



LOBBYING PRIMER FOR EMERGENCY PHYSICIANS

JULY 2021 // PREPARED BY DEBORAH FLETCHER, MD FAAEM FACEP



AAEM
AMERICAN ACADEMY OF
EMERGENCY MEDICINE
CHAMPION OF THE EMERGENCY PHYSICIAN

LET'S JUST START OFF WITH THE OBVIOUS -

We, as doctors, do NOT typically want to get involved politically. We have been taught that our education, hard work and effort will be rewarded, and we can just do our job and things will work out. Well, it is not that easy anymore. Our profession is being attacked from groups who want a piece of the pie. The pie that is already shrinking from administrators, government oversight, and insurance payments. Most of us would love to take back medicine and provide old fashioned patient care. The financial compensation, in some regions, just does not make up for the liability and lack of control of our practice. Many are quitting medicine altogether.

We can work on change, however - but will be small steps forward. Those that have control of the legal system in many ways control our destiny. How do we have an influence? For one thing, you need to know which legislative body controls the issue you are focused on. For example, we have found that the scope of practice battles are fought at the state level, so your state legislators need to have your focus there.



How To Lobby As
PHYSICIANS

3 STEPS TO LOBBYING AS PHYSICIANS

BUILD RELATIONSHIPS WITH YOUR LEGISLATORS

We need to make contact with them, especially in the “off-season”. As in sports, the legislators have a period of intense work during the legislative session - they have to be ready to bring bills, work in their respective committees, and then vote on so many issues in a short few months. We need to reach out to them when they are not in session, to have time to educate and discuss our issues when it is not crazy for them. My senator’s assistant said to make an appointment right after session ends in June and be ready to bring him ideas about future bills. The legislator’s constituents come in and give him ideas for future bills, and that is how he gets bills for the next year started. We need to be proactive from this point on - and stop playing defense. Work with your state medical society for bill strategy planning.

SPEAKING OF ASSISTANTS...TALK TO THEM!

Make calls personally to the office. They will have someone answering the phone, or the voicemails. A phone call is often better than an email, but most of them register all calls and emails and report the number for and against policies to their legislators. Be helpful and not condescending to their staff, as they can likely make or break your case. (Kind of how being kind to your nursing staff can make or break your shift.) If you establish a regular rapport with them, they can often key you in to what can be done to help your issue. The legislators rely on their assistants/staffers to give them data on a multitude of different bills. Let them help you, and ask them “What do you think is the best way to pursue this to make the most difference?”



(Again, using our medical analogy, when you were an intern and the night nurse called you about a problem - you asked them what the other doctors usually did in that situation - the staff can lead you in the right direction.)

DONATE TIME AND MONEY

This seems logical, but if you want help, be willing to give help. It honestly does not take a large amount of money - as little as \$50 - can get you noticed on a donor list. Offer to help out with the campaign, make calls, Facebook posts, etc. Hosting a gathering of friends and colleagues in support of the candidate is of course helpful as well.

201: TALKING TIPS BEFORE SESSIONS

PLAN AHEAD

- Know a little about the legislator first. Google them. Stalk their Facebook and Instagram. Ask your state medical society coordinator for information. Ask a colleague. Try not to go into a meeting or conversation without some knowledge of that legislator. Do not go in cold!
 - Send a Facebook message - this can be an introduction even before the meeting
 - See what they post and make notes - this can help you later when talking in person.
- Know what your “ask” will be and think about how you want the conversation to go. What do you want them to do for you? As we have patients with a “chief complaint”, we need to go to them with a “chief ask”. They hear asks all the time so don't be like the patient with a laundry list of complaints. Be focused on this part.

WHEN CALLING ON OR VISITING SOMEONE

- Introduce yourself and share a little about who you are and what you do. Ask them questions about themselves. You will often find that you know the same people or have similar interests.
 - One of our state senators was a big fan our local teaching hospital. Mention the fact that you did residency there and create a bond.
 - Have a brief personal conversation based on your advance planning. Do they post about mountain vacations? Ask about future travel plans and recommendations. Family pics? Ask about their kids and schools. Volunteering? Talk about your mission trip to Belize.
- Get to your ask. If you do not have a specific bill to discuss, let them know you want to be a resource for them as legislation is filed. For instance, tell them you understand there will be several scope bills and ask them not to commit to other groups without giving you an opportunity to follow up.

