TESTIMONY

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REVIEW OF SCOPE OF PRACTICE RULES IN ARKANSAS AND TASK SWITCHING

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ARKANSAS STATE LEGISLATURE

JOINT PERFORMANCE REVIEW COMMITTEE MEETING

REVIEW OF SCOPE OF PRACTICE RULES IN ARKANSAS AND TASK SWITCHING

TESTIMONY BY DAVID MITCHELL, PHD

DAVID MITCHELL

[39:00 39:13]

My name is David Mitchell. I am a professor of economics at the University of Central Arkansas and I am the director of the Arkansas Center for Research in Economics. We are a policy and education institute housed in the College of Business at UCA.

[39:23 40:13]

I wanted to show you guys a picture first instead of just my name, and I think one of the things that is pretty interesting is you can see that there are just not that many primary care physicians in Arkansas anywhere. There are big areas where there are hardly any primary care providers. We looked at the Medicare data and the number of people who are on Medicare who live in Arkansas but had to seek access to care outside of the state of Arkansas. It was one in five. Some of this is specialized, but then we looked at the codes just for primary care and that was pretty shocking. One out of ten Medicare patients either have to or choose to leave the state to receive primary care.

[40:23 41:15]

What I want to talk about is that broader authority for nurse practitioners leads to more nurse practitioners. And that is a good thing. If we reduced the rules and regulations for nurse practitioners, we get more nurse practitioners. So that, in my mind, is a good thing. Nurse practitioners provide good car for a wide range of primary care. We are not talking about oncology; we are talking about primary care. And I think the interesting thing – it's almost counterintuitive – is that there is no actual reason for physicians to lose money. Their salaries won't go down. And of course, you can imagine that they are going to be worried, like "oh, we

are going to be competing with nurse practitioners. What will happen? Does that mean that we are going to have lower incomes?" That is something we don't need to worry about.

[41:16 42:44]
So I'm actually a regulatory economist. I study regulation. That is what I wrote my dissertation on at George Mason; that is what I spent my career doing since I got my Ph.D. And what happens is that it is very easy to write very well-meaning regulation, and then over time, that regulation can begin to cause more harm than good. You can have well-meaning regulations build on themselves, and after a while, the marginal cost is greater than the marginal benefit. So the trick is to balance protection for consumers with this idea of we need providers to have some kind of competition so that consumers are getting a good deal. Balance the idea of are we protecting consumers but also are we watching costs and making sure that access to care is available and to make sure the providers are doing a little bit of competition just to kind of keep prices down. And the way we do that, as economists, we like to focus on outcomes. So outcomes is the main thing that we care about as economists. Did people get good care? Did life expectancy go up? What happened? Did we actually see, when we produced these regulations, do we see what providers in areas that didn't previously have a lot of providers? So it is always outcomes and almost never inputs.

[42:44 45:10]
The FDC has looked at this pretty broadly in a wide range of occupational licensing regulations. They looked at it in scope of practice and in a bunch of states and, again and again, they say that the regulations for nurse practitioners often exceed what is necessary to protect consumers. It is one of those things where the rules are written with the patients in mind, no one is writing these rules with anything in mind except how to protect patients, but over time, as the rules start to build on themselves and you could get into a situation where you have too much. Which is why you guys have this committee, to make sure that doesn't happen. To periodically come together to find a case where there is a little bit too much regulation so let's let these people compete and provide services. The more regulation you have, the less competition you tend to get. You are going to get more barriers to entry for nurse practitioners. And that will lead to additional waiting time for consumers. It is going to lead to higher costs and it's going to lead to less innovation, more consolidation, and less access to care. All we want, really, is to think about care

that is safe (that has got to be number one), effective, patient-centered, timely, equitable, and efficient. We have to remember that every hour of micromanagement by physicians over nurse practitioners is an hour that those two people are not providing care. So if you have a physician that is spending an hour looking at charts at the end of a quarter because of their collaborative practice agreement, that physician did not spend that hour providing care in a state where we need more primary care. That means that nurse practitioner who is dealing with that paperwork with that collaborative practice, that is an hour they did not spend doing primary care. And that is just a really high opportunity cost. Like, I am here today and that means that I am not at a committee meeting at the University of Central Arkansas. Opportunity cost is very low, it is very pleasing not to go to those committee meetings and I am very excited to be here. But imagine that I was actually a physician and this time I could be saving someone's life. You would feel almost guilty to bring me in.

