitates the recruitment of atypical health settings for dental care. With more than 2 million Pennsylvanians living in a shortage area, it is critical that medical settings begin doing more to prevent oral health disease as is often done through integrated care in Community health centers. These services must be incentivized by payers.

Another important factor in the workforce shortage is the lack of dental providers willing to accept Medicaid insurance. Only 8% of the general dentists in Pennsylvania accept all forms of Medicaid, leaving nearly 1.5 million children who rely on Medicaid with very few dental providers to choose from. Community health centers participate with all Pennsylvania Medicaid plans, leaving them as the primary provider of choice for Medicaid beneficiaries. In a poignant example, one small Pennsylvania FQHC is serving patients from 19 rural counties because of lack of access to dentists who will accept Medicaid. Statewide, the number of dental providers in non-rural areas compared to rural areas is 15 to 1[x].

Licensed Social Workers

In Pennsylvania, social workers and counselors require 3,000 hours in direct supervised clinical practice to qualify to sit for their Licensed Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC) exam. For many graduates in the social work and counseling field this can be quite difficult to achieve while working full time, often raising a family, and finding the time and supervision to complete the required 3,000 hours. For community mental health providers who operate under the policies and guidelines of OMHSAS, it is allowed for an individual working on their licensure hours to bill for encounters under the supervision of an LCSW or LPC for Medicaid. As you know, FQHC providers serve the Medicaid population and many individuals in Pennsylvania are unable to access mental health treatment. Allowing Community Health Centers to hire and bill for staff who are actively working on their direct clinical hours and are under the required supervision would help to reach the many individuals actively seeking care.

Community Health Workers

A Community Health Worker (CHW) is an individual who contributes to improved health outcomes in the community where they reside and/or where they share ethnicity, language, and life experiences. Community Health Workers proactively serve as a liaison between communities and healthcare agencies, provide guidance and social assistance to community residents, advocate for individuals and community health, provide referrals, follow up services for care, and so much more. These individuals are key to providing care in a community health center, but there is currently no reimbursement for their services under the Medicaid state plan. CHWs are incredibly important as community health centers work to assist the populations they care for address to not only their health care needs, but to also address their social determinants of health.

Social Determinants of Health

Health disparities persist throughout rural and urban Pennsylvania and across the nation, and the COVID-19 pandemic has underscored and magnified this reality. Residents across Pennsylvania die prematurely and live with a poor quality of life due to social, economic, service environment and physical environment factors, which are the social determinants of health.[xi] Figure 1 outlines examples of the social determinants that cause these harms.

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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Social determinants of health, including education, socioeconomic status, social supports, access to services, systemic racism and oppression, racial segregation, and housing have contributed to different health outcomes for Pennsylvanians. That's why it is so important for policymakers to look beyond the traditional rural health care barriers that we have all been working to address, and to also look at health care through another lens: Why people may not be able to access the care that is available.

Technology

The pandemic in general had a tremendous impact on health care. One of the biggest positives is that the pandemic has advanced the use of telehealth and technology in providing health care services much faster than we thought possible, and with quality outcomes. Community Health Centers have found telehealth to be extremely helpful in reaching those patients that have not been able or did not want to leave their house and for those struggling with increased mental health issues due to the pandemic. But the increased use of telehealth alone cannot fill the gap in rural health care. Telehealth is a terrific example of how an individual's Social Determinants of Health can impact an individual's access to care and how policymakers have an opportunity to break down those barriers to that same care.

In advocating for telehealth services, it has regularly been cited that this type of technology assists in addressing two common Social Determinants of Health – transportation and provider availability/specialists. However, as health care providers expanded the use of telehealth to meet the needs of their patients during the pandemic, they quickly realized that the technology was able to help overcome other barriers as well, such as linguistic and cultural competency, geography, childcare, employment, transportation, income, food insecurity, and support systems, to name a few.

But barriers to use the technology remain. A key component of telehealth, particularly in rural Pennsylvania, is the ability to provide care through an audio-only option. Many patients don't have access to the technology to conduct a virtual telehealth visit or do not have access to broadband to conduct such a visit. Even if they have the technology and broadband access, they cannot afford the technology or data plans that are needed. A solution is that telehealth, including audio-only services, needs to remain an option for patients to choose how their health care is delivered. The cost for providers to deliver telehealth services is equal to or greater than the cost to deliver in-person care. To deliver telehealth services, providers must invest in HIPAA-compliant technology and employ additional staff to coordinate the virtual meetings. The costs for the practitioners remain the same. Acknowledging that broadband is essential to success in the Commonwealth, it is crucial, not only for

Pennsylvania's Broadband Development Authority to address the lack of reliable broadband, but to find solutions to ensure that everyone is able to afford, access and utilize the technology.

Rural Homelessness: Research has found that homelessness in Pennsylvania rural areas has increased at greater rates than in urban areas in recent years. This increase has been most dramatic for unsheltered homeless and homeless veterans. A 2015 study[xii] found that among homeless individuals in rural Pennsylvania, nearly 24 percent had a disability, 27 percent experienced mental health challenges; 12 percent had a physical disability; and 10 percent had a chronic health condition. Pennsylvania's rural homeless must overcome challenges related to the lack of public transportation in rural areas and the geographically dispersed employment opportunities, health care providers, and social services. To better address rural homelessness in Pennsylvania, a strategy should be implemented to coordinate services and provide a rural focus on prevention.

Conclusion

Thank you for the opportunity to discuss our thoughts on health care and we hope that they help to provide background information for future discussions of healthcare needs. As shared earlier, Community Health Centers have had bipartisan support for more than 50 years, and there is good reason for that. The Community Health Center model is one that is not only community-responsive, but improves access to quality health care, treats individuals in a holistic way by serving as their one-stop health care home, improves health equity, and saves the health system substantial money by helping individuals get well and stay well. This network of non-profit organizations across our Commonwealth is making a difference in lives and health status every day. We are glad to answer any questions you may have or provide you with additional information. Questions after the hearing may be directed to me at eric@pachc.org.

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[i] The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now, https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/

[ii] Pennsylvania Primary Care Loan Repayment Program (LRP), https://www.health.pa.gov/topics/programs/Primary%20Care/Pages/Loan-Repayment.aspx

[iii] PHCPP Request for Application (RFA): https://www.health.pa.gov/topics/Documents/Programs/Primary%20Care/RFA%2067-171.pdf

[iv] PPS Rate: Under PPS, Community health centers are paid a predetermined rate, that encompasses reimbursement for all services. provided during a single visit, and it is adjusted. annually for inflation.

[v] Hoyert DL. Maternal mortality rates in the United States, 2020. NCHS Health E-Stats. 2022. DOI: https://dx.doi.org/10.15620/cdc:113967

[vi] Pennsylvania Department of Health. Pennsylvania Maternal Mortality Review: 2021 Report. Accessed February 10, 2023. https://www.health.pa.gov/topics/Documents/Programs/2021%20MMRC%20Legislative%20Report.pdf

[vii] Nurse-Family Partnership - Helping First-Time Parents Succeed, https://www.nursefamilypartnership.org/

[viii] Healthy Start Factsheet, https://mchb.hrsa.gov/sites/default/files/mchb/about-us/2023-mchb-healthy-start-factsheet.pdf

[ix] Dental Health Professional Shortage Areas, https://data.hrsa.gov/default/generatehpsaquarterlyreport

[x] A Study Pursuant to House Resolution 68: Rural Dental Health, https://lbfc.legis.state.pa.us/Resources/Documents/Reports/733.pdf

[xi] The State of Our Health: A Statewide Health Assessment of Pennsylvania, January 2021, https://www.health.pa.gov/topics/Documents/Health%20Planning/SHA%20Complete%20Report_2021.pdf

[xii] Feldhaus, H. S., and Slone, A., 2015. Homelessness in rural Pennsylvania, https://www.rural.palegislature.us/documents/reports/homelessness-2015.pdf

PENNSYLVANIA PSHA SPEECH-LANGUAGE-HEARING ASSOCIATION

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February 22, 2024

Dear Members of the House Professional Licensure Committee,

Thank you for holding a hearing on the critical topic of improving access to healthcare. We are submitting written commentary on behalf of the Pennsylvania Speech-Language Hearing Association (PSHA), representing speech-language pathologists (SLP) and audiologists across the Commonwealth. PSHA has previously supported legislation related to telehealth, including authorizing the regulation of telehealth by professional licensing boards and providing insurance coverage of telehealth services.

Our national organization, the American Speech-Language-Hearing Association, affirms that telepractice is an appropriate service delivery model for audiology and speech-language pathology services. Telehealth provides consumers with increased access to speech, language, hearing, and swallowing services, especially in rural and other underserved areas. Improved access to telehealth services via increased insurance coverage enhances access to care in several ways: it allows individuals unable to travel to receive care, it allows service providers to reach a larger geographical area and it supports the viability of small businesses offering healthcare.

We have the following suggestions regarding legislation related to the regulation of telehealth:

1. Any legislation regarding the regulation of telemedicine/telehealth should include habilitation/rehabilitation services for conditions such as developmental delays/disorders and diagnoses/conditions that result from injury, disease or illness. Previous legislation has included the term “health condition” but this was not defined. Therefore, it was not clear if habilitation/rehabilitation services, which treat **functional limitations** that result from health conditions, would be included in this legislation.
2. Enactment of the Speech-Language Pathology Interstate Compact (ASLP-IC) would further improve access to healthcare by reducing barriers to service providers wishing to practice in Pennsylvania.

Please reach out to us if you would like more information or to discuss these matters further at psha@psha.org.

Sincerely,

Dana Bitetti, Ph.D., CCC-SLP
PSHA President

Tamara Sepe, MS, CCC-SLP
PSHA VP of Governmental Affairs

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Chairperson

Richard J. Cohen, PhD, *FACHE*
President and CEO

Comments from the Public Health Management Corporation Regarding

Improving Access to Healthcare through Full Practice Authority for Nurse Practitioners

Joint Informational Meeting with the House Health Committee

Pennsylvania House of Representatives

February 29, 2024

Thank you for the opportunity to provide written comments to inform strategies that will improve access to healthcare. On behalf of Public Health Management Corporation, I am writing in support of House Bill 1825, which would provide **full practice authority for nurse practitioners** practicing in Pennsylvania. As the Chief Executive Officer for the largest and most comprehensive public health agency in the region, I urge the House of Representatives to move forward on house legislation HB 1825 (Guenst, Cabell, Khan) to improve access to health care delivered by nurse practitioners.

In passing SB 25, Pennsylvania would become the 27th state –including neighboring states such as New York, Maryland, Delaware, and West Virginia –to allow nurse practitioners to practice to the full extent of their training and expertise while eliminating unnecessary administrative burdens. By granting our NPs full practice authority, we can immediately—and meaningfully—address Pennsylvania's primary care shortage, improving public health and ensuring that more patients have access to highly-effective quality care. Moreover, study after study proves that nurse practitioners provide excellent care and achieve comparable outcomes when compared to treatment provided by a physician.

Finally, patient access to high quality healthcare within a reasonable distance from home is essential. According to the findings of a recent study, if Pennsylvania adopted full practice authority as Maryland has, the number of patients that could be seen by NPs per week would increase by 1,792 patients. Clearly, all Pennsylvanians deserve access to healthcare services and nurse practitioners can effectively and efficiently fill those gaps.

As you may know, legislation granting full practice authority has stalled in three prior legislative sessions despite strong support across constituents and stakeholder groups reflecting commerce,

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consumers, public health, education, and healthcare. This common-sense solution to expand access to care is available now at no cost. It is time to move forward.