REMEMBER

- You are the subject matter expert when talking about Medicine. This means that you will want to adjust your terms accordingly. Using 14 syllable words is not a good idea for the non-medical legislator. Make your conversation specific and understandable.
- If you ask for a certain amount of time, stick to that time frame. If you are having a good conversation and feel like that legislator may be willing to spend more time talking, mention that you know you asked for 15 minutes, but that you are certainly willing to continue the conversation now or to schedule more time when it is convenient.



FOLLOW-UP

- Always send a follow up email or call thanking them for their time and interest in your issue.
- Ask if they have had any questions that have come up since your meeting. Maybe they have been approached by other groups, and they want clarification on the issues.
- Ask if there is anything you can do for them. Offer to help be a medical advisor, help with campaigns, etc.

202: CRUNCH TIME LEGISLATION

Well, this is not how we would like to deal with legislation. Unfortunately, some bills are presented during the legislative session and we just are not prepared in advance. That does not have to mean we give up. It is a time to mobilize to action.

GET INFORMATION ON THE BILLS AFFECTING MEDICINE

Your state medical society will be involved in this, so join your state medical society now! Work locally so you will know what is happening.

KNOW THE PROCESS

Back to Civics class in high school. The bill will usually start in committee - whether Senate or House, depending on origin of the bill. Most of our medical bills will be in Health and Welfare Committee. Take for example: Louisiana HB 495 to remove the collaborative practice agreement for nurse practitioners. It was initially presented for discussion in the LA House of Representatives Health and Welfare Committee. There, in committee, physicians with the Louisiana State Medical Society had a time to present arguments against the bill, and the NPs presented their arguments. From there, unfortunately the bill passed committee, and was sent to the LA House floor for discussion. There are no invited discussions on the floor - only legislators discuss the bill and any amendments to add. It was voted on there and sadly, passed the house floor. Next, it was discussed in the LA Senate Health and Welfare Committee. Again, in committee meetings, they allow invited groups to discuss their opinions on the bill. I was able to testify for physicians in this Senate H and W Committee hearing! It is intimidating to do, but they have to hear from us - the NPs were there in force to present their case for independent practice. (This is a great opportunity to testify in committee -check with your state medical society since they typically organize the speakers, and can help with talking points.)



The LA bill passed Senate Health and Welfare Committee and looked like it was on the fast track to becoming law - BUT this is where our physician grassroots efforts made a difference. More on that later...As you can see, there are opportunities to stop bad bills before they get this far.

WATCH THE PROCEEDINGS ONLINE

We all should have access to these videos, whether in real time or to watch later. This was so eye-opening. Seriously. You get an idea of what the legislators consider important. Honestly, for our bill, we really thought that differences in education and quality of care were so important. This was not the point that resonated with the committee members. They were all about access to care. This is good to know for the future - and we can be more prepared in regard to how removing the collaborative practice agreement will NOT improve rural access to care. Also, they want data. Data and numbers. The bad part about scope issues is that there is very little hard data.

CONTACT COMMITTEE MEMBERS BY PHONE AND EMAIL

Unfortunately, sometimes there is not much time to do this. In the same vein as knowing your own legislator, find out about the committee member before contacting them. Know their background to know how to present your thoughts on the issue. Are they from the business sector? Mention the financial ramifications. Are they from a rural area? Mention that the bill will actually not help the rural communities they are trying to serve, and can worsen the health care. Are they a veterinarian/pharmacist/chiropractor? Try to make a connection.

IF THE BILL PASSES COMMITTEE, START CONTACTING ALL OF YOUR LEGISLATORS DIRECTLY

As our LA bill passed Senate H & W committee, we made a huge push to contact every senator in the entire state, even if not in their district. I know for a fact that the opposition was calling them, maybe 200:1 (or more). It takes everyone interested to do this - even my mom was making calls as a concerned patient.

