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FINAL REPORT OF THE BARRIERS TO GEORGIANS' ACCESS TO ADEQUATE HEALTHCARE SENATE STUDY COMMITTEE

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Senator Larry Walker
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Immediate Past President of the Georgia Board of Nursing

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Commissioner Frank Berry
Georgia Department of Community Health

Commissioner J. Patrick O'Neal
Georgia Department of Public Health

Prepared by the Senate Research Office 2017

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COMMITTEE FOCUS, CREATION, AND DUTIES

The Senate Study Committee on Barriers to Georgians' Access to Adequate Healthcare (Committee) was created with the adoption of Senate Resolution 188 during the 2017 Legislative Session. The Committee was charged with undertaking a study of the unmet medical care needs of Georgians and the practice authority of Advanced Practice Registered Nurses (APRN) in Georgia.

The following individuals were appointed by the President of the Senate to serve as members of this Committee:

- Senator Renee Unterman of the 45th, Chair
- Senator Larry Walker of the 20th
- Brenda Rowe, Immediate Past President of the Georgia Board of Nursing
- Dr. Erin Hernandez, APRN
- Dean Lucy Marion, Augusta University
- Dr. Karen Kinsell, Clay County Physician
- Dr. Aimee Manion, Immediate Past President of the Georgia Nurses Association
- Commissioner Frank Berry, Georgia Department of Community Health
- Commissioner J. Patrick O'Neal, Georgia Department of Public Health

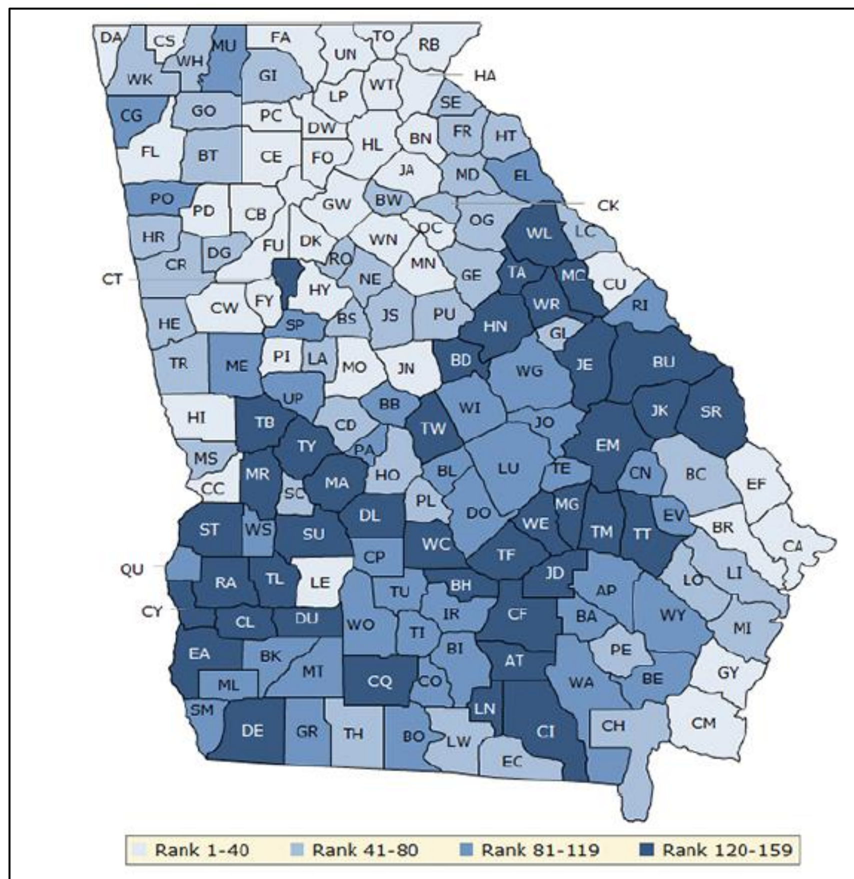
The following legislative staff members were assigned to this Committee: Jared Evans and Elton Davis of the Senate Budget and Evaluation Office; Ines Owens of the Senate Press Office; Megan Andrews of the Senate Research Office; Lynn Whitten of the Office of Legislative Counsel; and Avi'el Bland, Senate Health and Human Services Committee Secretary and Legislative Assistant to Senator Unterman.

