Sen. Curtis , Rep. Lewis and committee members,

Thank you for the opportunity to address Committee on Access to Healthcare in Rural North Carolina. I am here today to discuss how advanced practice registered nurses (APRNs); defined in the North Carolina Administrative Code (21 NCAC 36.0120(6), as **Nurse Practitioner**, **Nurse Anesthetist**, **Nurse-Midwife** or **Clinical Nurse Specialist**, can mitigate the impact the rural healthcare crisis. This discussion will focus on how current regulatory barriers, red tape, redundancy, and government overreach limit NC citizens from accessing the full complement of care that APRNs are educated and credentialed to provide. Removal of these unnecessary barriers can create an environment wherein APRNs can improve consumer access to healthcare in rural NC and beyond.

I am a family nurse practitioner (FNP) with 33 years' experience. I have experience in clinical practice in rural health, academia and regulation of nursing practice.

I served for 20 years as a Commissioned Officer of the U.S. Public Health Service. I served three different tours of duty in rural Southeastern and Eastern NC. As such, I am very familiar with the challenges of rural health and the need for ensuring access to qualified healthcare providers to meet the needs of these vulnerable citizens.

I have both taught and served as the director of master's and doctoral level APRN programs in our state. During my tenure in this role, the importance of placing rural health as a priority in our application process was recognized. We weighted the application and funding process for those living in rural NC with a commitment to serve in primary care in rural NC. After educating APRNs in their home communities, data supported that 50% of graduates chose rural, primary care as their employment venue of choice.

Clinical practice has always been part of my professional roles. I have continued to practice in rural Wayne County where the primary care management of multiple chronic conditions (MCCs) is a routine part of my daily practice. Every day that I am in practice, I see and navigate the barriers that our citizens; my friends and family members, face in accessing healthcare. This work informs my current role.

As the Education and APRN Consultant for the NCBON, I provide consultative oversight for 11,311 APRNs who account for 7.2% of the NC nursing workforce (see Table 1). This includes 7,502 nurse practitioners, 3,235 certified registered nurse anesthetists, 340 certified nurse midwives and 237 clinical nurse specialists. These APRNs are poised as key leaders in addressing the access to health care in rural NC.

To optimize access to these APRNs, there is a need for regulatory reform to remove the barriers that limit full utilization of this valuable healthcare resource while providing avenues for consumer choice in the selection of their preferred healthcare provider.

On a weekly basis, I receive inquiries from APRNs who are considering practicing in NC. The deciding factor is the removal of regulatory barriers that support consumers' unfettered choice in choosing their healthcare provider of choice. Removal of these barriers would increase access to

healthcare through more APRNs endorsing into our state while minimizing the migration of our healthcare resources to other states with less cumbersome regulatory environments. Furthermore, healthcare costs would decrease through elimination of duplicity in healthcare services, elimination of the costs of being tethered to other professions, and patient safety would improve through clear locus of accountability for healthcare; all in a budget neutral manner.

Nurse practitioners, CNMs, CRNAs and CNS all provide safe, effective healthcare to individuals, families and communities within their population focus. These APRNs provide a continuum of care ranging from primary care, chronic disease management of MCCs, urgent, and acute care as consistent with their educational preparation and national certification. Prescriptive authority, in concert with state and federal regulations, is part of the approval process for the NP and CNM roles.

Despite the research-validated value that APRNs bring to healthcare, regulatory barriers, red tape, redundancy, and, government overreach continue to limit NC consumers from accessing the full complement of services that these APRNs are qualified to provide. I speak from first-hand experience regarding how these barriers have and continue to limit NC consumers from accessing the full complement services that APRNs can provide.

For example, at one point in my career, the scope of care for which I have been educated and hold national certification was limited because of the regulatory requirement of being tethered to a supervising physician. When the family practice physician in my rural community health center resigned, my scope was limited to adult health because the only physician available was a hospital internist who did not see children or pregnant women. This forced my pediatric and pregnant patients to seek care elsewhere because regulatory red tape limited their option to continue to seek care from me as their chosen healthcare provider. This occurred in context of the very real social determinants of health for this impoverished population with transportation barriers. This regulatory red tape and government overreach ignored the healthcare access needs patients despite my credentials and longstanding history of safe, effective care. These vulnerable patients in my practice had to seek care elsewhere.

It is well established through surveillance data that citizens in rural North Carolina are in poorer health when compared to the rest of the state. Rural counties rank in the bottom 50 -100 rankings compared to urban areas in health outcomes such as obesity, chronic respiratory disease, cardiovascular disease, infectious diseases and access to healthcare. Furthermore, citizens employed in rural occupations such as farming, fishing, and logging have high levels of morbidity and mortality that are related to injuries, stress and risks inherent in such occupations. Because farmers are less likely to have health insurance, they are more likely to have chronic illnesses such as diabetes that if left untreated, result in increased morbidity and mortality.