ROBO-EMAILS LIKE VOTER-VOICE ARE OKAY IF NOTHING ELSE - BUT PERSONALIZED EMAILS ARE BETTER

Many of the legislative offices log the number of calls/emails they receive. However, they much prefer a personalized email stating your case for or against something. It really can make a difference to hear from a physician over the sea of other voices. A personal call to their office is even better. As mentioned before, speak with the assistant/staffer and they will relay your message. Relate a personal story of a patient care episode - it personalizes this issue. Something to remember here is that politeness matters.

We do not need to come off hostile. As far as the scope issues, physicians are portrayed as bullies keeping NPPs from "practicing at the top of their scope", and if we are hostile or rude this feeds into that rhetoric. Let them know that you value NPPs in health care and they provide valuable service, but that the physician needs to lead the patient care team for best health outcomes. We are frustrated, yes, but keep it professional, polite and always put the focus back on patient care and safety. Politicians respond to stories. You can say "Let me tell you about a problem one of my patients faced - who happens to be one of your constituents..."

GRASSROOTS EFFORTS

- Start with mobilizing all of the physicians. We are not doing a good job of reaching our own. Send articles, emails, texts, and calls to your colleagues. In every specialty. Our state started an all-specialty physicians advocacy Facebook page. Other specialties are fighting this battle, but our specialty groups are fractionated - and this FB group brought all concerned physicians in the state together on the same page and working together. It truly made a difference in getting information out, and in morale - knowing others care to get involved as well.
- Get people talking about it. Get to the public to help. Mobilize social media outlets. For instance, flood Facebook, Twitter, and Instagram. Contact your local TV station and newspaper to do a story. We have public attention now following COVID so use it to our advantage.



WIN FOR LOUISIANA!

Our state advocacy efforts had a great result this year. The Louisiana State Medical Society logged countless hours protecting physicians and patients from this bad bill. Emergency medicine physicians joined forces with physicians in other specialties, all working to defeat the bill. So many of our Louisiana colleagues (and family/friends) participated in the grassroots movements with calls and emails that the chair of the Senate Health and Welfare committee was making comments about this in the meetings. In the end, the bill did not have enough votes to pass the senate, so the committee chair decided not to even bring it up for a vote on the senate floor. He spoke at the time saying that he wanted the doctors and nurse practitioners to work out a compromise. We know this issue will be back next year, and we will be ready - but stronger. Working together with LSMS and other physicians across the state, we will be on offense and present bills to improve the collaborative practice agreement instead of remove it. We are stronger together.



FINAL THOUGHTS

YOU CAN STILL HELP BEHIND THE SCENES IF YOU ARE CONCERNED ABOUT JOB RETALIATION

Unfortunately, many are in the position where speaking out could possibly jeopardize their job. Some doctors are afraid to speak out to avoid hard feelings with the NPP staff. If you can, have an honest discussion with them about their value in the system, but your opinion is for physician-led care. If you are not in a position to speak, you can still contact your legislator requesting anonymity due to fear of losing your position, or backlash from NPs who may take this as a personal affront. You can still make calls and send emails across the state. Consider writing articles under a pseudonym or helping organize physician groups and supporting other leaders.

LOOK AROUND THE ROOM TO SEE WHO IS WORKING WITH YOU

Know the players and their motives. Interestingly, when we were working against the surprise billing legislation, we had hospital administrations and contract management groups encouraging doctors to get involved and advocate as a group, against insurance company interests. Now, look and see who is NOT advocating for doctors on scope of practice battles. Crickets. It is just us.

DON'T GET DISCOURAGED

It is hard not to take it personally, given all of the years and time we have spent training and practicing. Be ready for the next bill, and next year. Consider being proactive and taking a bill idea to your legislator. We are always on the defense with these scope bills - we should be proactive and bring up bills to increase supervision and limit the increased scope of practice! Be ready with your next ask - and let your legislators know you will be back to help them.

GET INVOLVED WITH AAEM

We are working for all emergency physicians - and welcome and NEED your input. It doesn't matter what type of job or staffing model you are with. Our voices are growing now more than ever. There are many ways to be work with us. Join your state AAEM chapter - if you don't have one, get some friends together and form a new state chapter. The AAEM Workforce Committee is very active right now. I am on the WF States legislative subcommittee, and can personally use help. It would be great to have a contact from every state who can keep us informed about new legislation, and we can provide advocacy help in return. You can email me at ddfletcher@mindspring.com if you would like more information, or contact AAEM at info@aaem.org.

