

Thank you for holding this much needed public workshop and for allowing me to share my comments. I am Nurse Practitioner (NP) Dr. Olivia L. Young. I am board certified as a family psychiatric mental health nurse practitioner (BC-FPMHNP). My comments touch on several of the questions posed in your February 24, 2014 Federal Register Notice but are intended to particularly focus on the following three.

1. Are there regulatory or commercial barriers that may restrict the use of retail clinics, telemedicine, or other new models of health care delivery? If so, are there any valid justifications to support such restrictions?
2. What recent developments have occurred in the regulation of health care professionals, particularly with respect to accreditation, credentialing, licensure, and supervision/cooperation requirements?
3. What are the consequences of such regulations? To what extent are these regulations necessary to protect consumers or serve other important state interests? How do they affect the supply of services, patient safety, costs, care coordination, and quality of care?

Before addressing the three questions, a quick review of a few statistics about the state in which I live and a brief review of my background can facilitate your understanding of my perspective on the above questions.

The state of Missouri is my home state. I have been a resident for over twenty-five (25) years. Numerous governmental and private studies have found that the state ranks in the lower quartiles on various health care indicators and, in a 2010 study, Missouri ranked 39th in terms of overall health rankings when compared to other U.S. states (Haycraft and Voss, 2014). One hundred and nine (109) of the state's 114 counties and one independent city are healthcare professional shortage areas (HPSA) or are medically underserved (Haycraft and Voss, 2014).

The statistics are even grimmer for mental health care. There is a severe shortage of psychiatrists and patients often wait months for care (Parks, 2013). The state has had one of the highest suicide rates for more than a decade with a rate of 14.1 per 100,000 in 2009 (Missouri Institute for Mental Health, 2012). Moreover, mortality rates among Missouri's severely mentally ill indicates that they continue to die about twenty-five years prematurely when compared to those without a severe mental illness (Parks, 2013). Tobacco smoking is the leading cause of preventable death in the United States (Substance Abuse and Mental Health Services Administration, 2013) and smoking rates among the severely mentally ill population ranges from 34 to 90% (Morris et al). In a 2010 study of seriously mentally-ill consumers of Missouri Department of Mental Health funded program services, about 70 % of study participants indicated that they smoke cigarettes in order to relax and relieve their sense of stress (Missouri Foundation for Health, 2010). Understandably, Missouri's public mental health system also suffers from shortages of psychiatric mental health care providers, and is only able to serve about 25% of the population in need (National Alliance for the Mentally Ill, 2010).

My Credentials

I completed the University of Missouri-Columbia, Sinclair School of Nursing post-master's family psychiatric mental health nurse practitioner (FPMHNP) program in May of 2013 and passed the *American Nurses Credentialing Center's* (ANCC) specialty exam a month later. Passing the exam entitled me to use the credential "BC" after my specialty credential, FPMHNP. The credential, "BC" means board certified. State boards of nursing require passing an ANCC exam as a condition for state recognition as an advanced practice registered nurse (APRN).

I entered my FPMHNP program with over twenty years of nursing experience, a second undergraduate degree in youth development and delinquency study from Southern Illinois University-Edwardsville, an initial Master of Science in Public Health Nursing, Family Nurse Practitioner (FNP) track, from the University of Illinois-Chicago, College of Nursing, and a Doctor of Philosophy in Political Science/Public Policy Analysis and Applied Research from the University of Missouri-St. Louis.

As a BC-FPMHNP, the scope of my psychiatric mental health practice covers population age groups from birth to death. Because my background included work in chemical dependency and addictions and because of my concern for the excessive smoking-related morbidity and mortality rates among the severely mentally ill; during my FPMHNP program of study, I completed additional course work and clinical practicums in substance abuse and smoking cessation. The chemical dependence practicum was supervised by a prominent psychiatrist who specialized in chemical dependency while the smoking cessation training was provided by Mayo Clinic's Tobacco Treatment Specialist program of study.

In summary, I have over 20 years of experience as a registered nurse clinician. I am also a highly educated researcher, nurse educator, healthcare consultant and internet technology-oriented 2013 APRN graduate of a post-masters FPMHNP certificate program who is about one year from completion of a DNP program, as well. I completed over 975 clinical hours of APRN psychiatric mental health nursing during the certificate program in order to specialize in chemical dependencies and addictions, especially cigarette smoking.

With this background information in mind, attention now turns to three of the questions posed for this workshop. The questions concern regulatory barriers and their justification, new regulations and care delivery models, and the consequences of regulatory barriers.

Response to Three Questions Posed for the Workshop

1. Are there any Valid Justifications for Regulatory Barriers? I start with the proposition that within America's constitutional republic, the only valid justification for government imposition of regulatory barriers is to promote the public welfare (LeLoup, 1989; Robertson and Judd, 1989). Yet, the State of Missouri has instituted a myriad of regulatory barriers that actually harm the health of Missourians by actively blocking their access to needed healthcare services (Haycraft and Voss, 2014; Kliethermes, 2012; Haycraft, 2011). For the sake of brevity, I only list the following few:

- 1) mandatory collaborative practice agreements with medical doctors for Missouri APRNs,
- 2) 30 days of same location APRN and collaborating physician (CP) practice before the APRN can legally practice at a location where the CP is not present
- 3) geographic proximity requirements that mandate the APRN must practice within 30-50 miles of the CP's location,
- 4) 1,000 hours of prescribing experience under physician supervision before the APRN is eligible to apply for controlled substance prescriptive authority, as well as disallowance of APRN prescription of Schedule II controlled substances
- 5) mandatory review of 10 to 20% of the APRN's documentation of patient encounters, and
- 6) face-to-face physician visits with patients being seen by APRNs about every two weeks.