BACKGROUND

According to the United Health Foundation, Georgia is ranked 41st in the nation for overall health of the state. These rankings are based on several measures in the categories of behaviors, community/environment, policy, clinical care, and outcomes. Specific indicators include the percentage of children in poverty, the uninsured population, low birthweight, cardiovascular deaths, etc. Within specific indicators, Georgia ranked lowest in the categories of children in poverty (49th), lack of health insurance (47th), low birthweight (47th), and dentist accessibility (46th).

The Robert Wood Johnson Foundation created county-specific health rankings based on health factors to highlight the areas of the state with the biggest health concerns, as shown in Figure 1. These rankings are based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment. Those counties indicated as dark blue are identified as the lowest ranking counties for health factors, whereas the lighter shades indicate better performance. As shown in the map below, the most concerning region is located in South and Middle Georgia.

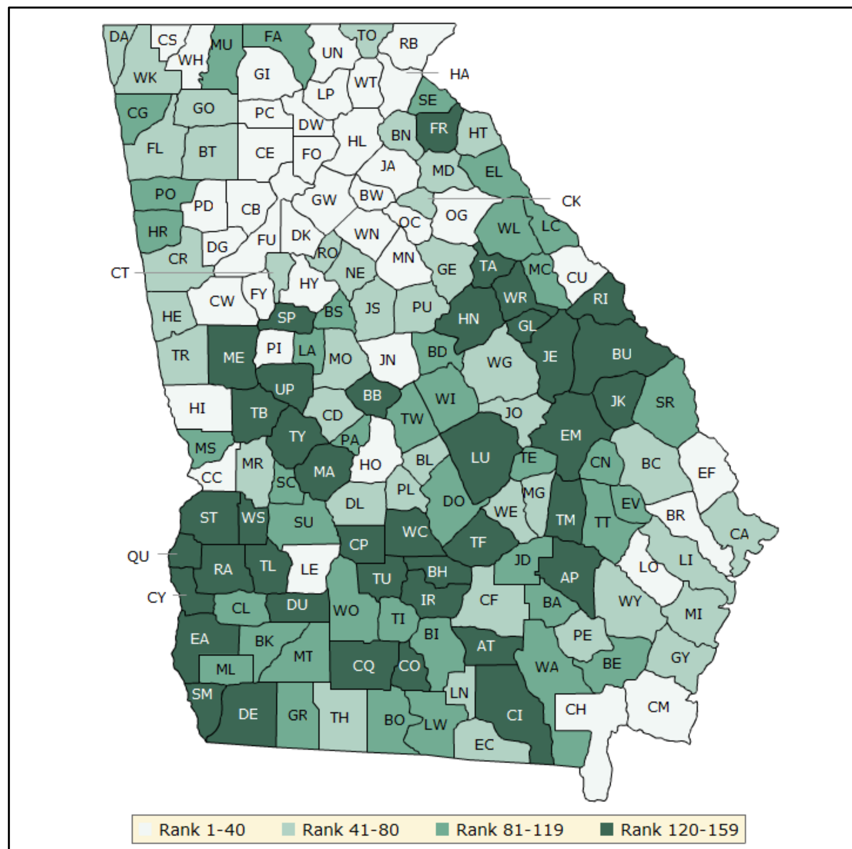
Figure 1. 2017 Health Factors County Rankings in Georgia



Source: Robert Wood Johnson Foundation, as of November 27, 2017.

Additionally, the Robert Wood Johnson Foundation created county-specific health rankings based on health outcomes to highlight the areas of the state with the worst health outcomes, as shown in Figure 2. These rankings are based on the average life span of individuals within the county and the quality of life of those individuals. Those counties indicated as dark green are identified as the lowest ranking counties for health outcomes, whereas the lighter shades indicate better performance. As shown in the map below, the most concerning region is again located in South and Middle Georgia.