ATTEND ADVOCACY DAY AT THE CAPITOL

AAEM and AAEM/RSA typically sponsor a Health Policy Symposium and Advocacy day in the summer. You can take your knowledge of issues directly to Capitol Hill and have targeted meetings with congressional leaders. You are placed in small groups with other participants and accompanied by a guide from Williams and Jensen. They take you around the Hill, give you handouts to leave, and are great coaches!

CONSIDER RUNNING FOR OFFICE YOURSELF

My daughter has already googled how many bedrooms there are in the Governor's mansion.



401: TARGETED SCOPE OF PRACTICE

INFO TO SHARE WITH LEGISLATORS: EDUCATIONAL DIFFERENCES

WHO IS TREATING YOUR EMERGENCY?

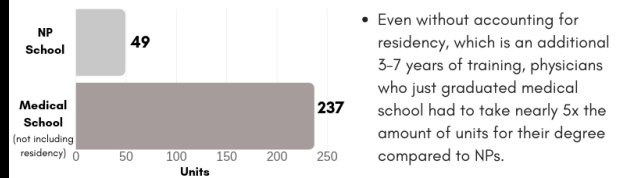
	Board Certified Emergency Physician	Physician Assistant (PA)	Nurse Practitioner (NP)
Minimum Years of Education After College	7 years Medical School and Residency	2 years PA School	2 years NP School
Standardized Exams	USMLE Step 1-3 >1,000 questions 41 hours of testing	PANCE 360 questions 5 hours	AANP/AANC 150-200 questions 3-4 hours
Formal, Supervised EM Training	3 years of emergency medicine residency		
Testing of Competency in EM	American Board of Emergency Medicine Certification Exams (Written and Oral) >300 questions and in- person management of 14 cases		
Board Certification by American Board of Emergency Medicine	YES	NO	NO



WHAT IT TAKES TO MAKE A DOCTOR

The Educational Differences between Medical Doctors and Nurse Practitioners

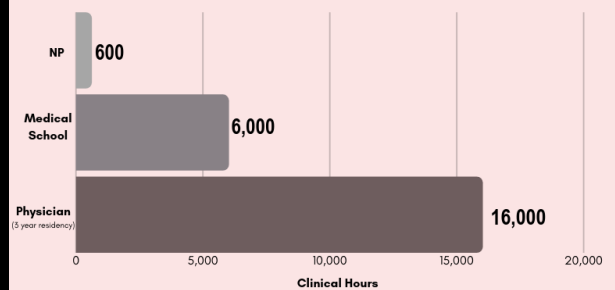
CERTIFICATION BY UNIT REQUIREMENT^{1,2}



- Even without accounting for residency, which is an additional 3-7 years of training, physicians who just graduated medical school had to take nearly 5x the amount of units for their degree compared to NPs.

*Example programs are listed that state their specific unit requirements for graduation. These sources closely resemble other programs of their same degree.

CLINICAL HOURS REQUIRED FOR CERTIFICATION



- While some nurse practitioner degrees can be completed 100% online in as little as 5 years including college, physicians must complete at least 11 years and more than 16,000 hours of hands-on training before treating patients independently.³
- An NP has less than 4% of the clinical hour training of an MD/DO (with the minimum 3 years residency training).⁴
- A medical student, who is not allowed to treat a patient independently, would have undergone nearly 5x the amount of unit requirements and 10x the amount of clinical training that a fully licensed NP has.




With the vast amount of education, training, and clinical hours required to produce a single physician (the most of any healthcare team member), physicians can rely on a much larger breadth of knowledge in each of the medical decisions they make. This is why we at AAEM/RSA believe that all healthcare team members, including nurse practitioners, should be under the supervision of a physician in order to ensure the safety and proper health care of our patients.