Respectfully submitted,

Michael Pearson
Chief Executive Officer
Public Health Management Corporation

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Comments from the Pennsylvania Public Health Association Regarding
Improving Access to Healthcare through Full Practice Authority for Nurse Practitioners
Joint Informational Meeting with the House Health Committee

Pennsylvania House of Representatives

February 29, 2024

Thank you for the opportunity to provide written comments to inform strategies that will improve access to healthcare. On behalf of the Pennsylvania Public Health Association, I am writing in support of **full practice authority for nurse practitioners** practicing in Pennsylvania, which is already before the House in the form of HB1825 as introduced by Representative Guenst, Representative Cabell, and Representative Khan. As the Executive Director for the largest and most comprehensive public health agency in the region, I urge the House of Representatives to move forward on house legislation HB 1825 to improve access to health care delivered by nurse practitioners.

In passing HB1825, Pennsylvania would become the 27th state –including neighboring states such as New York, Maryland, Delaware, and West Virginia –to allow nurse practitioners to practice to the full extent of their training and expertise while eliminating unnecessary administrative burdens. By granting our NPs full practice authority, we can immediately—and meaningfully—address Pennsylvania's primary care shortage, improving public health and ensuring that more patients have access to highly-effective quality care. Moreover, study after study proves that nurse practitioners provide excellent care and achieve comparable outcomes when compared to treatment provided by a physician.

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As you may know, legislation granting full practice authority has stalled in three prior legislative sessions despite strong support across constituents and stakeholder groups reflecting commerce, consumers, public health, education, and healthcare. This common-sense solution to expand access to care is available now at no cost. It is time to move forward.

Respectfully submitted,

Kristine Gonnella

Kristine Gonnella
Executive Director
Pennsylvania Public Health Association

THE WRIGHT CENTER for COMMUNITY HEALTH | THE WRIGHT CENTER for GRADUATE MEDICAL EDUCATION

February 29, 2024

Dear Members of the Commonwealth of Pennsylvania's House Health and Professional Licensure Committees:

On behalf of The Wright Centers for Community Health and Graduate Medical Education, thank you for your service and leadership in expanding equitable access to quality, “whole person” healthcare services. The Wright Center for Community Health is proud to be a Pennsylvania Opioid Use Disorder Center of Excellence (COE) and Coordinating Center for Medication Assisted Therapy, a HRSA designated Federally Qualified Health Center Look-Alike and Ryan White HIV/AIDS provider, a recognized National Committee on Quality Assurance (NCQA) Patient Centered Medical Home, with distinction in Behavioral Health Services Integration and historical School Based Medical Home Recognition. The Wright Center serves over 40,000 patients, operating ten primary care Teaching Health Centers throughout Northeastern Pennsylvania, inclusive of public school settings and a mobile medical and dental unit. The Wright Center for Community Health serves as the cornerstone ambulatory “whole person” health services delivery clinical learning platform for our Teaching Health Center Graduate Medical Education Safety-Net Consortium (GME-SNC), operated by our affiliated entity, The Wright Center for Graduate Medical Education. Together with GME-SNC partners, The Wright Center trains nearly 250 primary care residents and specialty fellows in a community-based, public health needs-responsive, interprofessional workforce development model to advance our shared mission to improve the health and welfare of our communities through inclusive and responsive health services and the sustainable renewal of an inspired, competent workforce that is privileged to serve.

As a FQHC Look-Alike and a Patient Centered Medical Home, The Wright Center is deeply engaged in delivering comprehensive, high quality, equitable and affordable primary health services to seniors, many of whom experience isolation and complex social determinants of health (SDOHs). With the lens of serving vulnerable geriatric patients, The Wright Center is pleased to offer recommendations aimed at enhancing the Commonwealth’s geriatric workforce and elevating the pivotal roles of teaching health centers and community health centers to expand essential primary health services access for this population. All of our initiatives to serve the geriatric population, notably a larger than state and national average size population in our service area, are intentionally designed to contribute to the Institute of Healthcare Improvement’s noble vision of a preferred future “Age Friendly Health System” and Governor Josh Shapiro’s Master Plan for Older Adults.

Background on The Wright Center's Services for Older Adults

In response to the community health needs of older adults in Northeastern Pennsylvania, The Wright Center secured HRSA Teaching Health Center Graduate Medical Education funding to develop an ACGME accredited Geriatrics Fellowship training program. Additionally, we joined the Institute for Healthcare Improvement's network to build an "Age Friendly Health System," and successfully integrated age friendly principles across The Wright Center for Community Health's care delivery processes and The Wright Center for Graduate Medical Education's Sponsoring Institutional curriculum. This has and continues to significantly enrich the overall geriatrics knowledge and skill sets across our provider care teams and primary care faculty and residents. We are proud to employ five board-certified Geriatricians that has enabled our capacity to expand our house calls and nursing home service lines.

Furthermore, several years ago, The Wright Center engaged as the eighth institution in UCLA's John Hartford Foundation supported UCLA Alzheimer's Dementia Unit Network. This service line provides consultation with a geriatrician led care team offering augmented care and case management infrastructure responsive to addressing complex health and SEDH needs and supporting caregivers. The Wright Center also partners closely with the Area Agency on Aging (AAA), and is a key partner supporting the operations and legacy of a federally funded Senior Day and HRSA funded Senior Companion Program at Telespond and the the soon-to-be launching the Telespond based, state supported Elderly Abuse Haven championed by Secretary Jason Kavulich.

Enhancing the Commonwealth of Pennsylvania's Geriatric Workforce

The importance of developing an Age-Friendly Health System and qualified, compassionate Geriatricians and interprofessional care teams has never been so urgent: Pennsylvania still ranks 9th out of the 50 states for the percentage of the state population 65 and older, and by 2034, older adults will outnumber children (according to Census Bureau projections). Further, Lackawanna and Luzerne counties have a significantly higher number of persons 65 years and older compared to state and national averages. The continued development of Geriatric competencies supports the shift into age-friendly health services by helping primary care doctors and care teams align with what impacts and matters most to older adults. Despite the expected national shortage of nearly 30,000 full-time geriatricians by 2025, there are national recruitment challenges in geriatrics: the position fill rate for Geriatric Medicine declined to 41.5 percent in 2023, down from 43.1 percent in 2022. The position fill rate has ranged between 43.1 – 52 percent since the 2019 Match. In 2023, geriatrics offered 419 certified positions (both Internal Medicine and Family Medicine-based programs) and only 174 positions filled.

Despite recognition of such undeniable historical systemic deficiencies and limited notable progress in planning a preferred future for caring for elderly Pennsylvanians, significant, illogical

barriers persist precluding expansion of our federally funded Geriatric Fellowship. Traditionally, geriatric fellowships often remain unfilled due to healthcare industry standards that fail to attract today's workforce. These barriers are related to the industry drivers of volume of visits and services delivered which absolutely undermines age friendly health system operations requiring intentional, value-driven time investments of provider care teams. Recognizing this formidable national debacle, The Wright Center discovered and utilized an American Council for Graduate Medical Education (ACGME) exception that offers the innovative solution of recruitment of exceptionally qualified applicants to complete a Geriatrics fellowship before they complete a primary care residency in internal medicine or family medicine. This allowed us to launch the Geriatrics fellowship and to more effectively recruit Geriatric fellows to expand the geriatrics workforce for older adults. However, the ACGME continues to stress that this is an exception and not the standard without proposed alternative solutions to produce the workforce America needs. Hence, updated systematic language has not yet been assimilated in stakeholder organizations to support this innovative recruitment initiative. This creates language and logistical confusion regarding the post-graduate year (PGY) of physicians recruited for training as most “fellows” are advanced learners, at a minimum a PGY4.

This ultimately led to a paralyzing disconnect with the Pennsylvania Board of Medicine (BOM), as the BOM firmly believes that early career physicians completing a fellowship prior to residency are post-graduate year four (PGY4), rather than a PGY1. This is illogical semantics and extremely unfortunate. The post-graduate training year distinction is crucial because progression to fellowship by traditional means of first completing a residency requires successful completion of USMLE step 3. The BOM’s refusal to acknowledge and responsibly adjust the semantic implications related to post-graduate year training of the ACGME endorsed recruitment exception of exceptionally qualified candidates for a Geriatrics fellowship paralyzes the pre-residency fellowship innovative solution to address the geriatrics workforce needs of Pennsylvanias and our nation.

As a result, in academic year 2022, the three fellows joyfully and successfully recruited for our Geriatrics fellowship program were traumatically unable to even start the pre-residency geriatric fellowship for this reason, despite tireless, unproductive advocacy and discussions with the ACGME and the BOM which should have been energized by the shared public trust purpose of responsibly and responsively generating the primary care and public health workforce Pennsylvanians’ need. The Wright Center had to accept this traumatic, nonsensical reality and work quickly to identify funding sources to transition the fellows into a primary care residency program to protect the fellows from deportation. This anecdote represents one of the many ways that policymakers and providers should better work together to identify and remove outstanding barriers to building an “Age Friendly Health System” that better honors and cares for older Pennsylvanians. Together, we can navigate through historical boundaries and semantic barriers, inspired and aligned with Governor Shapiro’s Master Plan for Older Adults, to demonstrate a

national Geriatrics workforce solution to be emulated and replicated across the country. We can collaboratively prompt and inspire necessary conversations with the ACGME regarding the post-graduate year semantics implications of their innovative exception which is potentially an awesome solution awaiting fruition to meet the Geriatrics workforce needs of the American people.

Elevating the Role of Teaching Health Centers

The pervasive clinical workforce gaps will require a reformative approach to address systemic challenges in the healthcare system driven by the highly competitive, siloed nature of the healthcare system. Notably, a robust primary care infrastructure is the cornerstone of a strong healthcare system, yet primary care has long been overlooked in the US and there is an imbalance between specialty and primary care. A key lever for the General Assembly to address maldistribution challenges, particularly as it relates to physician maldistribution, is bolstering and investing in the teaching health center graduate medical education program.

A simple look at the level of CMS funded positions for hospital-based graduate medical education, which happens to largely take place in large, academic, integrated delivery systems in urban or suburban areas, in comparison to the level of HRSA funded positions for teaching health center positions, provides a clear image of the ongoing contributors to maldistribution. Since the funding is going primarily to these settings, large, academic, integrated delivery systems become some of the most competitive employers and therefore attractive residency sites for physician learners. Policymakers must shift perspectives to recognizing graduate medical education funding as a public resource that must be invested in communities of greatest need or health professional shortage areas (HPSAs). This can be actualized by the General Assembly following suit of other states and investing in its network of teaching health center graduate medical education programs.

Teaching Health Centers and Graduate Medical Education Safety Net Consortiums (GME-SNC) are replicable, scalable solutions to our Commonwealth's primary care workforce shortages, maldistribution, and related health, healthcare, and healthcare career disparities. The GME-SNC model counterbalances historical hospital-centric dominance of public GME investments and alleviates the discordance between where most care is delivered and where healthcare workforce is trained. GME-SNCs should be supported by accrediting and state licensing agencies and the house of medicine because of their undeniable public health value and community benefit impact. State Medicaid investments in GME should be preferentially directed to such community based solutions that uphold public trust. This can force multiply the impact of HRSA's pioneering Teaching Health Center Graduate Medical Education program. GME-SNC's inclusive, hopeful spirit and innate cultural energy of "We Can Do More Together" are powerful antidotes for several ailments of U.S. healthcare and medical education systems rooted in unnecessary, traumatic divisiveness.