Figure 2. 2017 Health Outcomes County Rankings in Georgia

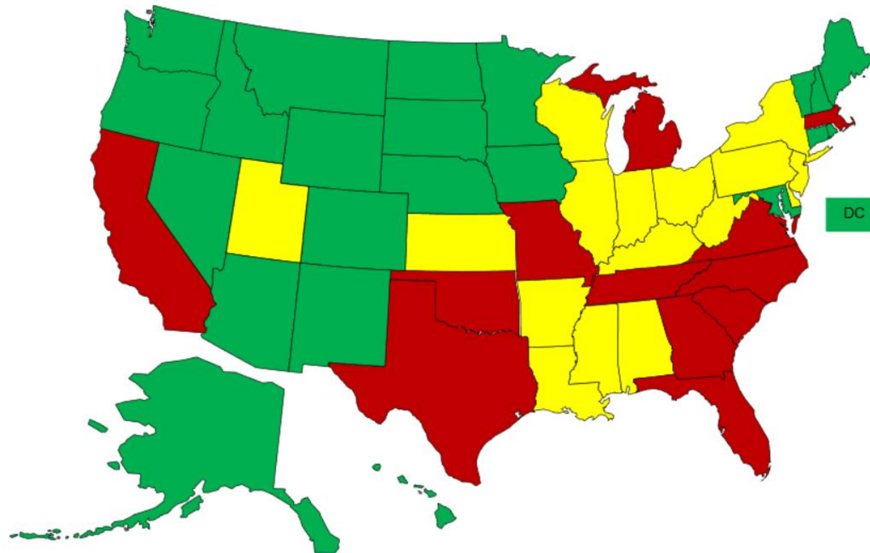


Source: Robert Wood Johnson Foundation, as of November 27, 2017.

According to the Georgia Board for Physician Workforce, there are specific provider shortages that their organization attempts to address through loan repayment programs. Some examples of these shortages are that 9 counties have no physicians, 63 have no Pediatric physicians, 79 have no OB/GYN physicians, and 22 have no APRNs. In order to maintain the status quo, Georgia will need an additional 2,099 primary care physicians by 2030. This is an increase by 38% of primary care physicians. Based on a 2015 survey, 53.4% of the physician workforce in Georgia is 50 or older and 23% of those physicians plan to retire in the next years, further exacerbating this issue.

Nurse scope of practice laws and regulations are unique to each state. The figure below shows the practice environment details for all 50 states, with red representing the most restricted practice environment, and green representing the least restricted practice environment. This figure shows that 22 states and the District of Columbia currently provide for full practice authority, 16 states provide for reduced practice authority, and 12 states provide for restricted practice.

2017 Nurse Practitioner State Practice Environment



Full Practice
State practice and licensure laws provide for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.

Reduced Practice
State practice and licensure law reduce the ability of nurse practitioners to engage in at least one element of NP practice. State requires a regulated collaborative agreement with an outside health discipline in order for the NP to provide patient care or limits the setting or scope of one or more elements of NP practice.

Restricted Practice
State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State requires supervision, delegation or team-management by an outside health discipline in order for the NP to provide patient care.

Georgia is currently classified as a restricted practice environment. Under this framework, APRNs must enter into a Collaborative Practice Agreement with a physician. This is referred to as a nurse protocol agreement in Georgia. Current law defines a nurse protocol agreement as a written document signed by an APRN and a physician, in which the physician delegates to the APRN the authority to perform certain medical acts such a prescribing drugs, medical devices, treatments, diagnostic studies, or in life threatening situations, radiographic imaging tests. Georgia is the only state in the nation that has a statutory restriction specific to radiographic imaging tests. Delegating physicians may not enter into a nurse protocol agreement with more than 8 APRNs at a time, and may not supervise more than 4 APRNs at any one time. Additionally, APRNs are unable to prescribe Schedule I or Schedule II controlled substances.

