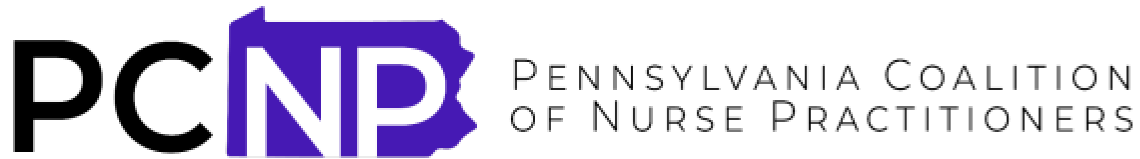

Testimony by Amanda Laskoskie DNP, FNP-C

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Pennsylvania Senate Republican Policy Committee Hearing

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Good afternoon, I would like to thank the committee for inviting me to speak today. It is an honor to be here. My name is Amanda Laskoskie. I am a Board-Certified Family Nurse Practitioner working in outpatient pediatrics in an urban underserved area. The practice sees largely Medicaid and uninsured patients.

Pennsylvania is in the throes of a healthcare provider shortage and this is forecasted to only get worse. By 2030, 30% of our primary care providers will be retiring; this leaves patients struggling to find replacement providers they trust to provide the care they so desperately need. We know Pennsylvania's fastest growing population is older adults, estimated to make up 24% of Pennsylvania's population by 2040. This is across the Commonwealth, in rural, suburban, and urban areas. Although there are many primary care offices in urban and suburban areas, these providers are not sufficient to meet the needs of patients in a largely populated area. Likewise, the shortage is felt in rural areas where the providers are far spread and as one retires, there are not enough to fill the gap. Between 2010 and 2020, the number of rural Pennsylvania primary care physicians decreased by 4% while rural nurse practitioners increased by 178%. Pennsylvania is in the throes of a mental health care crisis. We are suffering from a shortage of mental health providers, increasing needs for mental health treatment and substance abuse disorders, and increasing maternal death rates. The US recently hit a 58 year high in its maternal mortality rate (double the rate of the UK, Canada, or France), making it one of the most dangerous high-income countries in the world to deliver a baby. Maternal deaths due to pregnancy related causes were 32.9 deaths per 100,000 live births in 2021, greatly increased from a rate of 23.8 in 2020 and 20.1 in 2019. Women of color have a mortality rate 20.6 times higher than white women, and 30% of maternal deaths were among women of color. In 2020, Pennsylvania saw 111 maternal deaths. In Philadelphia alone, an average of 18 women die each year during or within 1 year following pregnancy. Nine percent of counties in Pennsylvania are maternity care deserts, without a hospital or a birth center offering obstetric care and without obstetric providers, this has only increased in the last year. More than 105,000 Pennsylvania women, between the ages of 18-44 years of age live in these areas. Over half of all maternal deaths occurring in the year following birth are caused by mental health issues and substance use disorders, including suicide and accidental drug overdoses. Nearly half of Pennsylvania counties have no psychiatrist, hindering care for postpartum depression, other mental health disorders, and addiction. Compared to the average state in the country, Pennsylvania has double the medically underserved areas, 30% more primary care health professional shortage areas, and 62% more medically underserved populations.

The issue at hand is that the current healthcare provider shortage, hindering patient access, is exacerbated by restrictive regulations on Nurse Practitioners (NPs). These regulations, particularly the collaborative agreement rule, limit NPs' ability to practice independently, despite their proven capabilities and training.

How can we solve the problem?

I propose a free-market, a less regulatory approach by supporting the passage of Senate Bill 25 and House Bill 739. These bills advocate for granting full practice authority to NPs, aligning with conservative values of reducing governmental oversight and promoting individual autonomy. This change will foster competition, improve efficiency, and enhance patient choice in healthcare providers.

There will be many suggested solutions but Nurse Practitioners are ready and able to serve the patients of Pennsylvania. They do not need to be recruited, they reside and practice right here throughout the Commonwealth. But their practice is restricted by an archaic rule requiring that each Nurse Practitioner have an agreement with two physicians in order to practice. This agreement called a collaborative agreement is required for the Nurse Practitioner to prescribe medications and to treat patients. The agreement might lead one to believe that the physicians are actively involved in the patient's care. Reality is quite different. In most cases, the Nurse Practitioner has never met the collaborating physician and the physician has never met the patients. It is simply a financial agreement in which the physician is paid a yearly fee for a signature on a piece of paper filed with the state board.

Nurse Practitioners are not Physicians, nor do we want to be. Nurse practitioners are expertly trained providers who have completed training in a population focus, such as pediatrics, neonatology, adult gerontology, family practice, women's health, and mental health. These Nurse Practitioners have completed at least 7,000 hours of clinical training (starting with basic nurse training through the nurse practitioner training) and passed certification exams. In order to maintain certification, Nurse practitioners must complete 100 continuing education hours and 25 pharmacology continuing education hours or sit for the certification exam, again. Additional education requirements remain in place for state licensure.

Senate Bill 25 and House Bill 739 would lift the requirement of an agreement between Nurse Practitioner and Physician, without diminishing collaboration — it is in our DNA. No more would a primary physician need a contract to collaborate with a cardiologist, than a Nurse Practitioner needs a contract to collaborate with a physician. Twenty-seven states, the District of Columbia, and the Veterans Administration have eliminated the need for collaborative agreements and allowed Nurse Practitioner Full Practice Authority. Not one state nor the VA has reversed this decision. Pennsylvania is an island surrounded by Full Practice States, including Maryland, West Virginia, Delaware and New York. We are losing precious health care capital, nurse practitioners who live in the Commonwealth but practice in these surrounding areas.

Currently in Pennsylvania, Nurse Practitioners are limited in practice due the inability to find collaborating physicians. Without these physicians, nurse practitioners cannot provide care to patients in need and the patients of Pennsylvania are suffering due to lack of care. During the COVID pandemic, the restrictions were lifted, allowing nurse practitioners in Pennsylvania to float to areas of greatest need, without needing collaborative agreements, to provide much needed care to patients in need. If Nurse Practitioners were capable during time of crisis, why not now? These bills do not change the care provided or practice of Nurse Practitioners but allow greater access to care for patients.

Empowering NPs not only addresses the healthcare gap but also promotes economic efficiency. It reduces bureaucratic barriers, leading to cost savings for both healthcare providers and patients. Additionally, it encourages entrepreneurial opportunities for NPs, contributing to local economies, rather than losing these forward-thinking practitioners to surrounding states of Maryland, Delaware, and New York. This approach is a cost free, commonsense solution.

Adopting these bills is a step towards a more efficient, patient-centered healthcare system in Pennsylvania. It reflects conservative principles of limited government intervention, individual responsibility, and free-market solutions to societal challenges at no cost.

Thank you again for hearing my remarks. I am happy to answer any questions the committee may have.