[45:11 47:00]
So ACRE has been working on this project for a little bit over a year now. It took quite a while to find what the requirements are in all 50 states for nurse practitioners, and we focused on nurse practitioners even though there are many other scope of practice issues for other people. So we began looking at the data and really analyzing what happens, and we have realized that there is a very strong relationship between nurse practitioners and the number of nurse practitioners per 100,000. We adjusted for poverty and state income and rural population and state minority population. We found a really strong negative correlation between the number of NP's in the state and the regulatory restrictions on NP's. And we found, just looking at these rules alone, just looking at cooperative practice and prescriptive authority, that we could get a 5% increase in number of NP's in Arkansas. There is a little bit of a lag for nurse practitioners to get their masters degrees (it is two years) so you would have to get someone who was interested in this, applied to graduate school, went through the two-year program and nurse practitioners are increasingly going to doctorate nursing practices, so it is a longer degree. But in my mind because the issue is so severe, it is almost worth getting started right away. We can get more current nurses thinking about going to grad school to become nurse practitioners so that they can provide primary care in Arkansas. We didn't even look at reimbursement rates or Medicaid. We just looked at some very straight-forward things, and what is the big difference?

[47:00 48:48]
One of the things we need to think about is the idea of the nurse practitioner as an entrepreneur. This person, normally a woman (most nurse practitioners are women while most nurse anesthetics are men), if you are thinking about becoming a nurse practitioner, you need to make sure that it is worth it. It is two-plus years of additional schooling, more for a doctorate in nursing practice, the courses are hard, it is expensive, you take two years away from your previous life, and you have to ask yourself "well, how much more money could I really make? Could I pay off my student loans? Is it worth it? How much more could I do for my patients?" As economists, we think of it as external and internal motivation. It is probably not that different from what you guys thought about when you decided to run for elected office. Perhaps you like the campaigning, but my impression is that that part, in some ways, is not that fun. But you said, "Okay, could I still pay my bills if I was a representative or a state senator?" and "What could I actually do for the people that are around me?" Because the great thing about state and local government is you see all of your constituents. I run into my representative at Kroger so it's maybe different than if you were somewhere else. You get to see these people that you are going to help. You get to say "Hey, what could I do for you?" "Is it worth dragging my family through an election? Yes, if I can help people and also make sure that I can pay my bills." So that is pretty similar to what any entrepreneur, or anyone thinking about making this kind of career change, would have to consider.

[48:49 49:45]
There is a cost to having a collaborating physician. So partly there is the time I was talking about. This, "Oh, we have to deal with the paperwork and check charts at the end of every quarter." But part of it is that the physicians charge for that because that it time that they are not getting reimbursed for providing medical care, which is what we would rather they do. So nurses have to think, "Is it really worth it?" and we want more of them to say "Yes, I would like to be a nurse practitioner. I would like to provide primary care because I can still make a living, I wouldn't have to eat Vienna Sausages and saltine crackers, and I could actually do good for my patients, and at the end of the day, I feel like I'm doing something important." I think that is pretty common for people. You want to feel like you're doing something important and making a difference.

[49:46 51:34]
So I think one of the dilemmas is that it is very easy in regulation to let perfect be the enemy of the good. And we can almost imagine a world where we don't need any NP's because there are many physicians that are ready to help us no matter how complex or how simple the case may be. Perhaps we would like to imagine a world where every nursing school has a pediatrician right there in every classroom. But that is not the world we live in. We live in a world where we have scarce resources. We live in a world where there are not enough physicians to go around, and so that makes me think "Wow, we might really need to allow NP's practice to the extent of their training, and let physicians work on other care, on more complex cases." The other thing about competition and reducing some of the barriers to entry is that you will get more innovation. You are going to get more innovation in health care delivery. As an example, nurse practitioner staffed clinics usually offer more evening and weekend hours, which is great. I never get sick at 9AM when my doctor can see me, it is always on the weekend. My kid never gets sick in the middle of the week, it is always late at night on a Saturday. We certainly don't want to go to the ER, so we end up at a nurse practitioner staffed clinic, even though we have a pediatrician that we like very much. I think this is the part that is the most counterintuitive when you are thinking about nurse practitioners and the regulations that restrict them. It really does feel like physicians are going to suffer. We already have so few primary care physicians and we don't want to be in a situation where we are pushing them out because we need them for the complex care.

[51:35 53:30]
Lots of studies by the Institute of Medicine and the American College of Physicians have all come out with papers talking about the importance of nurse practitioners, talking about the good care that they provide, and one of the things that I thought was interesting in the Institute of Medicine report about nurse practitioners says that full practice authority for NP's does not detract from the critical role of physicians in primary care. We still need physicians for these more complex cases. We have to remember that nurse practitioners have excellent care. They have excellent education and excellent training on a wide variety of primary care issues. They don't actually do everything. When we have more nurse practitioners, we find that the physicians' tasks switch. They are less likely to do the more simple things, they are more likely to do what you may deem high value but what we really mean is more complex services. They switch to more complex cases. It isn't that physicians suddenly can't afford to go to Hawaii; it's

that physicians switch from one type of primary care to a different type of case within primary care. So the Institute of Medicine report nor has the expansion of nursing practice scope of practice diminished the critical role of physician in patient care or physician income. In at least one study, we find that physicians made more money when nurse practitioners taking over a broader range of primary care. And in a few studies –there aren't many, but there are a few— come to the opposite conclusion. The main thing that we noticed is that there is a shortage of primary care providers missing from their analysis. And, Arkansas has a shortage of primary care providers, as you know. We have such a shortage of primary care providers that there is no reason for physicians to worry about the competition. It's not an issue at all for them.