MEETING TESTIMONY

This section provides a brief summary of topics covered at each meeting, including the names and affiliations of individuals who were asked to provide testimony to the Committee. Although testimony has been condensed to ensure the report could be timely submitted, copies of all presentations and materials submitted to the Committee are kept on file in the Senate Research Office.

Meeting 1- September 27, 2017

The first meeting was held at the Coverdell Legislative Office Building in Atlanta, Georgia, and consisted of an overview of the provider issues facing Georgia. The individuals who provided testimony and the subjects of each presentation are listed below.

- "Overview: Health in Georgia"
  - Karen Minyard, Ph.D., Executive Director, Georgia Health Policy Center
- "Provider Shortages"
  - Monty Veazey, President, Georgia Alliance of Community Hospitals
  - LaSharn Hughes, MBA, Executive Director, Georgia Board for Physician Workforce
  - Jimmy Lewis, CEO, Hometown Health
- "Overview of Nursing in Georgia"
  - Jim Cleghorn, Executive Director, Georgia Board of Nursing
  - Lisa Eichelberger, Ph.D., RN, Georgia Nursing Leadership Coalition
- "Infrastructure and Access to Care in Rural Georgia"
  - Terri Dumas, MPH, Deputy Director of District and County Operations, Georgia Department of Public Health

Meeting 2- October 16, 2017

The second meeting was held at Augusta University in the Lee Auditorium in Augusta, Georgia, and consisted of an overview of APRN preparation, education, and certification. The individuals who provided testimony and the subjects of each presentation are listed below.

- "Physicians of Georgia"
  - Dr. Scott Bohlke, Medical Association of Georgia
- "Primary Care Shortages and APRNs"
  - J.R. Richards, Chief Executive Officer of Medical Associates Plus, FQHC
  - Patsy Whaley, Executive Director of Georgia State Office of Rural Health
- "APRN Education- Doctor of Nursing Practice Education and the Scholar Clinicians"
  - Dr. Elizabeth Downes, Professor at Emory University
- "Panel of Augusta College of Nursing Faculty- Preparing Nurses for Rural Health"
  - Dr. Sandra Inglett, Health Start
  - Dr. Darrell Thompson, BHWET and IMPAACT
  - Dr. Julie Zadinsky, Rural Access to Care
  - Dr. Beth Nesmith, Acute Care NP/DNPs

- "Augusta University Center for Rural Health Support and Study"
    - Catherine Clary, Director of the Center for Rural Health Study and Support
- "APRN Licensure, Accreditation, Certification, & Education Consensus Model and APRN Education Standards 2017"
    - Dr. Suzanne Staebler, President of National Certification Corporation and Professor at Emory University
- "APRN Safety/Efficacy & Nurse Protocol Agreements"
    - Dr. Carolyn Clevenger, Director of Integrated Memory Care Clinic

Meeting 3- November 6, 2017

The third meeting was held at the Capitol Room 450 in Atlanta, Georgia, and consisted of a discussion of the specific issues facing APRN practice in Georgia. The individuals who provided testimony and the subjects of each presentation are listed below.

- "2015 Report on APRN Full Practice Authority"
    - Berneta Haynes, Director of Equity and Access of Georgia Watch
- "Retail Health"
    - Dr. Sony Morton, Chief Medical Director for CVS Minute Clinics
- "Preceptorship in Georgia"
    - Denise Kornegay, Executive Program Director of the Georgia Statewide Area Health Education Centers Network
- "Mental Health Access Crisis and APRNs"
    - Gale Macke, Executive Director of LPCA of Georgia
    - Dr. Kay Brooks, Executive Director of ASPIRE Behavioral Health and Developmental Disability Services, Albany Area CSB; not present to provide testimony, but the presentation was distributed to committee members
- "APRN Safety and Quality of Care"
    - Tay Kopanos, American Association of Nurse Practitioners
    - Dr. Michelle Nelson, President of UAPRNs
- "Wrap-up of Recommendations to Address Barriers to Care"
    - Dr. Dwyane Hooks, Assistant Dean for Community Partnerships & Associate Professor at Augusta University

Meeting 4- November 27, 2017

The fourth meeting was held at the Capitol Room 450 in Atlanta, Georgia. Committee members discussed and voted unanimously to adopt the final report.