Elevating the Role of Community Health Centers

As we work to grow a competent healthcare workforce, it's also equally important that we invest in our existing community health infrastructure. The Commonwealth is home to 54 FQHCs and FQHC Look-Alikes, covering 395 locations across 54 of Pennsylvania's counties. Forty-eight percent of FQHC and FQHC Look-Alikes locations are in rural communities. These critical essential community providers serve almost 1,000,000 patients annually, or 1 in 13 Pennsylvanians. The patients served include:

- 88.35% of the patients are at or below 200% of the Federal poverty level.
- 13.06% of patients are uninsured. This number is expected to grow as Pennsylvania and the country undergo the Medicaid Unwinding.
- 48.57% of patients are on Medicaid or CHIP.
- 2.86% of patients are homeless.[1]

Community Health Centers ensure patients can access and afford quality care through sliding fee discounts with income eligibility based on federal poverty standards. They offer enrollment assistance for health insurance coverage, provide care for all individuals regardless of ability to pay or demographic factors, and serve as patient centered medical homes, offering longitudinal, comprehensive primary, dental, mental, behavioral and addiction health services throughout patients' lives. Despite the sweeping benefits of Community Health Centers, the Commonwealth does not provide base funding to support their mission, services, or growth.

Investing in Community Health Centers is a strategic cost saving intervention for the Commonwealth, as Pennsylvania health centers save the health care system $1.59 billion per year.[2] It is crucial that Federally Qualified Health Center Look-Alikes be included in such state investments to ensure they are futuristic and unifying rather than divisive amongst the community ehealth center network. Health Centers across Pennsylvania are continually faced with narrowing margins and increased costs throughout their organizations. In addition to covering the cost of caring for the uninsured and to make up for inadequate Medicaid reimbursement, Community Health Centers are facing additional unfunded costs for a myriad of services that are needed to care for all their patients truly and comprehensively. At the same time, attacks on the 340B program, which enables covered entities, such as FQHCs and FQHC Look-Alikes, to stretch scarce federal resources as far as possible, inflation, and increasing workforce challenges are directly impacting the ability to provide care.

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[1] Combined Pennsylvania Health Center Program Awardee Uniform Data System (UDS) Data, Reporting Period: 2022 https://data.hrsa.gov/tools/data-reporting/program-data/state/PA and Pennsylvania Health Center Program LookAlike Uniform Data System (UDS) Data, Reporting Period: 2022 https://data.hrsa.gov/tools/data-reporting/programdata?type=LOOK-ALIKE&state=PA

[2] Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs, September 1, 2009, https://www.rchnfoundation.org/wp-content/uploads/2013/01/Bending-the-Curve-9-1-09--nal.pdf

There are also additional costs associated with telehealth services. FQHCs and FQHC Look Alikes quickly embraced telehealth services at the beginning of the pandemic. The use of telehealth is now a critical part of the care being delivered in both rural and urban communities. Nowhere is telehealth more important than in the delivery of behavioral health, addiction and recovery services.

Throughout the pandemic and moving forward, Pennsylvania's Community Health Centers have taken care of Pennsylvania's most vulnerable populations and have filled in the gaps to serve as the state's public safety net for much of this population across both rural and urban settings. The Wright Center would urge the esteemed members of the House Health and Professional Licensure Committees to consider a line item of $25 million in the Pennsylvania State Budget (FY 2024-25), to assist Community Health Centers, both FQHCs and FQHC Look-Alikes, in covering the cost for providing care to uninsured Pennsylvanians and to assist in covering many of the additional unfunded costs, such as Community Health Workers, transportation, translation services, care coordination, and technology costs.

Through bolstering the Commonwealth's geriatric workforce, teaching health centers and community health centers, we can increase healthcare access, advance health equity, and deconstruct disparities and divisive systematic dysfunctions that traumatize our healthcare workforce while under-serving Pennsylvanians. It's truly time for unifying, intentional, logical change to accelerate a preferred future vision for Pennsylvania's healthcare and workforce development systems. With our current Governor, Administration, and Legislature, we can lead the nation in public health solutions if we get our act together. If you have any questions about the information or recommendations outlined above, please feel free to reach out to me at thomasl@thewrightcenter.org or to Laura Spadaro, Vice President of Primary Care and Public Health Policy at spadarol@thewrightcenter.org.

Sincerely,

Linda Thomas-Hemak, MD

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President & Chief Executive Officer
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Nurse Practitioners Care for PA

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Comments from the Care for PA Coalition Regarding

Improving Access to Healthcare through Full Practice Authority for Nurse Practitioners

Joint Informational Meeting with the Health and Professional Licensure Committees

Pennsylvania House of Representatives

February 29, 2024

Thank you for holding an informational meeting to develop and advance strategies that can increase access to healthcare. The Care for PA Coalition is writing to express support of House Bill 1825, which would provide **full practice authority for nurse practitioners** practicing in Pennsylvania. The Care for PA Coalition is a bi-partisan, cross-sector, interprofessional group of organizations that are committed to the success of legislation that will expand access to care delivered by nurse practitioners across the Commonwealth. The coalition is led by a Steering Committee reflecting the diversity of support for this issue and includes AARP PA, Amazon, Americans for Prosperity, the Commonwealth Foundation, the Convenient Care Association, the National Nurse-Led Care Consortium, the Pennsylvania Coalition of Nurse Practitioners, the Pennsylvania State Nurses Association, the Pennsylvania Association of Community Health Centers, the Pennsylvania Rural Health Association, Public Health Management Corporation, and the University of Pennsylvania Health System.

Pennsylvania is surrounded by states that have already modernized their nurse practice acts to enable nurse practitioners to practice to the full extent of their education and training: New York, Maryland, Delaware, and West Virginia. Similar legislation is also moving in New Jersey. Pennsylvania's current regulatory environment adds burdensome red tape that prevents effective and efficient health care delivery especially for the Commonwealth's most vulnerable rural and urban communities. A recent study looking at the impact of full practice authority in Maryland found that if Pennsylvania adopted this legislation, an additional 1,792 patients could be seen every week.

As the PA House of Representatives considers avenues for expanding access to health care, we strongly urge you to pass the full practice authority legislation already before you. When nurse practitioners can practice without the need for a costly business agreement with a physician that has repeatedly been proven unnecessary, it reduces costs to health systems, health providers, payors, and, most importantly, patients. At its worst, the regulatory burden imposed by these contractual requirements prevents nurse practitioners in areas with physicians from practicing at all.

Full practice authority is not a professional turf war, and when it is treated as such, patients are the ones who bear the consequences. Full practice authority is a no cost solution that will immediately expand access to care. The evidence supports this policy change, and Pennsylvania should as well.

Nurse Practitioners Care for PA

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Americans for Prosperity – PA
Bucks County Woman's Advocacy Coalition
CareSpan Integrated Networks
Carlow University
Centre Volunteers in Medicine
Commonwealth Foundation
Convenient Care Association
Free Clinic Association of Pennsylvania
Geisinger Health System
Greater Philadelphia Business Coalition on Health
Hospital & Healthsystem Association of Pennsylvania
Insurance Federation of Pennsylvania
Lehigh Valley Health Network
Main Line Health
National Association of Hispanic Nurses, Philadelphia Chapter
National Nurse-Led Care Consortium
Optum Complex Care Management
Penn Medicine: the University of Pennsylvania Health System
Pennsylvania Association of School Nurses and Practitioners
Pennsylvania Coalition of Nurse Practitioners
Pennsylvania Health Access Network
Pennsylvania Health Law Project
Pennsylvania Homecare Association
Pennsylvania Organization of Nurse Leaders
Pennsylvania Public Health Association
Pennsylvania Rural Health Association
Pennsylvania State Nurses Association
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Full Practice Authority for Nurse Practitioners Improves Equity in Healthcare - National Nurse-Led Care Consortium

Joint Informational Meeting with the House Health and Professional Licensure Committees - Pennsylvania House of Representatives on March 7, 2024

Submitted February 29, 2024

As Executive Director of the National Nurse-Led Care Consortium (NNCC), a nonprofit public health organization working to strengthen community health through quality, compassionate, and collaborative nurse-led care, I thank you for the opportunity to provide comments on the important issue of healthcare access in Pennsylvania. NNCC would like to express our deep support of full practice authority for nurse practitioners, which is before the House in the form of **HB1825**, introduced by Representative Guenst, Representative Cabell, and Representative Khan.

By 2026, 21% of Pennsylvanian primary care physicians will reach retirement age. That is 23,000 physicians predicted to permanently leave the healthcare profession, leaving a gap that will impact Pennsylvanians across the state, especially the most vulnerable. One way in which Pennsylvania has met this demand has been through Nurse-Managed Health Clinics (NMHCs). NMHCs are a nurse practice arrangement, led by advanced practice nurses, that provide primary care or wellness services to underserved or vulnerable populations and are associated with another entity, whether a university, a nonprofit, or other services. NNCC has been a proud advocate for the establishment of nurse-led centers across the country as healthcare that has a dual function in workforce development and community-based care. Pennsylvania has approximately 32 NMHCs, and it is estimated that these clinics, which primarily serve the most vulnerable and underserved communities, provide 200,000 patient visits annually.

In passing **HB1825**, Pennsylvania would become the 27th state to allow nurse practitioners to practice to the full extent of their training and expertise while eliminating unnecessary administrative burdens. Over 80% of NPs are certified in primary care, equating to more than 14,000 nurse practitioners ready and able to provide essential primary care services to their communities. According to the findings of a recent study, if Pennsylvania adopted full practice authority, the number of patients that could be seen by NPs per week would increase by 1,792 patients. By granting NPs **full practice authority**, we can both address the primary care shortage and ensure Pennsylvanians have access to quality care that meets their wellness needs.

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Study after study proves that nurse practitioners provide excellent care and achieve comparable outcomes when compared to treatment provided by a physician. All Pennsylvanians deserve access to high-quality healthcare, no matter where they live or their socio-economic status, and nurse practitioners have the unique skills and insight to meet these needs and efficiently fill the current gaps.

This solution to expand access to care is available now - at no cost to Pennsylvanians. I urge the House of Representatives to move forward on House legislation **HB1825** to improve access to health care delivered by nurse practitioners.

Respectfully,

Sarah Hexem Hubbard
Executive Director
National Nurse-Led Care Consortium

NNCC is a United Way of Greater Philadelphia and Southern New Jersey Community Partner.

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A healthy PA through nursing

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Comments from the Pennsylvania Action Coalition Regarding

Improving Access to Healthcare through Full Practice Authority for Nurse Practitioners

Joint Informational Meeting

PA House Health Committee and Professional Licensure Committees

Submitted February 29, 2024

Thank you for the opportunity to provide written comments to inform strategies that will improve access to healthcare. On behalf of the Pennsylvania Action Coalition (PA-AC), I am writing in support of House Bill 1825, which would provide **full practice authority for nurse practitioners** practicing in Pennsylvania.

As the Director of the PA-AC, a coalition of healthcare leaders from health systems, academia, foundations, and nursing organizations across Pennsylvania, I urge the House of Representatives to move forward on house legislation HB 1825 (Guenst, Cabell, Khan) to increase access to health care delivered by nurse practitioners.

The PA-AC was established in 2011 to create a healthier Pennsylvania through improvements in the quality, accessibility, and safety of nursing. As part of the national Campaign for Action, established by the Robert Wood Johnson Foundation, AARP and the AARP Foundation, the PA-AC works to implement the recommendations of the 2010 Institute of Medicine (now National Academy of Medicine) *Future of Nursing: Leading Change, Advancing Health* and *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* report. The PA-AC is a program of the National Nurse-Led Care Consortium, a subsidiary of Public Health Management Corporation.