#ASKTOSEEYOURPHYSICIAN



1. https://www.aanp.org/education/np_rnursing/curriculum
 2. <http://med.startfirst.edu/med/medbook/booksection-4-curriculum-overview.html>
 3. https://http.org/media/default/downloads/advocacy/scope_education.pdf
 4. <https://www.aanp.org/Media/Default/Downloads/advocacy/scope-rnmas.pdf>

INFO TO SHARE WITH LEGISLATORS: EDUCATIONAL DIFFERENCES CONTINUED



Scope of Practice: Myth vs. Fact

MYTH	VS	FACT
Changes to scope of practice expand patient access to care.		While the number of nurse practitioners doubled between 2010-2017, there has been no noticeable increase of nurse practitioners within rural, underserved areas. CMS data and countless state examples show nurse practitioners tend to practice in the same areas of the state as physicians, irrespective of state scope of practice laws.
Patients welcome scope of practice changes.		Sixty-eight percent of U.S. voters say it is very important to them for a physician to be involved in diagnosis and treatment decisions. Patients want and expect a physician to be present on their care team.
Scope of practice changes would decrease health care costs.		Studies from the Mayo Clinic and JAMA found nurse practitioners and physician assistants are more likely to make unnecessary referrals and imaging orders, resulting in higher costs for patients
Patients are the primary beneficiaries of scope of practice changes.		<p>By allowing increased scope expansions, lawmakers are allowing for-profit entities to shape our health care system – regardless of what patients want – while also reducing patient choice in who provides their care.</p> <p>While some procedures seem simple and uncomplicated, there are too many examples of practitioners with less education and training having bad outcomes that harm patients for the rest of their lives.</p> <p>Studies from the Mayo Clinic and JAMA found nurse practitioners and physician assistants are more likely to make unnecessary referrals and imaging orders, resulting in higher costs for patients.</p> <p>While the number of nurse practitioners doubled between 2010-2017, there has been no noticeable increase of nurse practitioners within rural areas for those patients who are underserved.</p>

It's clear, patients benefit least from changes to scope of practice.

INFO TO SHARE WITH LEGISLATORS: AMA MAPS

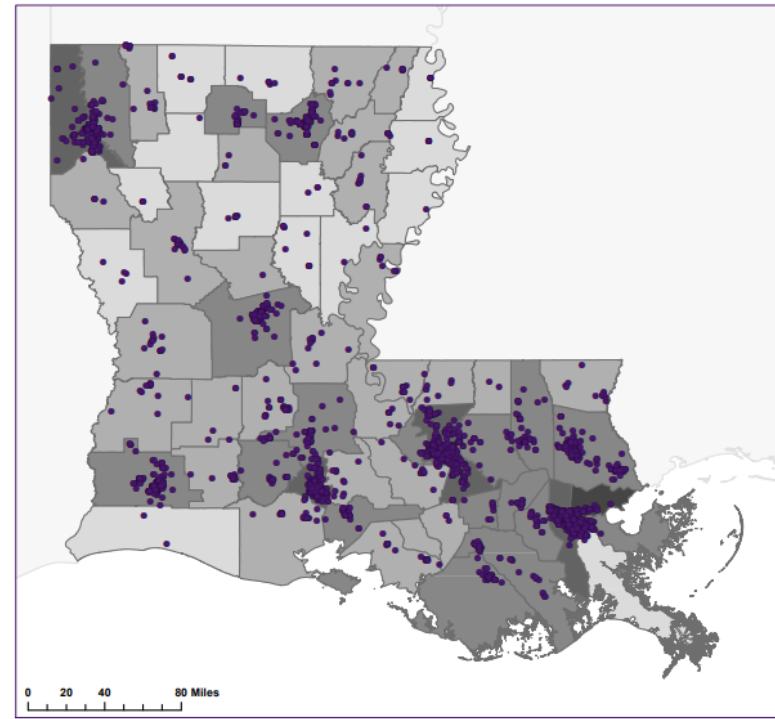
We have data from the AMA Health Workforce Mapper. They have a free, customizable, interactive tool that illustrates the geographic distribution of the health care workforce. It gives you the data needed to help you personalize your state/region for your legislative issues. Our LSMS created some maps that show that even in states that have increased the scope of practice for NPs, this has not changed the numbers working in rural areas. For instance, Minnesota and Colorado have full practice authority for NPs, and you can see by the density of practitioner maps for Primary Care Physicians vs Nurse Practitioners that this has not increased their presence in the rural areas. They still do not move to rural areas as advertised.

NOTE: The following state geomaps courtesy of the American Medical Association.