[53:31 54:40]
The other thing, and I think this is pretty interesting, is that nurse practitioners, in part because they do have student loans but their student loans aren't on the level as physicians' student loans, are more likely than physicians to practice in underserved areas. I have a couple citations if you guys want me to email you these bibliographies; I'd love to do that. That'd be great. We are coming up with our own research as well in just a few weeks. But nurse practitioners are more likely to go to underserved areas than physicians are. So we looked at some primary care providers in Arkansas. We looked at what kind of counties there are. Of course there are more providers, it is easier to make a living, in an urban area than in a rural area, but if you look at the ratio, you'll see that the ratio is better for advanced nurse practitioners, they are a lot more likely to work in rural areas. We have many rural areas where there aren't many providers and people are waiting for primary care.

[54:41 55:50]
Then, I wanted to talk about something specific. I don't want to just talk in generalities. I know you guys had another guy come in and talk from a thousand foot up kind of level. I wanted to talk about a couple of things specifically. And I think diabetes is the perfect example for Arkansas. If you are thinking about how do these regulations impact Arkansans, what is really going on? I think diabetes is the one to think about. It is a major killer in Arkansas. Prevalence is very high in a big county. If you look at the counties with high prevalence, you will think, "huh, those look a lot like the counties that didn't have-very many primary care providers." Nurse practitioners are great at helping people control their diabetes. So they are great at helping people

control their Type 2 Diabetes and work with them, and of course every person who has Type 2 Diabetes has some other co-morbidity. They also have high blood pressure and all kinds of other issues. That is like a nurse practitioner's bread and butter. That is what they do. So helping these people put together all of their issues and think about it and come up with a real plan. That's what nurse practitioners are trained to do. So having more nurse practitioners can really help.

[55:51 57:09]
I downloaded a little bit of data from ARHQ (Agency for Research in Healthcare and Quality) just on diabetes hospitalizations in Arkansas. And you can see some kinda big numbers. They're pretty big, and they're growing. And if we want to talk about saving people money, what can we do about just this? What can we do about reducing hospitalizations for uncontrolled diabetes? Many people's diabetes can be controlled if they get proper primary care. So imagine if we could just cut these numbers by a little bit. Think about what you could do. Imagine we cut the number from 44 million to 40 million. Well that is 4 million dollars more to spend on –pick any project you think- and we have a list of stuff we can do in Arkansas. So that could go for better training, it could be better outreach, it could be bonuses for the best high school teachers in Arkansas. Whatever you want to do with the money is up to you guys – that's your job – but if we could reduce these rates just a little bit by having better primary care, and this is only one disease – that would be really important for us.

[57:10 58:31]
Sometimes these things seem kind of radical. You're like, "Oh man, these crazy professors, they come in with their crazy ideas," but 21 states already have full practice authority. New Mexico has had full practice authority for 20 years. So it's not really a radical idea. It's a pretty straight-forward idea. And lots of states have a more relaxed regulatory burden than Arkansas does. And states from Texas to South Carolina are thinking about these issues, in part because they have the same issue we do. Access to care is a problem, prices is a problem, waiting lists are a problem, all of these states between Texas and South Carolina have rural areas where they don't have enough practitioners. And I kinda think Arkansas has in many ways tried to be a leader in healthcare in the south, whether it's private option, or having new programs for pediatricians to look at asthma payments, there is just a wide range of things that Arkansas has done. I'd love for Arkansas to be the first southern state to really open up regulatory burdens on nurse practitioners.

And I want to reiterate the comparable primary care (again it is primary care that we are talking about; it's not oncology).