One conclusion of *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* states that "Eliminating restrictions on the scope of practice of advanced practice registered nurses and registered nurses so they can practice to the full extent of their education and training will increase the types and amount of high-quality health care services that can be provided to those with complex health and social needs and improve both access to care and health equity" (7).

The critical nature of removing scope-of-practice barriers in increasing access to healthcare was demonstrated by the easing of restrictions placed on nurse practitioners during the COVID-19 pandemic. Several states and the Centers for Medicare & Medicaid Services eliminated these restrictions to increase the capacity of the healthcare workforce. Clearly, if government leaders concluded that this imperative would lead to better health outcomes, it would be counterproductive for those restrictions to be replaced or continue during the pandemic's waning. Until nurse practitioners are permitted to practice to the full extent of their education and training, "significant and preventable gaps in access to care will continue," ultimately leading to progression of chronic and acute disease processes for millions of people and ultimately increased healthcare cost (89).

PENNSYLVANIA ACTION COALITION
A healthy PA through nursing

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The PA-AC looks forward to a future where red tape no longer holds Pennsylvanians back from accessing healthcare. This no-cost solution will reduce health disparities and decrease disease burden across our state. It is time for this to be the reality in the Commonwealth.

Sincerely,

Jennifer Gimbel

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National Academies of Sciences, Engineering, and Medicine. 2021. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. Washington, DC: The National Academies Press. https://doi.org/10.17226/25982.

Pennsylvania Academy of Dermatology and Dermatologic Surgery

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February 29, 2024

Dear Members of the House Professional Licensure Committee,

Access to dermatologic care is a critical component of healthcare, impacting both patient outcomes and overall well-being. As representatives of the Pennsylvania Academy of Dermatology and Dermatologic Surgery (PAD), we appreciate the opportunity to provide insights on improving access to healthcare, particularly within the realm of dermatology. Our comments encompass various topics, including scope-of-practice changes, telemedicine, physician payment issues, PBMs, truth in advertising, and the regulation of medical spas.

The PAD supports truthful, non-deceptive advertising by health care practitioners. The PAD strongly recommends the implementation of direct and concise regulations and enforcement against fraudulent, deceptive, or misleading advertising and strongly endorses transparency and disclosure of one's degree, field of study, board certification, and state licensure. America's patients deserve to know the licensure and qualifications of their health care providers. The PAD believes those who regulate and deliver medical care have an obligation to inform the public of the qualifications and limitations of their care prior to beginning treatment, and should identify or disclose their degree, field of study, board-certification (if any), and state licensure to each patient. This should be disclosed in all forms of advertisement, expressed when appropriate to each patient, and displayed prominently in writing in the provider's office.

Additionally, the regulation of medical spas requires attention to ensure patient safety and quality care. Medical spas offering dermatologic procedures must adhere to stringent guidelines, with procedures performed only by appropriately trained personnel under the supervision of a licensed physician. Transparency in advertising, including disclosure of credentials and qualifications, is vital to informing patients and promoting trust in healthcare providers.

The importance of a physician-led team in dermatology cannot be overstated, as it ensures the highest standards of patient care and safety. Dermatologists, as highly trained physicians specializing in skin health, possess the expertise needed to diagnose and treat a wide range of dermatologic conditions, including skin cancers and complex dermatoses. They lead interdisciplinary teams comprising non-physician clinicians, allied health professionals, and licensed personnel, coordinating efforts to deliver comprehensive and effective care to patients. This physician-led approach is essential for upholding patient safety and optimizing treatment outcomes, as it allows for careful oversight, expert decision-making, and timely interventions tailored to each patient's unique needs.

As advocates for patient safety and quality care, the PAD opposes the independent practice of nurse practitioners and physician assistants in dermatology. While these healthcare providers play valuable roles within the healthcare system, they should operate under the direct supervision of a board-certified dermatologist to ensure the highest level of patient care. Dermatologists have the specialized training and expertise necessary to lead clinical teams, make complex medical decisions, and perform intricate procedures safely and effectively. By maintaining a physician-led team-based approach, we can safeguard patient safety, uphold professional standards, and provide the best possible care for individuals seeking dermatologic treatment and services.

Physician workforce shortages, compounded by reimbursement cuts and ongoing challenges, threaten to reduce access to dermatologic care across the nation. The projected shortage of dermatologists, particularly in rural areas, raises concerns about meeting the growing demand for dermatologic services. Moreover, unsustainable Medicare physician reimbursement and escalating operating expenses further strain dermatology practices, jeopardizing patient access to care. We urge the committee to recognize the strain on practices of flat and declining Medicare physician payments and address regulatory challenges that hinder small physician practices.

The role of Pharmacy Benefit Managers (PBMs) in medication pricing and reimbursement requires increased transparency to mitigate conflicts of interest and ensure fair practices. Transparency in PBM operations, including disclosure of discounts and rebates, is essential to understanding their impact on formularies, tiers, and drug prices. Furthermore, regulatory oversight is necessary to prevent undue influence on medication access and affordability.

Telemedicine has emerged as a valuable tool for expanding access to dermatologic care, particularly in underserved areas. The PAD supports responsible expansion of telehealth services, emphasizing the importance of maintaining high standards of care and patient-provider relationships. Permanent integration of telehealth services post-pandemic could enhance access for rural communities and disabled patients, complementing traditional in-person care.

In conclusion, we appreciate the committee's dedication to addressing challenges in healthcare access. The PAD remains committed to collaborating with policymakers to advance initiatives that promote patient-centered care, uphold professional standards, and improve access to dermatologic services.

Thank you for your consideration of our perspectives on these critical issues. The PAD is open to setting up a future meeting where the top issues can be discussed in more detail for education either via Zoom or during our Advocacy Day on the Hill on May 8th, 2024 to learn more about the issues at hand.

If you have any additional questions or would like to set up a meeting, please contact Executive Director, Amy Blankenhorn (717-909-2681/ ablankenhorn@pamedsoc.org) or our lobbyist from McNees-Winter Group, Natalie Cook (717-581-3740/ ncook@wintergrouppa.com).

Sincerely,

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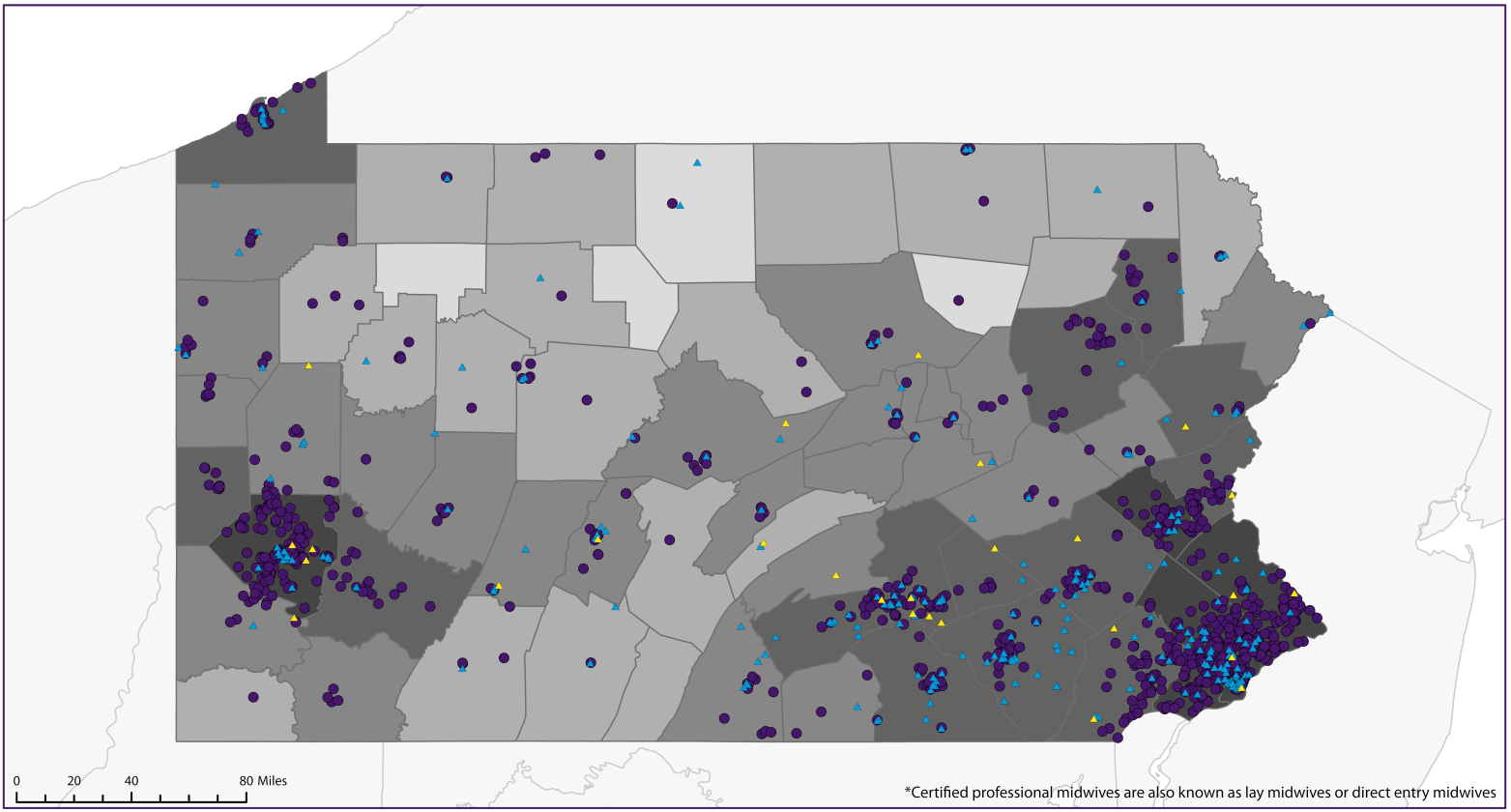
President
Pennsylvania Academy of Dermatology and Dermatologic Surgery

Bruce Brod, MD
Chair, Political Advocacy Task Force
Pennsylvania Academy of Dermatology and Dermatologic Surgery

Obstetricians and Gynecologists to Nurse Midwives and Certified Professional Midwives

AMA AMERICAN MEDICAL ASSOCIATION

PENNSYLVANIA



- Obstetricians and Gynecologists (n=1,580)
- Nurse Midwives and Certified Midwives (n=536)
- Certified Professional Midwives* (n=27)

Population per square mile

Source: 2017-2021 American Community Survey

<=25	26 - 75	76 - 250	251 - 1,000	>1,000

Source Notes: AMA Physician Masterfile 2022; U.S. Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System 2022; U.S. Census Bureau county and state shapefiles 2020