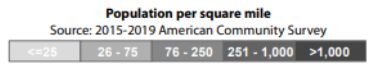
Primary Care Physicians



LOUISIANA



● Primary Care Physicians (n=3,617)



Source Notes: AMA Physician Masterfile 2020; U.S. Census Bureau county and state shapefiles 2010

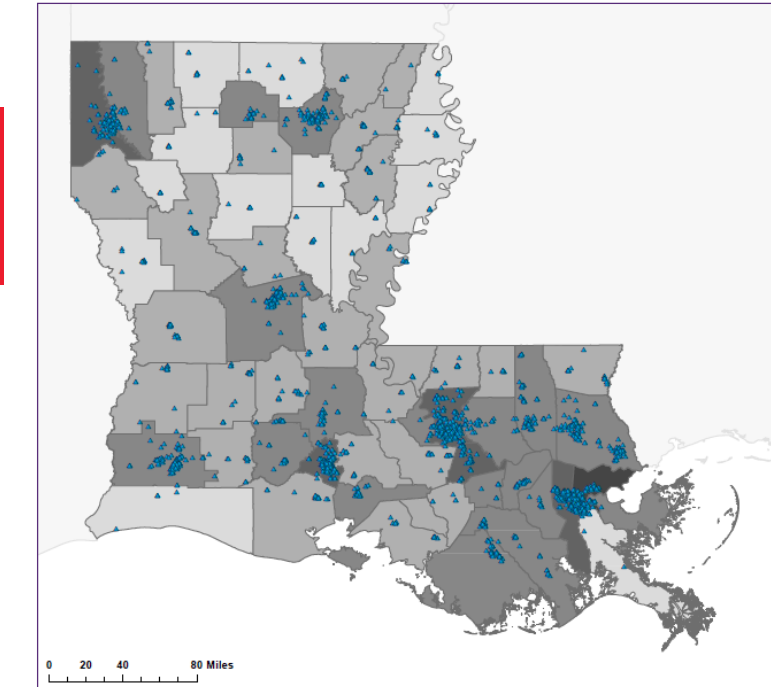
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LOUISIANA

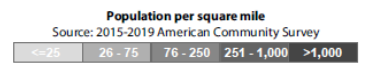
Nurse Practitioners



LOUISIANA



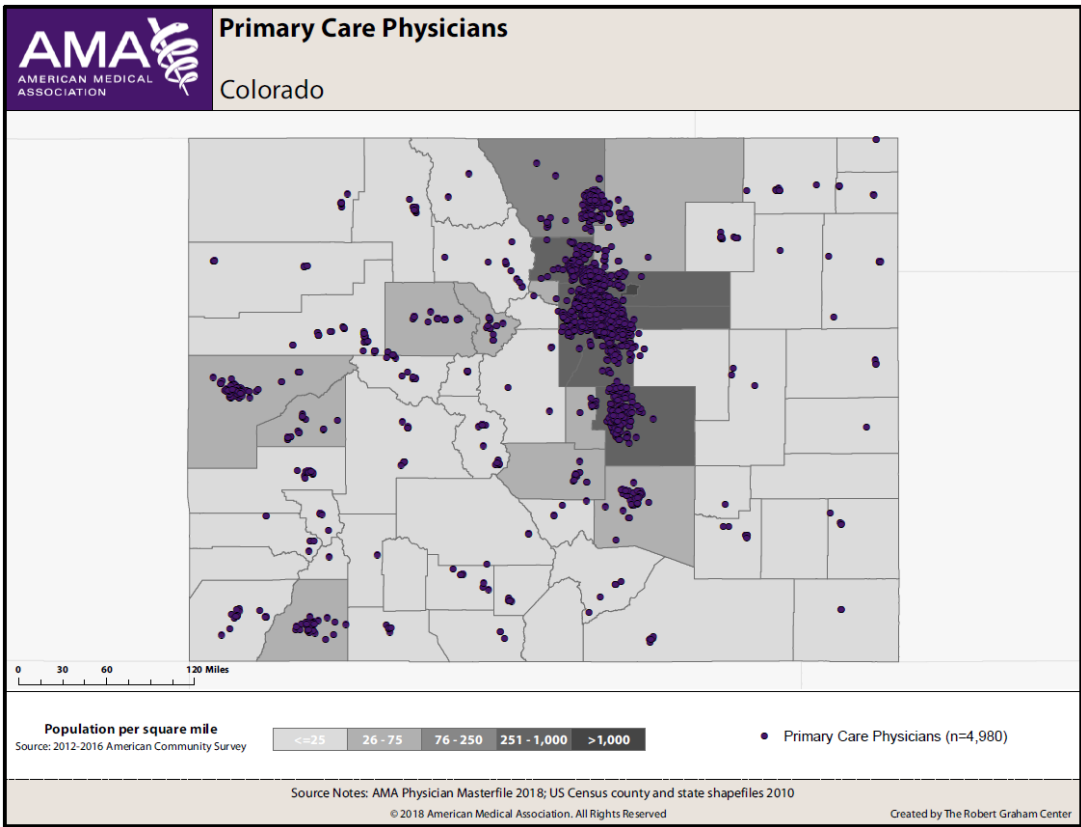
▲ Nurse Practitioners (n=4,664)