The level of MCC, which are already high in NC, will continue to rise in the future as the elderly population increases in our state. North Carolina is the 10th most populous state in the country with a population of 10.39 million citizens. In a 2018 report, 12.7% our state's population was in the 65 or older category with predicted increases to 20% by 2030.

APRNs can improve access to healthcare and mitigate the impact of MCC's in rural NC and beyond. As is appropriate for all healthcare professionals, APRNS collaborate at the point of care, when clinically appropriate, to ensure safe, effective care for consumers. This is a professional norm and expectation that does not require regulation.

The healthcare access needs for the citizens of rural NC and beyond requires ethical, fiscal and thoughtful consideration. We have more than 11,000 under-utilized, highly qualified APRNs who could significantly mitigate these healthcare access needs should there be the courage and the will to remove the unnecessary regulatory barriers that limit consumers from choosing APRNs as their healthcare provider. This is a budget-neutral process. Arizona and 20 other states have demonstrated success in such measures, providing evidence for safe and improved healthcare access.

Thank you for your ongoing work and your commitment to excellence. I stand as a committed and willing partner to provide information for consideration in protecting the public and ensuring access to evidence-based healthcare.

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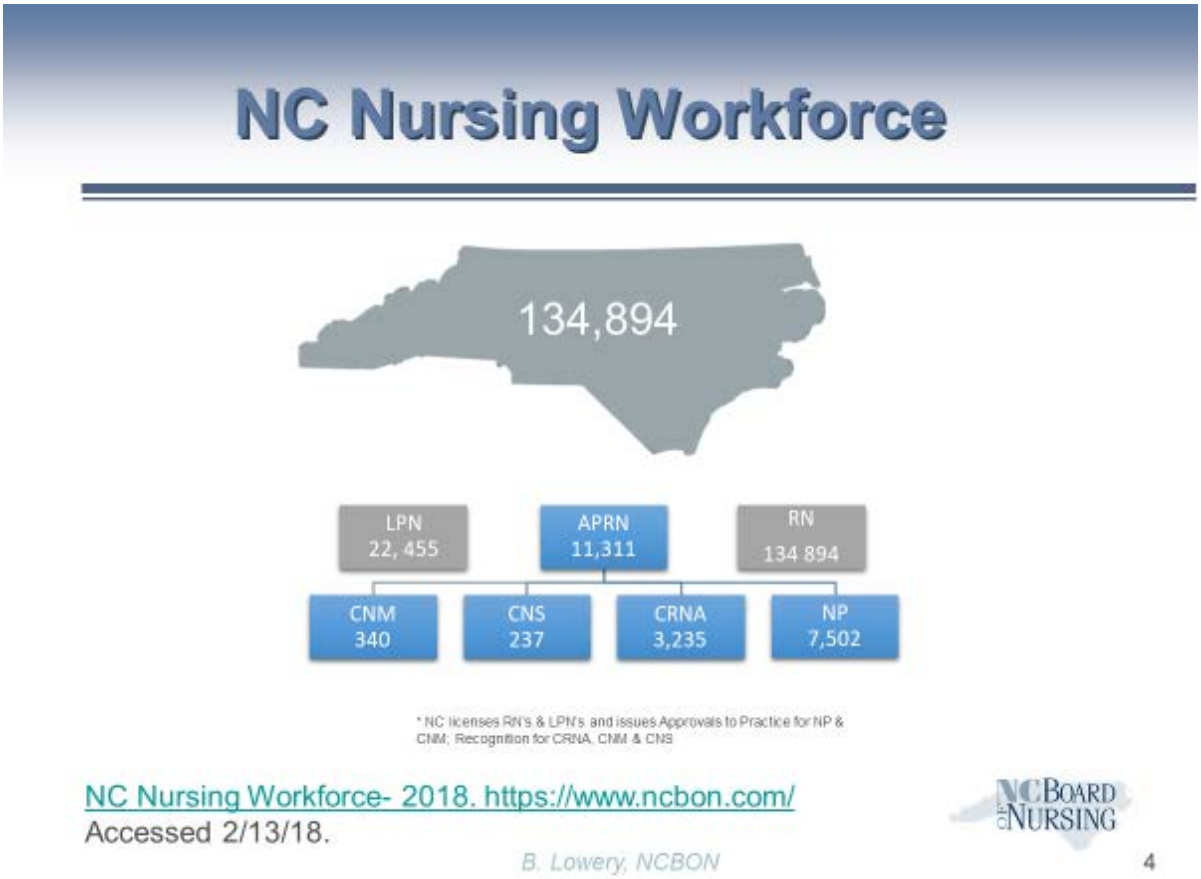
Table 1


NC Nursing Workforce
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LPN
22, 455
APRN
11,311
RN
134 894
CNM
340
CNS
237
CRNA
3,235
NP
7,502
* NC licenses RN's & LPN's and issues Approvals to Practice for NP & CNM; Recognition for CRNA, CNM & CNS
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