Primary Care Physicians to Nurse Practitioners

AMA AMERICAN MEDICAL ASSOCIATION

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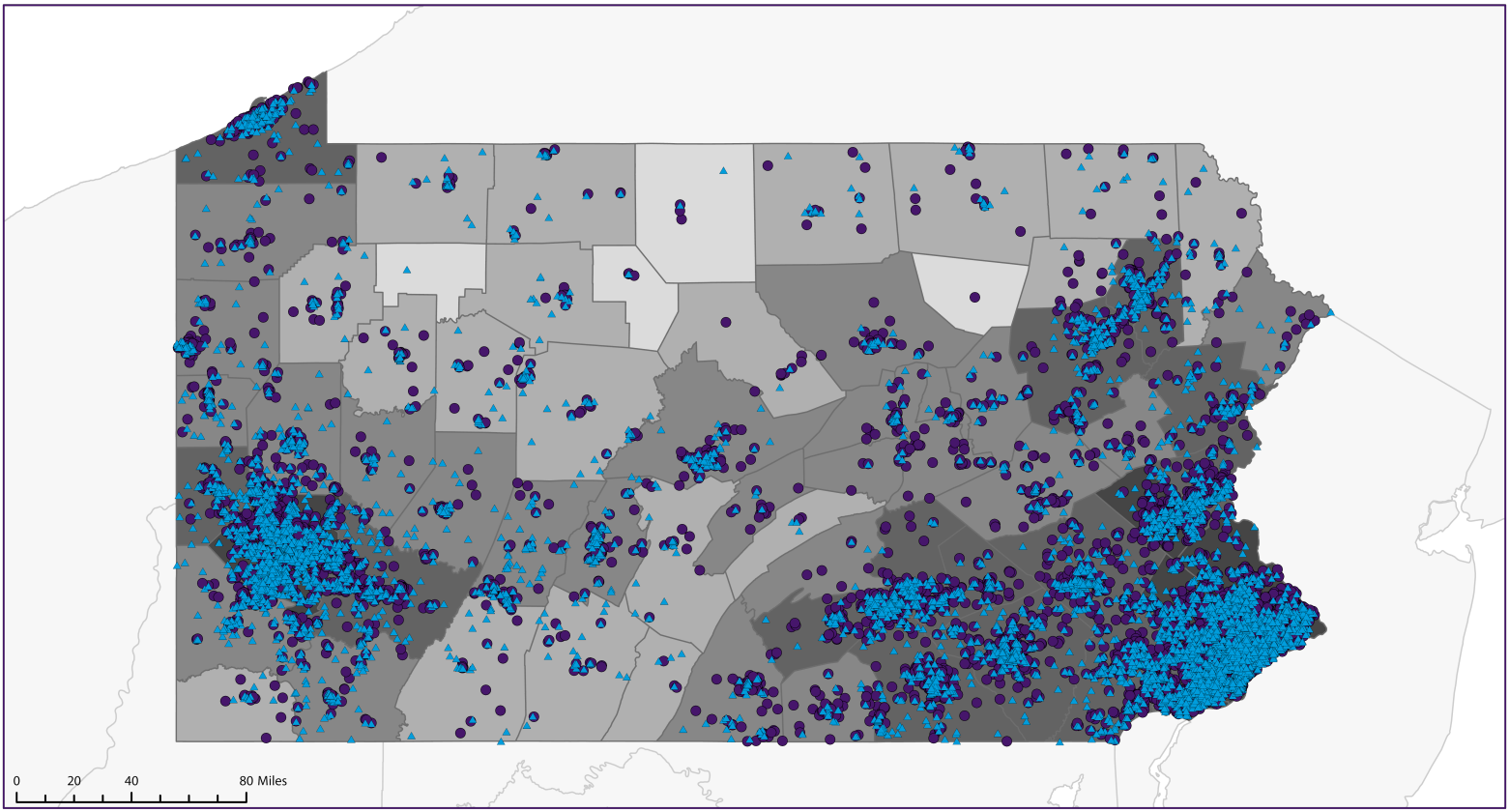


- Primary Care Physicians (n=11,213)
- Nurse Practitioners (n=13,997)

Population per square mile

Source: 2017-2021 American Community Survey

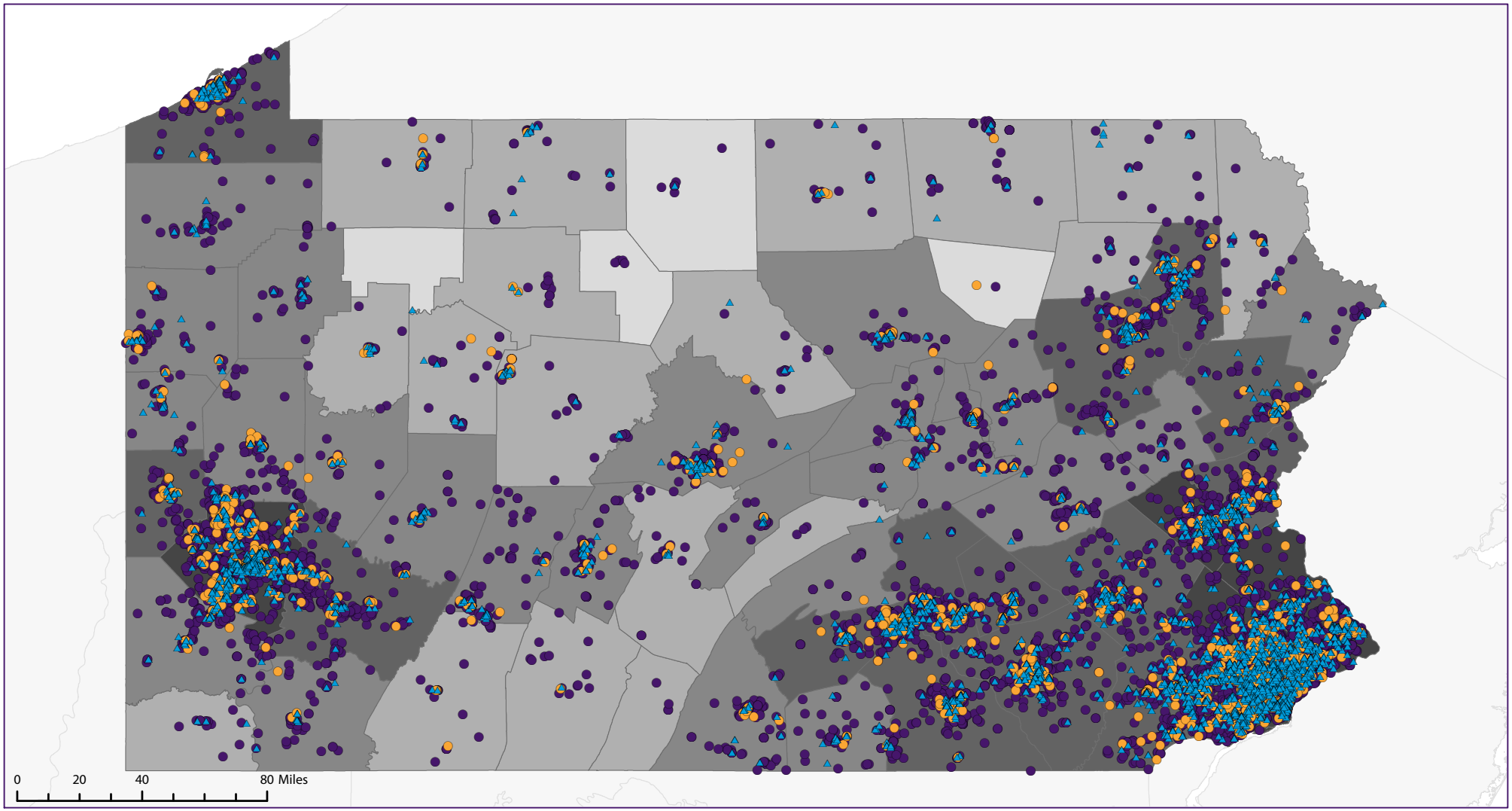
<=25	26 - 75	76 - 250	251 - 1,000	>1,000

Source Notes: AMA Physician Masterfile 2022; U.S. Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System 2022; U.S. Census Bureau county and state shapefiles 2020

Psychiatrists and Primary Care Physicians to Psychologists

AMA AMERICAN MEDICAL ASSOCIATION

PENNSYLVANIA



- Primary Care Physicians (n=11,450)
- Psychiatrists (n=1,819)
- Psychologists (n=5,233)

Population per square mile

Source: 2015-2019 American Community Survey

<=25	26 - 75	76 - 250	251 - 1,000	>1,000

Source Notes: AMA Physician Masterfile 2020; U.S. Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System 2020; U.S. Census Bureau county and state shapefiles 2010

Pennsylvania Medical Society
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Representative Frank Burns, *Chairman*
Representative Carl Walker Metzgar, *Chairman*
House Professional Licensure Committee
501 N. 3rd Street,
Harrisburg, PA 17120

Representative Dan Frankel, Chairman
Representative Kathy L. Rapp, Chairman
House Health Committee
501 N. 3rd Street,
Harrisburg, PA 17120

Thank you, Chairman Burns and Metzgar and Chairman Frankel and Rapp and also to the members of the House Professional Licensure Committee and House Health Committee for having me here today. My name is Dr. David Csikos and I am an internist with over 40 years of clinical practice experience. For more than a decade, I served as the Chief of Internal Medicine and Director of the Critical Care Unit at the Chan Soon-Shiong Medical Center in Windber, Pennsylvania where I am now the Chief Medical Officer. On behalf of the Pennsylvania Medical Society (PAMED) and the physicians, residents, and medical students we represent, thank you for providing us with this opportunity to present our comments on the general subject of scope of practice expansion for non-physician health care professionals.

PAMED believes that all health care professionals play a critical role in providing care to patients. However, we strongly believe that the physician-led team-based model of healthcare delivery offers the best of each professional's education and training and provides optimum patient care.

For example, Pennsylvania law currently requires Certified Registered Nurse Practitioners (CRNPs) to maintain a collaborative agreement with a physician. This formal relationship guarantees the immediate availability of physician input or intervention and ensures that every patient has a physician involved in the management of their care. We believe this is critical because the depth and breadth of nurse practitioner or physician assistant education and training does not sufficiently prepare them for the wide array of challenges that regularly confront an independent practitioner.

There is strong evidence that nurse practitioners and physician assistants, practicing without any physician involvement, results in worse patient outcomes while also increasing costs due to overprescribing and overutilization of diagnostic imaging and other services. Directly on

point is a 2022 high-quality economic analysis of care provided by nurse practitioners practicing independently in emergency departments (ED) within the Veterans Administration, which found that nurse practitioners used more resources than physicians including x-rays, CT scans, and formal consults.[1] The study found that nurse practitioners increased the cost of ED care by seven percent—about $66 per patient compared to physicians. This study further estimated that continuing the current staffing allocation of nurse practitioners in the ED would result in a net cost of $74 million per year compared to staffing the ED with only physicians. The study also confirmed that removing physicians from the care team is associated with lower quality of care, finding that nurse practitioners demonstrated lower levels of skill than physicians and achieved worse outcomes, despite using more resources. Furthermore, the study found that nurse practitioners raise 30-day preventable hospitalizations by 20 percent, which the authors suggest may reflect poorer decision-making over whom to admit to the hospital or that nurse practitioners produce lower quality of care conditional on admitting decisions compared to physicians.

Finally, the study also found that nurse practitioners' prescribing patterns are consistent with lower levels of skill compared to physicians. While nurse practitioners are valuable members of the health care team, this study reinforces that they are not a replacement for a physician. Similarly, an analysis conducted by Hattiesburg Clinic (the Clinic), a leading Accountable Care Organization (ACO) in Mississippi, found that allowing non-physicians, including nurse practitioners and physician assistants, to have their own primary care panel of patients led to higher costs, more referrals, higher Emergency Department use, and lower patient satisfaction than care provided by physicians.

Based on Medicare cost data, the Clinic found that the Medicare ACO patients spend was nearly $43 higher per member per month for patients with a non-physician as their primary care provider compared to those with a physician.[2] These costs could have translated to an additional $10.3 million in spending annually for the clinic. Adjusting for patient complexity, this number jumped to over $119 in extra costs per member per month or $28.5 million in additional costs annually.