COMMITTEE FINDINGS

APRN Practice Authority

The Committee was created to examine the current framework regulating the practice of APRNs in Georgia, including the potential removal of the requirement for physician supervision. At Meeting 2, the Committee heard testimony from various individuals on the education, certification, and current practice environment for APRNs in Georgia. Specifically, the Committee heard testimony from Carolyn Clevenger, the Clinical Director at the Emory Integrated Memory Care Clinic. She discussed the day-to-day challenges of providing care to patients in a Collaborative Practice Agreement environment.

States that are identified as full practice authority means that the state practice and licensure laws provide for all nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, and initiate and manage treatments (including prescribing medications) under exclusive licensure authority of the state board of nursing.

At Meeting 3, the Committee heard testimony from Tay Kopanos from the American Association of Nurse Practitioners on other state's results from expanding to full practice authority. The Committee heard that Oregon previously utilized a regional approach to the expansion of full practice authority in rural areas, however, no states currently provide for a similar regional approach. Additionally, Tay Kopanos provided the committee with several studies and reports showing that APRN patient outcomes are comparable to physician patient outcomes.

Preceptorship Tax Credit

The Committee heard testimony from Denise Kornegay, the Executive Director and Associate Dean for the Georgia Statewide Area Health Education Centers (AHEC) on the preceptorship program in Georgia. The Preceptor Tax Incentive Program provides a tax credit for providers to participate in the training of future health care professionals. Under current law, physicians who serve as the community based faculty physician for a Georgia student studying in a program for medicine, physician assistant, or nurse practitioner may claim a tax deduction in an amount equal to $1,000.

The Committee also heard from Representative Lott who is the sponsor of House Bill 301, which is currently pending in the Senate Finance Committee. This bill deletes the current deduction and creates a new, more expansive tax credit for a community based faculty preceptor when he or she conducts a preceptorship rotation, allowing up to ten per year. The credit is accrued on a per preceptorship rotation basis in the following amounts:

- Physician Preceptor: $500 for the first through third rotations and $1,000 for the fourth through tenth rotations completed in one calendar year; and

- Advanced Practice Registered Nurse and Physician Assistant Preceptor: $375 for the first through third rotations and $750 for the fourth through tenth rotations completed in one calendar year.

To receive the credit, the preceptor must claim it on the tax return for the year in which he or she completed the preceptorship rotation and submit any supporting documentation as required by the commissioner. This tax credit cannot exceed the taxpayer's tax liability, and there is no carryforward on unused credits.

Hospital Board Education Program

At Meeting 2, the Committee heard testimony from Catherine Clary, the Director of the Center for Rural Health Support and Study. She testified regarding recommended actions for rural hospitals, including an orientation and ongoing education for hospital CEOs and board members. This recommendation was based on the fact that the Board can often outlast the CEO or other Administrators. Additionally, these board members may not understand their responsibilities or healthcare finance. Generally they are community leaders, and may not have relevant experience of the issues faced as a hospital board member.

In 2007 New Jersey was the first state to pass legislation that requires individuals who serve on the board of trustees of a general hospital to complete a training program.[1] This program must be approved by the Commissioner of Health and be designed to clarify the roles and duties of a trustee. Individuals must complete this training within 6 months of appointment to the hospital board.

Centering Pregnancy Program

In Meeting 1, Terri Dumas from the Department of Public Health (DPH) presented on the specialized services provided in some health departments, such as the Centering Pregnancy program. Additionally, Dr. Sandra Inglett from Community Healthy Start testified that one way to improve the health of Georgians is to design and provide innovative pregnancy programs such as centering.