[58:32 1:00:08]
So here is an article out of the New England Journal of Medicine (hey, that is run by physicians) "physicians' additional training has not been shown to result in measurable difference from that of nurse practitioners in the quality of basic primary care services." No significant differences were found in patients' healthcare. The Advance Practice Nurse Workforce as well provided positions to provide safe and effective care. That's the International Journal for Quality in Healthcare. So big time journals, big time research, often by physicians, has shown that nurse practitioners do good work. And that's really interesting. So I don't want you guys to think that nurse practitioners having a broader regulatory framework where they are able to do all things, that's not going to solve all problems. I think that we all know that there are a lot of issues going on, but they could mitigate the primary care shortage. Decreasing regulation and allowing NP's to practice to the full extent of their capabilities is going to attract NP's, it's going to incentivize nurses to become NP's. I was thinking, man if diabetes hospitalization is really expensive, how much could Arkansas save if we change the licensing laws? I don't know the answer to that yet, but I am working on it. It is weird to think that just very small changes to occupational licensing regulation could actually save lives. That is kind of exciting. You could save lives. If you were thinking "Am I doing a good job? This is why I did it. This is my intrinsic motivation." Hey, you could be saving lives.

[1:00:09 1:01:13]
Consumers are likely to benefit for several reasons. We find slightly lower healthcare costs, greater access to care, greater choice among settings where healthcare is provided, not having collaborative practice agreements that are costly to nurse practitioners, the cost of the NP care itself would be decreased, the supervision delegation requirements create a huge administrative cost to NP's, so those costs could be reduced. Some of these costs could be passed on to the public and private third-party payers, and ultimately to Arkansas healthcare consumers in the form of a lower price. That sounds like good stuff to me. Arkansas could be better off. We could have more access to care. Physicians are no worse off. It's not a radical idea. It is a tested idea based on looking at outcomes. I hope you guys have a lot of questions for me. This is a really

important issue so I hope that we get to talk about it a lot.

QUESTION & ANSWER SESSION

REPRESENTATIVE WALKER

[1:01:14 1:05:08]

A couple of comments and a question. The problem, if you put it into real perspective, has to first begin with doctors because our nation needs twice as many doctors as we have, which means we need another equal number of medical schools to provide them. The argument that you make seems to cry out for a real national healthcare system. One where everyone gets healthcare without competition. I don't know why healthcare has to be competitive on a supply and demand basis, but if you deal with demand, the demand is going to be greatest in the poorest areas because they have the most problems. But the supply is not going there because they have the least money. So if you address it as you are suggesting, the people with the least training will be dispatched to the areas with the greatest need, with the least money – and those would be the nurse practitioners. The number of nurse practitioners, in my observation, is very small. We don't have the capacity to produce more than 30 to 50 in a year. And that in no way deals with the demand in the underserved and black areas where there is the greatest need. I would like to have you explain why you think the competition model applies to this. We know that people want to live in areas where there are people like themselves. And doctors, as well as APN's will want to be around people with higher incomes unless they are socially or humanitarian motivated. So I'm trying to see how, but you were saying, from a research position, will be helpful to us as a committee. The main question is, always has been, and always will be, how do you get quality healthcare for people who live in poor areas? I don't see that this addresses it. And the other thing I don't see you mention (well you said it one time), you go over things such as poverty and location, but you're really talking about race and you know it and the medical schools and APN schools only produce white persons that are not going to be going into black areas. So if you are going to address this, and you want to be helpful to us, why don't you do that when you come back to us because I'm sure you will be invited again, why don't you address it dealing with the realities of the situation without dealing with it as everything is simply

competition-based. Doctors are not necessary to competition-based. They want to be in Fayetteville, where you have other rich people. They're going to be around in Chenal and other places like that, and they are going to build a hospital as far away from poor people as they can. It isn't competition. And the need is the greatest where you have the greatest health problems, and it is where you have the least money. You can't address it on an altruistic basis. Certainly we need more APN's, but we don't have the means to do it. So the question out to be why should not we have more schools to develop more APN's, as well as more nurses. And the competition really comes from the doctors and the others that say "well we don't really need more competition to get into the field." What we really need is more medical schools and more APN schools. Now, that is a lecture as much as it is a question. Don't you agree with what I said?

DAVID MITCHELL
[1:05:09 1:05:45]
I think the question is, "what can we do to create even more nurse practitioners [and doctors]?" So, one, more medical schools means more doctors, more residency programs means more doctors, more fellowship programs means more doctors, more nurse practitioner programs means more nurse practitioners. So that is definitely true. I definitely agree with that 100 percent. I think the question is how expensive would it be to double the amount of nurse practitioner schools we have? I think there is someone in the room that can probably answer that.

REPRESENTATIVE WALKER
[1:05:46 1:06:00]
You don't have to double it. Take 10 percent. You were talking about a 5 percent. 5 percent isn't going to do anything but keep the situation static because of the attrition rate. You will need to have more than the attrition rate in order to be able to make any kind of dent into the need of healthcare delivery.

DAVID MITCHELL
[1:06:01 1:06:25]
Of course. For sure. The first easiest step is to encourage nurse practitioners to have a relatively low regulatory burden. Of course, they are still licensed and accredited. They are still educated and certified with a master's degree, and they are in the process of going toward a doctorate degree. It's not like there are no checks on nurses. There are lots of checks on nurses.