Other studies found the same thing, nurse practitioners and physician assistants are not interchangeable with physicians. Nurse practitioners and physician assistants practicing

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independently of physicians order more diagnostic images and prescribe opioids, antibiotics and more – more frequently. [34567891011]

Before allowing advanced practice nurses or physician assistants to practice without any physician involvement we encourage you to carefully review these studies.
I have the utmost respect for CRNPs and PAs, and they are an important part of a physician led Healthcare Team. CRNPs and PAs are in addition to physicians and surgeons, but they are NOT to replace physicians. The training for physicians, CRNPs and PAs is distinctly different. CRNPs and PAs are NOT physicians. My daughter is the best physician assistant in the world, but she's not a physician. When patients address her as "doctor," she corrects them and informs them that she's a PA, not a doctor.

We have also seen legislation introduced to expand the scope of practice for psychologists and grant them the authority to prescribe psychotropic medications. PAMED values the critical role psychologists play in our health care system as behavioral experts and key members of the health care team. However, we caution that granting psychologists prescriptive authority will put patients in danger without meaningfully increasing access to mental health services in Pennsylvania. This well-intentioned proposal would only expose vulnerable patients – including children, adolescents, seniors, and pregnant women – to substandard mental health care. Psychologists' training is focused entirely on non-medical therapies and a course in prescribing does not provide the comprehensive medical education necessary for treating psychiatric illness. An individual prescribing a psychotropic drug must have the ability to spot and distinguish the cause of physical and mental symptoms, fully understand co-morbidities and other medical conditions beyond mental illness, identify contraindications and respond appropriately.

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We believe there are better ways to address access to care concerns. In the few states where psychologists have been granted prescriptive authority, psychologists continue to work in the same areas as physicians. As I stated earlier, we support the physician-led team-based model for health care delivery, and this applies to mental health care as well. Better access can be achieved by the support of the Collaborative Care Model which was included in HB 849. Finally, we have also seen legislation introduced that would allow pharmacists and pharmacy techs to perform childhood vaccinations. For the health care of children of Pennsylvania, it is important to keep their vaccines at their routine well-child visits by their pediatrician or family physician. Allowing access to childhood immunizations outside of a physician's office significantly increases the chance that serious health concerns will be missed. Pediatricians and other primary care medical providers routinely identify developmental deficits and early signs of disease that would simply be left undiagnosed by pharmacists or pharmacy technicians.

Pharmacists do not provide wellness checks and likely will not know the medical history of the child/patient. When physicians and other health care providers vaccinate children, it is typically done during a well-child visit. The clinicians take the patient's background and health care information into account.

We've heard this topic come up because pharmacists played a huge role in the distribution of the vaccine during the COVID-19 pandemic. When the COVID-19 vaccine first became available, it was very difficult for physicians to obtain due to limited supply and the Department of Health's allotment strategy routing most of the vaccines to pharmacies and hospitals.

The issues affecting health care today are not going to be solved by expanding the scope of practice of non-physician health care professionals. We believe the focus ought to be on how to train and keep qualified physicians in Pennsylvania.

I encourage the legislature to include the funding of the Primary Care Loan Repayment Program for this year's state budget; providing loan forgiveness for all health care professionals, including physicians, who agree to practice for two years in rural or underserved communities in Pennsylvania.

Not only will this program retain and recruit young physicians to work in Pennsylvania, but it will also attract them to work in the communities throughout the Commonwealth who have struggled with access to care.

We all play an important role in effectively delivering health care. Whether it's certified nurse practitioners, pharmacists, psychologists, or even surgical technicians, there is a role to be

played but the quality of health care is MORE important than getting enough bodies to deliver that care.

It is and always will be about patient safety and quality care.

Thank you again for the opportunity to appear before you. I would be happy to answer any questions you have.

PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR PENNSYLVANIA

Pennsylvania Academy of Family Physicians testimony for House Professional Licensure and House Health Committees joint informational meeting on improving access to health care

March 7, 2024

Honorable Chairmen and Members of the House Professional Licensure and Health Committees, on behalf of our more than 6,000 family physician, resident, and student members, we are delighted this meeting has been called.

Pennsylvania, with its 10 medical schools, 55 Family Medicine Residency Programs, and a diverse workforce engaged in various practice models, stands as a key hub for nurturing the future generation of Family Physicians.

The PAFP has and will continue to work closely with the Department of Health's Bureau of Primary Care to expand Family Medicine residency opportunities and engage in direct outreach in the communities our physicians serve.

Challenges

The PAFP, for many years, has and will continue to work with you in addressing structural problems that inhibit the physician/patient relationship. With your help, we have made strides in addressing prior authorization reform, but more can and should be done to ensure access to high quality, timely patient care.

The credentialing processes imposed on physicians by health insurance providers take physician time away from patients, thus delaying access to quality health care. The PAFP supports legislation that would streamline

health insurer credentialing processes and address other administrative hurdles to ensure timelier patient care.

Additionally, prohibiting the use of non-compete clauses, or restrictive covenants, in health care provider employment contracts would empower physicians with greater career options, helping to ensure better access to and continuity of care for patients across the Commonwealth.

Non-compete contract clauses negatively impact employed physicians and other health care providers by limiting their ability to switch employers, continue seeing their patients, and practice medicine in their home communities. This leads to the interruption of quality patient care and the physician-patient relationship, especially in rural and underserved communities where access to quality health care is already challenging.

Let's keep working together to relieve Pennsylvania's physicians from administrative burdens that delay the delivery of high-quality health care.

Family Physicians, with their comprehensive training in all facets of medicine, serve as the cornerstone of our healthcare system, epitomizing a profound commitment to their patients.

We encourage you to think in terms of fostering a health care system that prioritizes primary care as a cornerstone of overall health. With this as your baseline hypothesis, and our unyielding commitment to ensuring the highest quality health care for all, we can improve the health of Pennsylvanians now and in the future.

<u>Scope of Practice</u>

We must resist simplistic solutions that overlook the intricacies of medicine. Despite medical breakthroughs, a paradigm shift is necessary to truly focus on advancing the physician-led primary health care team. This shift can pave the way for eliminating inequalities in health care, whether due to injustice or simply based on one's zip code.

As Dr. Martin Luther King, Jr. stated, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

The PAFP strongly opposes permitting mid-level providers to practice independently without the oversight of a physician. Patient safety should guide any discussion about improving access to care, especially for our most vulnerable patients.

While acknowledging the valuable contribution of Certified Registered Nurse Practitioners (CRNPs) as our colleagues within the physician-led model of care, we respectfully differ on the elimination of collaborative agreements in Pennsylvania. These agreements serve as a crucial safety net by providing physician support to CRNPs when faced with diagnostic and treatment complexities beyond their training. All patients deserve the assurance of comprehensive care and the highest level of expertise in managing their health.

CRNPs are utilized in current employed models to care for smaller patient panels that are less complex; however, this does not prepare them for the multiple complexities of high-risk populations in undeserved regions and health care deserts where referrals are not readily available. We firmly believe eliminating collaborative agreements is not the solution to improving health care access, despite claims to the contrary.

While CRNPs are an essential component of the primary health care team, they are not a one-to-one replacement for physicians when determining the adequacy of the available workforce due to the significant differences in their education, training, and skill sets.

We, instead, encourage effective, sustainable solutions that don't jeopardize patient safety by disregarding the critical need for physician oversight of mid-level providers.

Likewise, Family Physicians value psychologists as an integral part of their patients' health care team. Family physicians are often the first point of care for a patient's mental health and behavioral issues.

The connection between physical and mental health is undeniable. Family physicians' education and training includes extensive pharmacological training that makes them highly qualified and well-equipped to prescribe medications for mental illness, pain management, and opioid use disorder,

while managing the complex intricacies of balancing mental health and physical health treatment and medications.

The PAFP supports collaboration between physicians and mental health professionals to ensure the highest quality care for patients.

We must continue to work together on alternative approaches to providing the highest quality of care for all Pennsylvanians, without compromising patient safety.

Telemedicine and AI

The promise of technology cannot be overlooked. The Covid-19 pandemic has catapulted the world into a virtual age previously unimagined. And despite its obvious limitations, the entire health care sector must look to harness the lessons learned and move forward in areas that can foster greater access to care.

Artificial intelligence too will have an enormous influence on health care in the future, advancing diagnostic and treatments, as well as patient education. State policies to ensure quality and accessibility of telemedicine and ethical use of AI are complex topics the Pennsylvania General Assembly must grapple with to ensure the best health care possible for all Pennsylvanians.

Importance of and Investment in Primary Care

Critical to this entire discussion, is the substantial evidence that supports the idea that countries that invest in primary care tend to have better health outcomes. Low investment in primary care is a systemic issue that requires a long-term, sustainable, and comprehensive fix.

Primary care is the first point of contact for individuals seeking health care. Primary care physicians conduct more office visits and provide the most comprehensive set of health care services than any specialty, lowering costs and improving utilization of health care services. Here are some reasons why investing in primary care is associated with better health:

1. **Prevention and Health Promotion:** Primary care emphasizes preventive measures and health promotion. Regular check-ups,

vaccinations, and early detection of diseases can lead to better overall health outcomes and reduced health care costs in the long run.

2. **Continuity of Care:** Primary care providers establish long-term relationships with patients, enabling them to better understand their medical history, lifestyle, and individual needs. This continuity of care contributes to more effective management of chronic conditions and overall health.
3. **Early Detection and Management:** Primary care is often the first line of defense in identifying and managing health issues before they become more severe. Timely intervention can prevent the progression of diseases and complications.
4. **Coordination of Care:** Primary care providers coordinate and manage health care services, ensuring that patients receive appropriate and timely referrals to specialists when needed. This coordination helps in the comprehensive and efficient management of health conditions.
5. **Accessibility and Affordability:** Primary care services are typically more accessible and affordable than specialized care. This accessibility encourages individuals to seek medical attention earlier, leading to better health outcomes.
6. **Population Health:** A strong primary care system is associated with improved population health. Countries with a robust primary care infrastructure often have lower mortality rates, better control of infectious diseases, and improved overall health indicators.

Thank you for the opportunity to share our thoughts and concerns. We look forward to continuing the discussion and working with you to address the many challenges faced by both physicians and patients in rural communities across Pennsylvania. It is our shared goal to ensure optimal health for all Pennsylvanians.

Pennsylvania Psychiatric Society

Advocacy | Education | Community
Pennsylvania District Branch of the American Psychiatric Association

February 29, 2024
Committees on Health and
Professional Licensure
Main Capital Building
Harrisburg, PA

RE: Access to care issues
To Chairs Frank Burns and Dan Frankel, and members of the House Committee on Professional Licensure and Committee on Health:

On behalf of the Pennsylvania Psychiatric Society, an American Psychiatric Association district branch, which represents nearly 1500 psychiatric physicians, as well as their patients and families, we are pleased to offer written testimony for the joint session of the Health and Professional Licensure committees. We are heartened that the legislature is working to address the problem of access to care, which our members deal with every day. We receive countless calls from family, friends, other physicians and health care providers asking for help in accessing services; our testimony will focus on access to mental health care.

The pandemic, along with the welcome reduction in stigma, has increased the numbers of individuals seeking mental health care. The harvest is plentiful, the laborers are few. There are many complex reasons for the shortfall in availability of services, and a few good answers to how to improve this.