In addition to actively blocking access to healthcare, the above Missouri regulatory barriers also actively limit competition among the only two groups of providers that are qualified to deliver comprehensive health care: medical doctors and APRNs.

The barriers also arbitrarily impose an artificial hierarchy of power on the relationship between medical doctors and APRNs. The hierarchy favors medical doctors overwhelmingly by legally relegating APRNs to a subservient position relative to medical doctors. The effect is to block unimpeded consumer access to health care and eliminate competition and consumer choice. That is, under Missouri laws, consumers can choose to see a medical doctor for their health care without having any linkage to an APRN but they cannot choose to see an APRN without coming under the preview of a medical doctor.

There is no valid justification for the imposition of the above regulatory barriers because the safety, quality and efficacy of APRN provided health care has been clearly demonstrated (Institute of Medicine, 2011). That this is so, is not surprising because as Milk (2009) notes, most APRNs enter their program of study with many years of experience as a registered nurse (RN).

By tradition, the RN role has been a dual one--the practice of professional nursing and the facilitation of medical doctors' practice of medicine--with some overlapping functions. One of the RN's main responsibilities is to review medical doctors' orders before they are implemented, in order to ensure patient safety. Medical doctors value this RN function because it has saved countless patient lives and prevented many physician initiated medication errors. RNs also

administer and monitor patients' responses to all therapies and treatments. Therefore, RNs monitor patients for side effects from prescription drugs, including all controlled substances.

RNs are also expected to hold drugs when side effects occur and notify the attending physician. RNs are also the keeper of controlled substances once they leave from pharmacy's control and they are responsible for ensuring their correct use. In particular, they are expected to know whether or not a dose is within the standard parameters for the patient's condition. Yet, Missouri's prescriptive authority regulations requiring APRNs to practice under a medical doctor for 1,000 hours and disallowing APRNs prescriptive authority for Schedule II drugs are dismissive of this reality. This dismissiveness blocks patients' unimpeded access to all available necessary therapies--to the detriment of public safety and welfare.

2. Recent Developments in Missouri APRN Laws

A seventh Missouri policy, *Utilization of Telehealth Nursing*, went into effect January 1, 2014. The policy incorporates the above six policies and also restricts APRN telehealth practice to only those rural areas designated as HPSAs.

3. Consequences of Missouri's Barriers

What this has meant for me is that I have been prevented from practicing in the state of Missouri. That is, I have not been able to find a physician collaborator because I have not been able to find a psychiatrist who specializes in all of my areas of expertise. In addition, finding one that is willing and one that I want to "collaborate" with, or in essence, *hire to supervise my practice*, has been extremely difficult to do. Moreover, the inability to prescribe Schedule II drugs means that I cannot serve consumers with opiate addictions or attention deficit hyperactivity disorder.

For instance, a national telehealth company provided me with a collaborating Missouri licensed physician and offered me a contract to provide telehealth services to children and adolescents in a rural HPSA in Missouri. However, the rule requiring that the APRN and the APRN's collaborating physician must practice together at the same location for one month before the APRN can practice at a different location from where the collaborating physician is located could not be met. In effect, this one month practice at the same location rule nullifies the feasibility of utilizing telehealth care to help abate the shortage of providers in the HPSA. Thus, so far, Missouri's policies have prevented me from being able to practice my trade.

The impact of the policies can be deduced from morbidity and mortality rate described by Missouri's Department of Mental Health Chief Clinical Director and is even more tragic for the severely mentally ill (Parks, 2013). While some argue that Missouri's regulatory barriers protect the public safety, the claim rings hollow in the face of the lives being shortened and the health care being denied to those who need it most. Finally, I ask the reader to consider this. If public safety were the concern of states that have passed laws with restrictive APRN policies, then; wouldn't at least some of them have passed laws that allowed *experienced* APRNs to serve as collaborators to inexperienced ones? Wouldn't at least some of them have passed laws that allowed their boards of nursing to assess whether or not an APRN applicant needed more supervision? Or, wouldn't at least some of the legislatures have directed their boards of nursing

to instruct APRN educational facilities to provide the needed additional clinical practice experience?

In conclusion, there is a crisis in mental health care in the state of Missouri, especially among one of its most vulnerable populations, the severely mentally ill. I and many other APRNs are willing and able to help ameliorate the problem. Yet, the Missouri legislature appears oblivious to this state of affairs. Therefore, APRNs are prevented from independent practice by the legislature's eagerness to appease medical associations. This means maintenance of a medical doctor monopoly on the health care that can be delivered in the state. The harm being done to Missouri citizens by this monopoly is incalculable. Breaking this monopoly is literally a matter of life and health as well as a matter of life and death.

Thank you, again, for holding this much needed public workshop and for allowing me to share my comments.

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