The Centering Pregnancy program is an evidence-based model of group healthcare. This model supports positive health behaviors and improves health outcomes by combining health assessment, interactive learning, and community building. This program has been shown to decrease the rate of preterm and low birthweight babies, increase breastfeeding rates, and lead to better pregnancy spacing. In Georgia there are 17 Centering Pregnancy Programs, two of which are located within public health settings (Dougherty and Colquitt counties). Work is being done to expand this program to Richmond County Health Department in early 2018. The Health Department programs collaborate with private providers and hospitals to implement the program.

[1] N.J.S.A. 26:2H-12.34

Many of the programs in Georgia are currently grant-funded through nonprofit organizations. In order to expand access to this program, funding will be required for their startup and ongoing staffing costs. South Carolina currently incentivizes group prenatal care through enhanced Medicaid reimbursement.

Telehealth

At Meeting 1, the Committee heard testimony from Jimmy Lewis, the CEO of Hometown Health. He testified that one way to address the barriers to care issue in Georgia is to expand the use of telehealth. This can be done by increasing payments, loosening rules, training presenters, and increasing application in high access areas such as schools, prisons, state health benefits plans, etc. Additionally, DPH testified regarding their telehealth projects in nutrition education, pediatric children's medical services, behavioral health, etc. They discussed their goals of expanding the telehealth network to address provider shortages in rural Georgia.

At Meeting 2, JR Richards from Medical Associates Plus Federally Qualified Health Center (FQHC) recommended that Georgia increase the use of telehelath to deliver care. Additionally, Dr. Sandra Inglett from Community Healthy Start testified that one way to improve health care is to prepare APRNs for telehealth methods of delivery for the treatment of mental health disorders and to provide OB services. An expansion of the telehealth network, and utilization of APRNs in rural areas to facilitate use of the telehealth technology is one way to address provider shortages in rural areas.

Mental Health

In Meeting 3, Gale Macke with the Licensed Professional Counselors Association described the challenges in providing behavioral health services to Georgians. These challenges include an uneven geographic distribution of providers, recruitment challenges across the treatment field, and a fragmented system of provider silos. Jimmy Lewis testified regarding the barriers to accessing mental health services, including insufficient licensed practitioners to meet the needs of the community, Community Service Boards (CSBs) with inadequate beds, and the opioid epidemic. One suggestion was the possibility of expanding the use of telemedicine to cover mental health services. DPH discussed a telehealth project they are working on as a collaborative school-based behavioral health telemedicine pilot in Lamar County Schools.

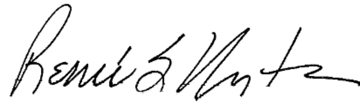
COMMITTEE RECOMMENDATIONS

Based on the foregoing findings, the Committee makes the following recommendations:

1. The Committee agrees that at a time of critical need, the underserved rural areas in Georgia require an innovative approach to healthcare to improve access to care. Therefore, legislation should be introduced to grant APRNs full practice authority in the counties identified as the lowest ranking in health factors and outcomes.
2. The Committee agrees that the Preceptor Tax Incentive Program should be expanded to allow Physician Assistants and APRNs to serve as preceptors and receive a tax credit for such service.
3. In order to promote the governance of Georgia hospitals, the Committee supports efforts to ensure hospital board members receive education and training relevant to their responsibilities.
4. The Committee recommends that the Centering Pregnancy model utilized in Albany, Georgia should be expanded to Department of Public Health facilities statewide, and the state should provide additional funding for such expansion.
5. The Committee supports the expansion of telemedicine and allowing APRNs to be utilized in facilitating and providing patient care through the use of telemedicine.
6. The Committee supports efforts to improve Georgians' access to mental health services by improving the practice environment for mental health providers and working on recruitment efforts to counties without a mental health provider.
7. In order to ensure APRNs receive reimbursement in those areas with full practice authority, a Current Procedural Terminology (CPT) code should be created to allow APRNs to serve as a primary care provider and properly bill health insurance providers, such as Medicaid. Additionally, state agencies should their examine policies that create barriers to delivering services to patients.

Respectfully Submitted,

THE SENATE STUDY COMMITTEE ON BARRIERS TO GEORGIANS' ACCESS TO ADEQUATE HEALTHCARE



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Senator Renee Unterman, Chair
District 45