One possible answer, which has been introduced this session by chairman Frankel so we are circumspect, is to give prescribing privileges to psychologists. We must respectfully oppose such a measure as put forth in HB1000. While psychologists are experts in behavioral interventions,

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they are not required to have any medical training. A crash course in pharmacology does not begin to empower them to prescribe any medication for any patient of any age with any comorbid medical condition. Allowing them to prescribe jeopardizes the health and safety of Pennsylvania patients.

There is often confusion about the difference between psychiatrists and psychologists due to the similar names. While psychologists are valuable mental health professionals and respected colleagues, only psychiatrists are medical doctors who have education in biology, pharmacology, pathology of diseases, and drug-drug interactions. Like neurosurgeons, cardiologists, and internists, psychiatrists are physicians who have attended medical school (4 years) and then complete a rigorous four-year residency in psychiatry. Psychiatrists spend over 12,000 hours of training specializing in the medical treatment of mental health conditions and substance disorders. They focus on the prevention, diagnosis, early intervention, treatment, and recovery of mental, emotional, and behavioral disorders. Through their rigorous medical training, psychiatrists are equipped to conduct psychotherapy, prescribe medications, and perform a full array of other medical treatments. Psychiatrists are medically trained to identify and treat behavioral symptoms of medical conditions, as well as medical complications of mental illness. They often consult with other medical specialists about their patients with both physical and mental issues.

Psychologists treat mental disorders with psychotherapy and other behavioral interventions. A psychologist has an advanced degree, usually a Ph.D. in psychology or Doctor of Psychology (Psy.D.). Psychologists often have extensive training in research or clinical practice and in psychological testing and evaluation, but they **do not** have medical training.

Psychologists prescribing will not meaningfully improve access. This legislation does not address workforce shortage issues because it does not increase the net number of behavioral health providers in Pennsylvania. We don't need more prescribers; we have primary care providers – such as physicians (including psychiatrists) advanced practice nurses and PAs—across the commonwealth. Pennsylvanians need access to a coordinated continuum of quality mental health and substance use services, not just more access to psychotropic drugs. We very much need psychologists doing the work they are trained to do.

Psychologists are not medical professionals and do not have the medical foundation to safely prescribe powerful psychotropic drugs. While doctoral level psychologists are highly educated, advanced medical training is required to understand how psychiatric drugs affect the entire body and interact with other medications. They impact every system in our bodies, not just the brain, and can have dangerous consequences such as seizures, heart arrhythmias, blood diseases, or even death.

Pennsylvanians deserve effective, safe solutions. Investing in programs that truly expand access, integrate care, and do not compromise patient safety is the right solution to address our crisis. Telepsychiatry, collaborative and integrated care, consultation support, school-based clinics, increasing the number of psychiatric residencies available, and improving network adequacy are solutions that increase access and capacity without compromising safety.

The **collaborative care model** is already in use by many of the large health systems in the commonwealth. It pairs practicing psychiatrists with primary care practices, in which a behavioral

health case manager (BHCM) is embedded. They share an electronic health record, can view rating scales filled out by the BHCM, and the psychiatrist advises on management. This leverages the skills of the psychiatrist and empowers the PCPs. Large health systems have found this model to be very helpful and cost-effective, saving $6 for each $1 invested according to many studies. Start-up costs and lack of coordination have stymied expansion through smaller practices and rural areas. Funding for these start-up costs and technical assistance would go a long way toward expanding real care, and help leverage the knowledge and skills our members have. HB 24, currently before the Human Services committee provides such funding.

We would like to have more psychiatrists in Pennsylvania, but while the numbers of graduating medical students applying in psychiatry has never been higher, the bottleneck of too-few psychiatry residency slots has hindered efforts to increase the pool. We think the model New Jersey passed two years ago, **state funding for one additional slot for each of that state's psychiatry residency training programs**, is a good one. The PA legislature appropriated funds for additional family medicine training spots last year; we believe such a move would be welcome by our teaching hospitals. (There were 11 programs in NJ; we have 14 in PA.)

A particular vexing problem with access to care is the **inadequate networks** of many of the insurers operating in the commonwealth. Many, many people have health insurance, which by law (parity) must cover mental health services, but they discover when they try to use this coverage, they cannot find any provider willing to see them, or add them to a waiting list months-long. Desperate parents of troubled young people often then pay out of pocket to an out-of-network provider. This impoverishes the family and enriches the insurance company, who now continues to collect premiums but does not have to pay for care. The American Psychiatric

Association did a "secret shopper" evaluation of the marketplace in several states, including Pennsylvania, a few years ago, which documented this. **Better enforcement of existing parity laws**, as well as **calling out frankly deceptive business practices**, would go a long way to help such families.

Please focus on getting Pennsylvanians the care they need by utilizing safe, effective, evidence-based approaches Psychologists are needed practicing the skills they already have, not adding authority to do what they will not do as well.

Thank you for your efforts to improve access, and the opportunity to submit this written testimony.

Sincerely,

Kenneth M Certa MD
Co-chair, Government Relations Committee
Pennsylvania Psychiatric Society

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Valentins Krecko, MD
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February 19, 2024

The Honorable Frank Burns
Chairman, Professional Licensure Committee
1234 State Street, Harrisburg, PA 17101

Dear Chairman Burns,

As a board-certified psychiatrist I am writing to offer my strong support for HB1000, which would grant prescriptive authority to qualified psychologists in the Commonwealth of Pennsylvania.

Licensed psychologists are highly trained health care professionals whose path to licensure includes completion of a doctoral degree (PhD or Psy.D.); a postdoctoral residency; and passing a national licensure exam and a state jurisprudence exam. This prescriptive authority would be regulated, in that only psychologists who complete an additional two-year postdoctoral master's degree in clinical psychopharmacology would qualify. This rigorous training exceeds that of many nurse practitioners and physician assistants who already have prescriptive authority of psychotropic medications.

Adding prescriptive authority for psychologists would help ease the severe shortage of mental health prescribers in Pennsylvania. This shortage has resulted in long wait times for treatment, which in turn has resulted in poorer clinical outcomes and greater health care costs.

Respectfully,

Valentins Krecko MD

Valentins Krecko, MD
Board certified psychiatrist

March 2023

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Prescriptive Authority for Psychologists

Proposed Legislation to Grant Prescriptive Authority to Psychologists with Advanced and Specialized Training in Clinical Psychopharmacology

PPA RxP Workgroup

Lead Authors:
John Gavazzi, PsyD ABPP
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Proposed Legislation to Grant Prescriptive Authority to Psychologists with Advanced and Specialized Training in Clinical Psychopharmacology

EXECUTIVE SUMMARY

There is a growing national mental health crisis and a shortage of psychiatric specialists to meet the demand (Merritt Hawkins Report, 2018). Most psychotropics are currently prescribed by primary healthcare professionals, including physicians, nurse practitioners, and physician assistants; however, these professionals often have limited training in mental health treatment.

Prescribing psychologists can increase patient access to psychotropic medications, reduce travel, decrease wait times, and ensure better follow-up care for patients already on psychotropic medications. Importantly, suicide rates have decreased in states that have added prescribing psychologists to the workforce (Choudry & Plemmons, 2021). Prescribing psychologists can manage medication treatment for most mental health disorders. They must earn an additional post-doctoral master's degree emphasizing psychopharmacology and the biological bases of behavior, pass a rigorous national exam, an engage in supervised practice.

Currently six states have prescription authority for appropriately trained psychologists: Colorado, Iowa, Idaho, Illinois, Louisiana, and New Mexico. Also, prescribing psychologists have safely and effectively prescribed psychopharmacologic medications in the Public Health Service, Indian Health Service, and the US Military for more than 25 years. The health and welfare of Pennsylvania citizens would improve if this legislation passed into law.

PPA PROPOSAL

The Pennsylvania Psychological Association (PPA) is pursuing legislation to grant prescriptive authority to licensed psychologists with advanced degrees and training in prescribing psychotropic medications, with the goal of increasing access to appropriate mental health treatment for Pennsylvanians.

To become a prescribing psychologist, a doctoral-level psychologist would need to complete the following additional qualifications (on top of the existing requirements for psychology licensure):

1. Complete a two-year (450 hours) post-doctoral master's degree in clinical psychopharmacology, focusing on physiology, pathophysiology, neuroscience, pharmacology, clinical psychopharmacology, and legal/ethical issues;
2. Pass the national board examination (Psychopharmacology Examination for Psychologists);
3. Complete a preceptorship under the supervision of a physician (MD/DO) that comprises at least 100 patients and 400 hours of direct clinical contact; and,
4. Prescribe psychotropic agents via a collaborative agreement with primary care providers.

The additional post-doctoral education and training for prescribing psychologists are comparable to other mid-level prescribers, such as nurse practitioners and podiatrists, and the knowledge and competency are comparable to psychiatrists, psychiatric nurse practitioners, and physician assistants (see Chart 1).

After additional training and supervision, psychologists will be credentialed as an independent prescribing psychologist, only allowed to prescribe psychotropic agents that are approved for the treatment of mental and emotional disorders. To maintain the prescribing psychology certificate, prescribing psychologists would be required to completed additional continuing education hours, on an ongoing basis, in psychopharmacology.

This proposed legislation seeks to expand the scope of practice for licensed doctoral-level psychologists with the additional training described above. Once prescribing psychologists gain prescriptive authority in other states, they have been viewed by other prescribers positively, and as competent practitioners (Linda & McGrath, 2017). No state that has granted prescriptive authority to appropriately trained psychologists has rescinded it.

WHY THIS MATTERS

Psychiatric service gaps are found across Pennsylvania.

Rural, urban, and suburban areas all struggle to provide sufficient psychiatric services to meet the demand. There are two Pennsylvania counties with the highest Health Professional Shortage Area (HPSA)[1] scores: Philadelphia County (urban) and Potter County (rural). Meanwhile, suburban areas such as Westmoreland County or Chester County have moderate scores, demonstrating insufficient psychiatric care to meet local population needs. PPA conducted a recent survey of licensed psychologists and found that over 41% of clients are required to wait four or more weeks for psychiatric care, including active clients. Based on the evidence (Malowney, et. al, 2015; Warner, 2022), there is not enough psychiatric availability to meet Pennsylvania's needs (see Map 1: Pennsylvania Psychiatric Shortage Map).

Even if there were enough psychiatrists, many do not accept Medicaid or Medicare. In terms of Medicaid, only 35.4% of psychiatrists accept new Medicaid patients, while 73.3% of other medical specialists accept Medicaid (Wen, et al., 2019). As of March 2022, Pennsylvania has enrolled 3,524,494 individuals in Medicaid and CHIP programs (Medicaid & CHIP, 2022). A survey of prescribing psychologists in New Mexico indicated 90% of prescribing psychologists accepted Medicaid (Vento, 2014). Therefore, there is a higher likelihood of Pennsylvanians with Medicaid coverage will have greater access to medication management by prescribing psychologists.

With respect to older Pennsylvanians, only 36.8% of psychiatrist participate in Medicare (Oh, et al., 2022). As of 2020, Pennsylvania has over 2.7 million Medicare beneficiaries (Statista, 2022). Prescribing psychologists will likely increase access for senior citizens.

Pennsylvania needs nearly 1,000 prescribers to meet the need by 2030

The Health Resources and Services Administration (HRSA) Quarterly Reports reveals a pattern of demonstrated need: Pennsylvania will need approximately 1,000 prescribing professionals to meet the most rudimentary mental health standards by 2030. Legislating prescribing psychologists is essential to achieve this goal. The healthcare system is unable to support enough psychiatrists to cover the demand, as psychiatrists are expensive and rare. The recent increases in psychiatry resident numbers (Moran, 2021) are insufficient to fix Pennsylvania's lack of prescribers. The *Psychiatric Times* admits this point and suggests that psychiatrists collaborate more with nurse practitioners (NPs), especially in states that limit their license (Kuntz, 2022).