REPRESENTATIVE WALKER
[1:06:26 1:07:19]
There are only 5 to 7 PhD. nurses coming out of medical schools in Arkansas. When you mention it, it's not irrelevant because you don't have enough there to matter. 3, 4 or 5 coming out of medical schools in a year in Arkansas does not contribute to dealing with a solution. You have a few people, like yourself, going into academia and you like to talk about everything. Now my point is that you are producing those people to teach others, but you're not really dealing with the main problem that we need some guidance on – how do we get better healthcare to more people in the shortest possible time within the means that we choose to devote to that.

DAVID MITCHELL
[1:07:20 1:08:03]
So I think the question is what is the quickest, easiest way we can get more healthcare to underserved areas? And I think a big part of that answer is to reduce regulations that are on nurse practitioners. So right now, they require a masters degree, soon they will be required to get a doctorate, but the more you let them do, the more that they can go and do. So right now, you're thinking "Oh man, if I have diabetes and I also happen to have a diabetic ulcer and diabetic neuropathy and I need a Schedule II drug," even if you have a nurse practitioner in any of the counties between Arkansas and Crittenden, then where is your physician? You're going to have to drive. So that is what part of the dilemma is.

REPRESENTATIVE WALKER
[1:08:04 1:09:16]
This is my last point. You talk about regulation but there is no demonstration that nurse practitioners are overwhelmed with regulation, and you talk about regulation. Regulations are absolutely necessary for nurse practitioners because they are held to a high level of care, and it is necessary they do because they are acting like doctors without being doctors, and we are holding them to this kind of care. Poor people need their people to be held to a high standard of care, just as the people who are rich need to have that. So the regulations are absolutely essential. I see where you are standing from your perspective, you're anti-regulation, but you see that all these things don't need to be put in a situation where it is all capitalistic. It's humanitarian first, and we are here as legislators to make sure the basic needs of our people are actually addressed rather than you're going to regulate to see who is going to make what money. We have to deal with that

fundamentally and I hope you agree with that and that the people here agree with me as well.

SENATOR IRVING
[1:09:17 1:09:40]
I have a simple answer to Representative Walker. It is because of reimbursement rates. That's why people don't go there. Because they don't get paid and they don't make a lot of money. If there is a high population of Medicaid folks, we all know that Medicaid doesn't pay. So one of the things, number one, who initiated your report, your study?

DAVID MITCHELL
[1:09:41 1:10:29]
I am a regulation economist, that is the kind of work I have been doing since the 90's. I think your question is who funded ACRE, is that right? [No, who asked for you to come here and present this study and who paid for it?] Nurse practitioners, I'm not related to any nurse practitioners. I haven't received a nickel from any nurse practitioners, they didn't even buy me a Diet Coke. I work at UCA as a professor and there is a group of Arkansas businessmen that came together and wanted to look at what was going on in Arkansas from a regulation and tax basis, basically got tired of Arkansas being number 49. They were looking for a regulation economist and they picked me.

SENATOR IRVING
Have you looked at other regulations other than this topic? I just find it a little interesting you only looked at this topic.

DAVID MITCHELL
I would love to come back and talk about other regulation-manufacturing regulation, education, entrepreneurship. I could come back and talk about something every week.

SENATOR IRVING
[1:10:50 1:11:12]
Are you aware that if you are on Medicaid, you have to have a primary care physician? You said there is an access to care issue; however, if you are on Medicaid, you are assigned a PCP, so you don't have an access to care issue when you have an assigned primary care physician.

DAVID MITCHELL
There is a difference of being assigned a primary care physician and actually being able to get in to see them.

SENATOR IRVING
There are a lot of physicians that see these patients on a day-to-day basis, and take phone calls from patients all day and all night. I'm just asking, I'm hoping that we will present the other side of the issue that is physician friendly so we have a fair and balanced debate here. The other thing you said that you did not look at was reimbursement rates.

DAVID MITCHELL
We didn't look at reimbursement rates because we didn't want it to be more complicated than it had to be.

SENATOR IRVING
[1:11:50 1:12:06]
Let me ask you this from a business point of view for an economic perspective. If you decide that you are going to put something on your menu and you're just going to break even, or you're actually going to lose money on it, would you do that from a business point of view?

DAVID MITCHELL
No, that is why so many physicians don't want to work with Medicaid patients.

SENATOR IRVING
Right, so don't you think reimbursement rates should be something we look at from an economics point-of-view?

DAVID MITCHELL
Yeah, we should definitely look at that. It is a multi-faceted issue.

SENATOR IRVING
And speaking on collaborative physicians, you have it on your list of collaborative physicians, there is a cost to that. But do you know what goes into that cost as a collaborating physician?

DAVID MITCHELL
So I think they can pay about 2,000 a month

SENATOR IRVING
But what is involved in the cost to the physician?

DAVID MITCHELL
I think this is a question for an actual NP or MD, but my impression is that at the end of the quarter, they look at a certain number of charts.

SENATOR IRVING
Okay, but that's all they do?

DAVID MITCHELL
That is my impression. There is a check involved and there is time involved.

SENATOR IRVING
[1:13:02 1:13:14]
There is also a liability issue there. Did you calculate malpractice insurance and liability in who is responsible for signing off on those charts and who can get sued at the end of the day?

DAVID MITCHELL
Physicians pay high malpractice costs for this collaborative practice.

SENATOR IRVING
It isn't just for the collaborative practice, it is for all liability. But they are signing off on these charts.

DAVID MITCHELL
Collaborative practice is raising the malpractice costs, making it harder for them to practice. That is a strong argument for getting rid of it. We don't want it to be harder to become a primary care physician in Arkansas. We want it to be easier to be a primary care physician in Arkansas.

SENATOR IRVING
So you're saying we should get rid of malpractice insurance?

DAVID MITCHELL
[1:14:00 1:14:19]
Well, there is a reason we have malpractice insurance. Remember, we look at outcomes, and the outcomes say that you don't get a better outcome when you have these strict requirements for nurse practitioners. If you have some evidence that says that getting rid of malpractice insurance leads to better outcomes, I would be excited to see that.

SENATOR IRVING
I think there are a lot of arguments on that and it is not so very cut and simple, and I think that is my issue with your report. It's not all cut and dry and it isn't all due to rules and regulation.

DAVID MITCHELL
Oh yeah, changing these rules and regulations won't make everything rainbows, but it will make an improvement.

SENATOR IRVING
[1:14:40 1:14:54]
That is your suggestion and opinion, and there is some data that I would argue with. The map you have here on primary care physicians per 1,000 population, where did that data come from?

DAVID MITCHELL
It came from AHRF – the Area Health and Research File.

SENATOR IRVING
So let's just look at Stone County, for instance. It has a 0.58, can you explain that?

DAVID MITCHELL
So you don't have one physician per 1,000 people if it says .58

SENATOR IRVING
Do you know how many patients per practice is normal?

DAVID MITCHELL
No, I don't know that. So you're saying a physician could work 100 hours a week and solve the access to care problem?

SENATOR IRVING
Well they aren't seeing 1,000 patients a week. Most physician clinics have more than 1,000 patients that they serve. You're not seeing those 1,000 patients every single week

DAVID MITCHELL
If all these people are super healthy, we don't need as many physicians.

SENATOR IRVING
Even if they're not super healthy, there are still limitations. You realize that a Medicaid patient can only visit a primary care physician 12 times a year. That is not a regulation burden, that is just the rules of Medicaid. I have a lot of questions, but there is something I just took issue with – when you said that primary care is not oncology.

DAVID MITCHELL
[1:16:20 1:16:23]
Right, because nurse practitioners aren't trained in oncology, they are trained in primary care.

SENATOR IRVING
Yes, but by saying that, you are inferring that primary care is less of a medical practice.

DAVID MITCHELL
No, they are just trained differently. Nurse practitioners are never trained in oncology. They are trained in primary care.

SENATOR IRVING
Right, and primary care is just as serious of a practice of medicine as is oncology.

DAVID MITCHELL
In some ways, it is more serious because it affects so many people. Many things could be solved with primary care if you caught them.

SENATOR IRVING
But to that point, that is why doctors train. That is why they go to four years of college. That is why they go to four years of medical school, and at the very minimum, they have a three year

residency for primary care.

DAVID MITCHELL
Right, those are all inputs.

SENATOR IRVING
[1:17:04 1:17:18]
But you said, it's not like we are doing oncology, so that somehow demeans primary care physicians.

DAVID MITCHELL
We want to give the physicians the more complex cases. We want physicians to do complex cases related to primary care.

SENATOR IRVING
[1:17:25 1:19:39]
Okay but do you not understand that sometimes when you go into a primary care situation, what presents is not a complex case, but the primary care physician, because he is trained in medicine from all those years of education, finds that there is a very complex issue that is going on with that patient who does not present that, particularly with folks that are really poor because they don't have a lot of education or training to understand what is going on with themselves. So I take issue with that statement and I would hope that the chairs would also have the other side of the issue addressed because I believe that access to care issues, there is nothing that prevents a nurse practitioner from practicing in any place in Arkansas right now. There is nothing that prevents them to practice in any corner in the state of Arkansas. There are a lot of folks out there that collaborate with nurse practitioners and there is a good, working process in place. But the fact of the matter is, they don't go there. They don't go there because they can't get paid because there are not a lot of private insurance folks out there. There is self-pay, medicare, Medicaid, and private insurance. But if you don't have jobs-manufacturing jobs or any kind that provide any kind of benefits in those areas, then the economy is so depleted that people won't move there because they can't afford to practice medicine there. That is the same for a doctor as it is for a nurse practitioner. Changing a nurse practitioner to become a doctor without going to school to do it does not change the problem. The problem is because we don't have jobs in those areas.