Psychiatric NPs could, in theory, address this need. However, another recent analysis (see Map 2: Psychiatric Nurse Practitioner map) demonstrates an inadequate number of psychiatric NPs in Pennsylvania to meet demand (total NPs is 673). More than 70% of Pennsylvania counties have 10 or fewer psychiatric nurse practitioners (Warner, 2022).

ADDING ESSENTIAL PRESCRIBERS

Psychologist prescribers are uniquely positioned to address the psychiatric access gap in Pennsylvania. There are two ways to measure the possible increase in doctoral-level prescribing professionals in Pennsylvania.

First, we can measure other states with prescribing psychologists as exemplars. In New Mexico, 6.4% of psychologists became prescribing psychologists. The total number is 50. However, because there are 274 psychiatrists in New Mexico, those 50 prescribing psychologists increased the total doctoral-level prescribers by 18.25%. In Louisiana, there are approximately 110 prescribing psychologists, which boosted their number of doctoral-level prescribers by 23.5%, as there are 471 psychiatrists in that state. Given that there are roughly 6,000 psychologists in Pennsylvania, these estimates predict between 384 (6.4%) and 684 (11.4%) doctoral-level prescribers. This estimate of potential prescribing psychologists is in the range of current Psychiatric Nurse Practitioners as of July 2022 (See Map 2: Psychiatric Nurse Practitioner Map).

Second, a recent Pennsylvania Psychological Association survey found that 14% of PPA members would "likely" or "very likely" pursue the necessary training to become prescribers if permitted. Given 6,000 psychologists in the Commonwealth, Pennsylvania could add 840 prescribing psychologists into the workforce, increasing doctoral-level prescribing by 36%. Furthermore, the distribution of these psychologists and a telemedicine option enables them to work with a wide range of Pennsylvania residents (Warner, 2022). Again, there would likely be greater access to care from those Pennsylvanians who have Medicaid coverage (see Vento, 2014).

Prescribing psychologists will help fill the lack of access to psychotropic medication treatment by doctoral-level professionals. Family medicine providers agree that having a prescribing psychologist embedded in a family medicine clinic is helpful to their practice, safe for patients, convenient for patients, and improves patient care (Shearer, Harmon, Seavey, & Tui, 2012).

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ENDNOTE

[1]The Health Resources & Services Administration (HRSA) is the federal bureau that calculates scores measuring quantity and quality of access to various medical services, including psychiatry, over designated geographic areas. The HRSA process is broad and implemented through various subsidiary programs. Thus, it is difficult to establish a singular cohesive perspective on one or more communities. For instance, the HRSA has separate programs for facility deficits, geographic area deficits, and deficits affecting 'special populations' (elderly, children, impoverished groups, etc.). However, HRSA has yet to provide a complete assessment of any particular region's total needs, and may underestimate actual psychiatrist availability (Malowney, et. al, 2015).

Chart 1: Prescribing Professionals in Pennsylvania

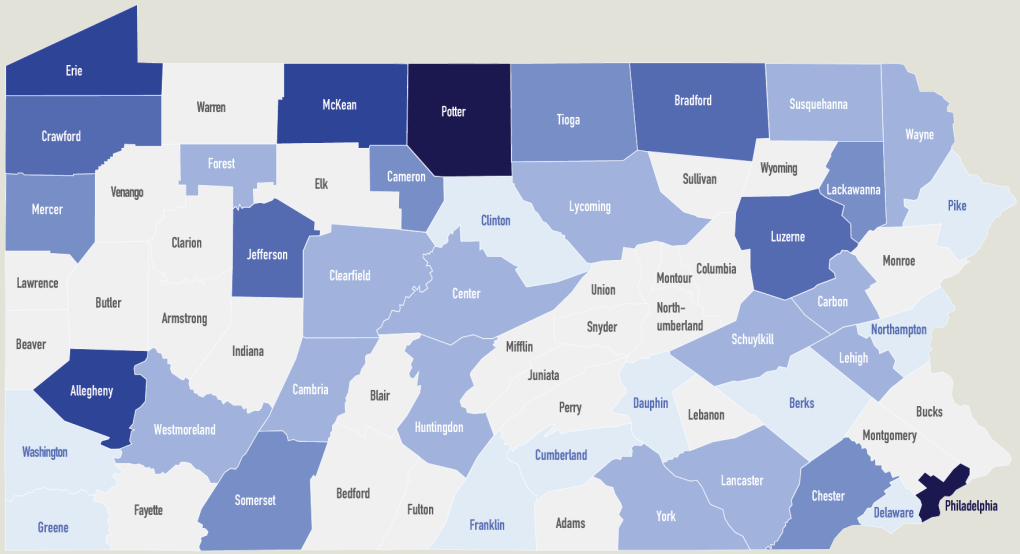
Comparisons in Education Prior to Licensure

Psychiatrist	Primary Care Physician	Physician Assistant	Nurse Practitioner	Prescribing Psychologist	Podiatrist	Optometrist	Dentist
Bachelor's Degree	Bachelor's Degree	Bachelor's Degree	Bachelor's Degree	Bachelor's Degree	Bachelor's Degree	Bachelor's Degree	Bachelor's Degree
Doctoral Degree	Doctoral Degree	Master's Degree	Master's Degree	Doctoral Degree	Doctoral Degree	Doctoral Degree	Doctoral Degree
Licensing Exam	Licensing Exam	Licensing Exam	Licensing Exam	Licensing Exam	Licensing Exam	Licensing Exam	Licensing Exam
Grad Med Trainee License	Grad Med Trainee License	PA-C License	CRNP License	Psychology License	Podiatry License	Optometry License	Dental License
Residency (4 years)	Residency (3 years)			Additional Master's Degree			
Licensing Exam	Licensing Exam			National Examination			
Physician License	Physician License			Prescribing Certificate			
Prescribe Any Medication	Prescribe Any Medication	Prescribe medications under physician co-signature	Prescribe medications with collaborative agreement	Prescribe psychotropic medication only with collaborative agreement	Prescribe medications relative to speciality	Prescribe medications relative to speciality	Prescribe medications relative to speciality

Pennsylvania Psychiatric Shortage

This map illustrates psychiatric shortages across Pennsylvania.

Key Finding: Mental health service gaps are found across the state: Rural, urban and suburban areas all struggle with providing a sufficient psychiatric workforce to meet need.



HPSA Score Range

61-100	51-60	31-50	21-30	11-20	1-10	0

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Psychiatric need being met by current psychiatric workforce: **40.28%**

Pennsylvania citizens directly affected by shortage: **1,729,047 people**

Percent of counties with a shortage of child or adolescent psychiatrists: **97%***

Number of PA psychologists "very likely" or "likely" to become prescribers if permitted: 850**

GET INVOLVED!
Learn how other states are addressing this crisis with prescribing psychologists:
www.papsy.org/RXP

This map provides the county level sum of the federal government's various Health Professional Shortage Area (HPSA) scores. Darker regions have a larger psychiatric shortage gap, which means more high needs populations and less access to care. For more details on the construction of the Pennsylvania Psychiatric Shortage Map please visit our website: www.papsy.org/RXP

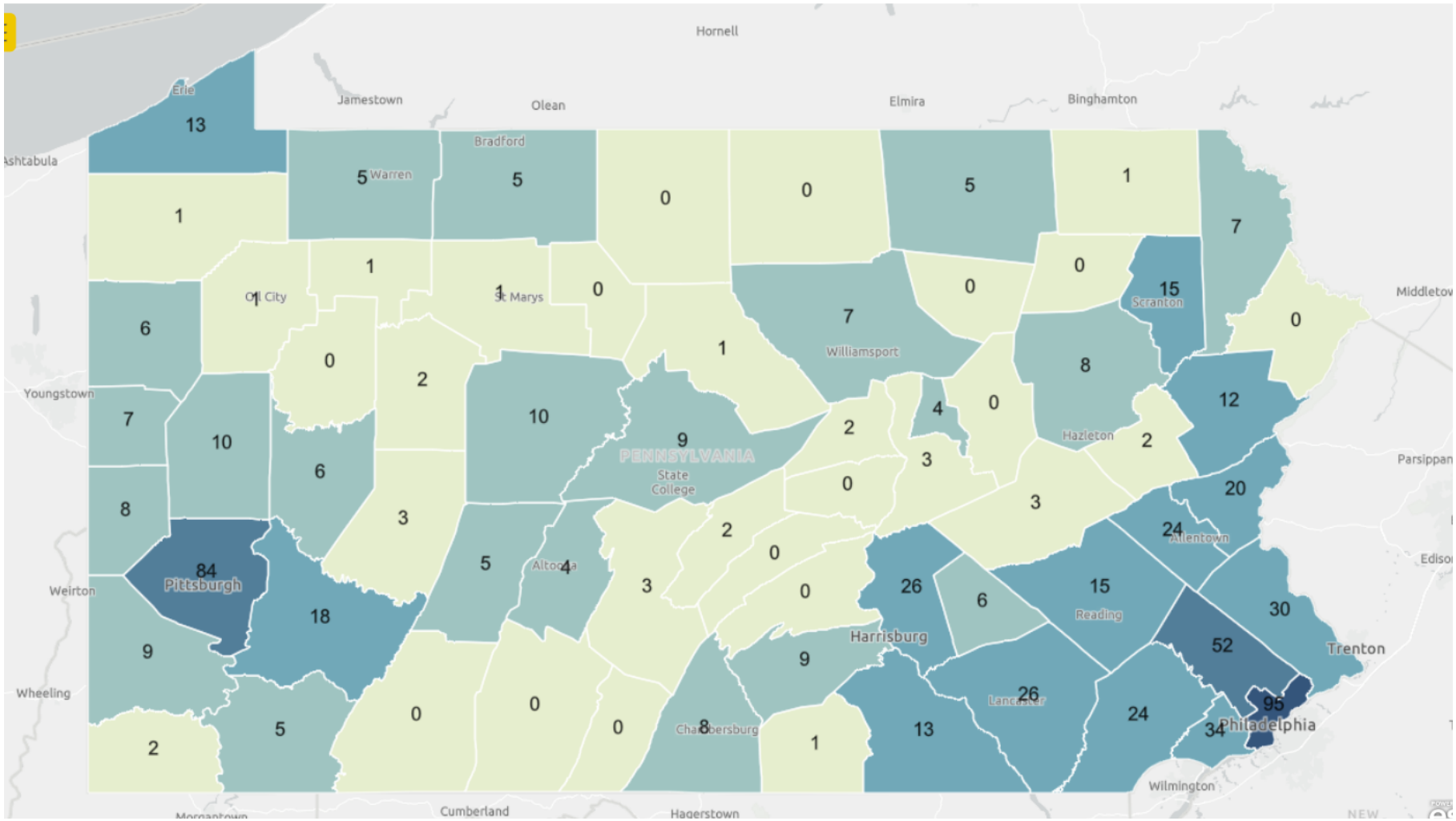
*According to American Academy of Child & Adolescent Psychiatry Workforce Maps: https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

** According to the most recent (2022) Pennsylvania Psychological Association membership survey.

This map data comes from HRSA, and is of 01-20-2022, downloaded from web page: https://data.hrsa.gov/tools/shortage-area/hpsa-find

This map was last updated 07-26-22

Map 1: Psychiatric Shortage in Pennsylvania



Map 2: Psychiatric Nurse Practitioners in Pennsylvania

Total Number = 673