Because they don't have a way to pay for healthcare, because they don't work or because they are on Medicaid or medicare or those programs, that is what causes that effect. It is not the rules and regulations based on who can do what under what licensing. And the final thing I will say is that you should look closely to the information you provide on diabetes and those types of issues because what is the number one thing that can drive diabetes down?

DAVID MITCHELL

Changing obesity, not smoking, and having a job. It turns out having a job is really important for healthcare. So you and I agree on almost everything.

SENATOR IRVING

Right, but you could achieve so much if people just exercised. Exercise. And that has nothing to do with primary care doctors or nurse practitioners. It has everything to do with us teaching people how to take care of themselves and their bodies. That's what that is for. So I would caution us to put all of our eggs in one basket as if this is the answer to everything. I do appreciate your time; I would just have large disagreements with your conclusion.

SENATOR STUBBLEFIELD

[1:20:38 1:20:44]

Do you know Arkansas' ranks as far as occupational regulation?

DAVID MITCHELL

So for overall occupational regulation, we are 49th out of 50.

SENATOR STUBBLEFIELD

[1:20:50 1:22:18]

So we are one of the toughest states across the border. I listened to Representative Walker, and he did make an excellent case for telemedicine, but I had spoke with a senator from New Mexico for a long time this past week. New Mexico has done a huge amount as far as doing away with the regulatory burdens on their ARPN's and CRNA's. In fact, their CRNA's, the latest study they've done shows that there is no difference in the quality of care, no difference in mortality, and yet a huge difference in cost savings. And he also showed me the data for when they drastically reduce regulations on ARPN's and all the other nurse practitioners. That too did not

result in overall change in healthcare, in fact, it resulted in an improvement in healthcare. Not only in districts where people were making a lot of money, but also in districts where people were making little money, in the poor districts. It was a huge cost saving with no loss of healthcare quality. And he had the figures and showed me.

DAVID MITCHELL
It is the easiest thing you could do. You could really raise reimbursement rates for Medicaid, but that is coming out of budget. So this is the easiest thing you could do to improve people's lives.

SENATOR STUBBLEFIELD
Why aren't we doing this?

DAVID MITCHELL
I don't know the answer to that but I would love to see nurse practitioners do more because we could save more lives in Arkansas.

SENATOR STUBBLEFIELD
If I were to summarize your entire statement here, are you saying that Arkansas is overregulated? Would you agree heavily overregulated?

DAVID MITCHELL
We are overregulated. Definitely heavily overregulated – there is no doubt about that.

MR. CHAIR
Let me ask you a question. When you say overregulated, you're not just narrowing it down to one area. You don't mean just nurse practitioners. We have a list and members I remind you that we are going to bring up some of the boards that will have a little latitude to talk about some of these things. But would you say that is a fair statement across the board?

DAVID MITCHELL
I think we are overregulated across the board. I don't want to talk too much about other health practitioners because the data I have is on nurse practitioners.

REPRESENTATIVE RATLIFF
[1:23:50 1:23:56]
I have a couple of questions. Have you got any evidence that nurse practitioners can reduce costs?

DAVID MITCHELL
Oh yeah, I'm glad you asked that question. There is a recent NBER paper (National Bureau of Economic Regulation and Research), and they looked at insurance claims. Again, outcomes, what actually happened. And they found that just changing these rules would reduce a well-child visit by 3 to 16 percent. When they looked at states that relaxed these rules versus states that didn't, the states that had the more relaxed rules had well-child visits between 3 and 16 percent less. That is based on the actual claims data.

SENATOR STUBBLEFIELD
Did you compare that to any Arkansas facts that you have?

DAVID MITCHELL
I didn't use any Arkansas claims data but I wish that I had. We can try to do something if you want to and I can come back in two weeks.

SENATOR STUBBLEFIELD
How did you get the research for diabetes? Since I'm a diabetic, I am pretty interested.

DAVID MITCHELL
[1:25:03 1:25:37]
So, I was looking for something that Arkansas has as a serious issue. Something that was really affecting the largest number of Arkansans. So that is how I picked diabetes. I said, what is going on in Arkansas that I can really focus on? And that is the one that I came up with. Even if you weren't diabetic, everyone in the room knows someone who is diabetic. So how do we control this, how do we treat it? How do we make sure that you live a long time?

SENATOR STUBBLEFIELD
In the Stevens group, they recommended that Arkansas start a health score card. How could these nurse practitioners play a role in it?

DAVID MITCHELL

So I think what you're saying is "hey, it seems like these health score cards is kind of an alternative. If people really don't want to use a nurse practitioner, they want to use a physician for their primary care, well then they could just schedule with physicians, of course. But what would also be great, wouldn't it be nice if we could look, just like before you make reservations for dinner, if you could look on yelp, you might say, oh, how did they score? That is all just users putting in their stuff. But there is a lot of things we could do with a score card based on what kind of results they have had with their patients, how patients have looked at the experience, whether patients have felt that their practitioner was really responsive. Wouldn't that be great for when you're thinking, alright, where should I go now? Representative Walker pointed out there aren't any choices but in places where there are choices, wouldn't it be great to pop open your cellphone, and instead of playing some video game, say oh, this provider has better scores on outcomes than my current provider. I guess I should switch. Or this other provider and mine have the same outcome results, but people really like this other provider. The experience is better. One thing that is interesting about nurse practitioners is that they spend more time with their patients. On average, physicians spend about seven minutes on primary care and nurse practitioners spend about twelve minutes. That is a five minute difference, but it is almost double.

SENATOR COOPER

[1:27:39 1:27:55]

Let's go back to diabetes again. Isn't it true that diabetes is one of the most expensive diseases that there is over long term?

DAVID MITCHELL

It is super expensive. What can we do to make it cheaper? That is my question. But still keep people alive with their hands and toes.

SENATOR COOPER

In other states that may have more nurse practitioners than we do, is there any direct correlation, not only the cost of outcomes of diabetes that is a direct correlation?

DAVID MITCHELL
[1:28:23 1:29:09]
So the question is what is the relationship between nurse practitioners and diabetes in other states? There is study after study and journals by the American Diabetes Association showing that nurse practitioners provide good primary care, and also, the best part, the hospitalization for uncontrolled diabetes tends to go down. So not only did we save money in hospitalization, but those people didn't have to go to the hospital. So I showed you some numbers about the direct cost of hospitalization, but we didn't show anything that if they had controlled their diabetes, they wouldn't have had to go to the hospital.

SENATOR COOPER
Well if you educate on diabetes through education or whatever they were doing did not result in hospitalization, where otherwise they might have, that is an avoidable cost.

DAVID MITCHELL
Yeah, that is a huge cost, and wouldn't it be great to save that money and do something else with it?

SENATOR COOPER
Now you just made a statement concerning how much time each one spends with a patient. Isn't it true that a lot of dealing with diabetes is educational?

DAVID MITCHELL
That is certainly my impression, but I would probably bring in a practitioner for that. My impression is that the practitioners talk to you about your insulin and they talk to you a lot about your diet and you talk a lot about actually doing it. Some practitioners have it set up to where they have an automatic phone call to remind a patient about taking medicine.

SENATOR COOPER
Well regardless of who is doing it, and whether there is actual data there or not, it is a fact that if you do not control your diabetes, you're going to have problems. So education, regardless of who is doing it, is a critical factor in that. Somebody needs to be doing the educational side of that. So if we have more people at the lower end of the spectrum, educating that person on the

critical nature and educating them on how to control their illness, they're going to be healthier.

DAVID MITCHELL

[1:31:00]

They're going to be healthier, and that is going to make their lives better. They are going to spend more time with their kids. They are going to spend more time with their grandkids. It is going to save taxpayers money.

ABOUT DR. DAVID MITCHELL

Dr. David Mitchell earned his B.S. and M.A. in Economics from Clemson University. He was awarded his Ph.D. from George Mason University. While at George Mason, he had the pleasure of studying under two Nobel Laureates: James Buchanan and Vernon Smith. Prior to earning his Ph.D., he worked in the insurance industry in both the United States and Germany. Before starting at UCA, he taught at St. Mary's College of California, Washington and Lee University, and the University of South Alabama. At the University of Central Arkansas, Dr. Mitchell teaches principles of economics and policy courses. His research interests include state level public finance, and entrepreneurship policy. He has published in the *Journal of Economic Education*, the *Cato Journal*, *Forbes*, the *Journal of Small Business Management*, and the *Southern Economic Journal*. He and his family live in Little Rock.

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The Arkansas Center for Research in Economics (ACRE) is an Arkansas focused research center housed in the College of Business at the University of Central Arkansas. ACRE is dedicated to understanding, teaching, and advancing the principles that support prosperity that can be applied to improve the lives of all Arkansans. ACRE is committed to personal and economic freedom - principles proven to lead to improvements in human well-being. Learn more about ACRE and its activities at http://uca.edu/acre.

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