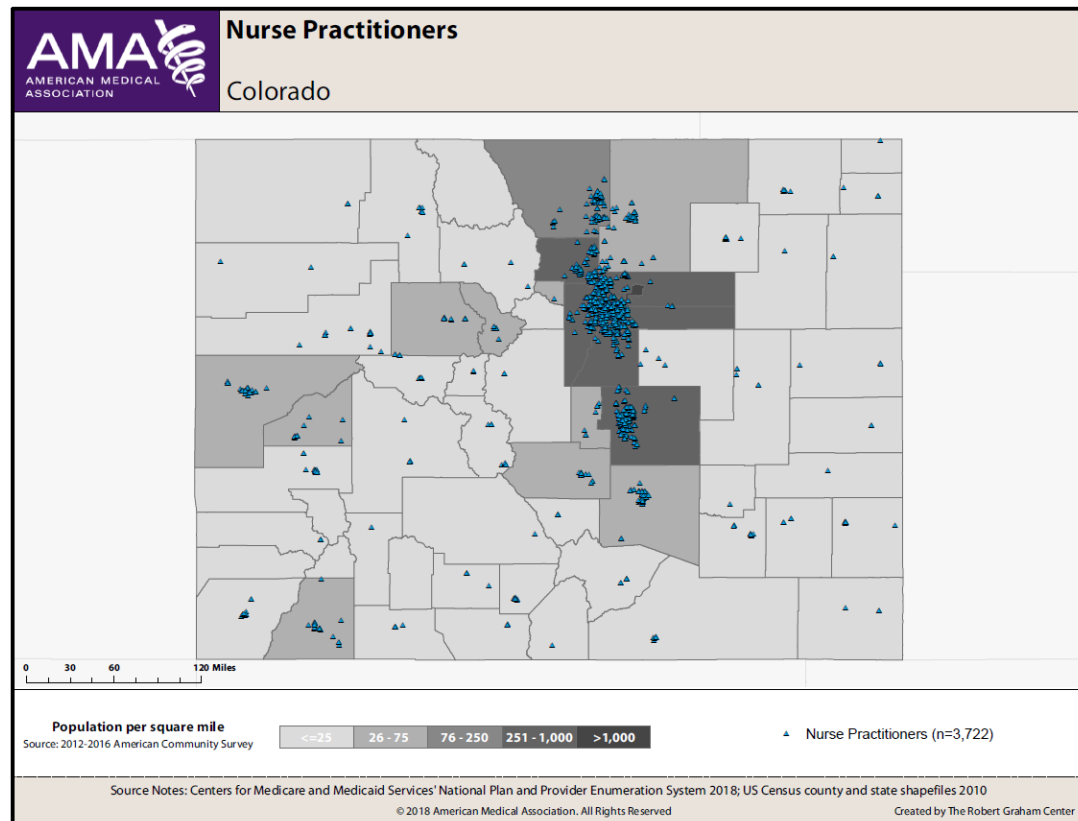
Source Notes: U.S. Centers for Medicare and Medicaid Services National Plan & Provider Enumeration System 2020; U.S. Census Bureau county and state shapefiles 2010

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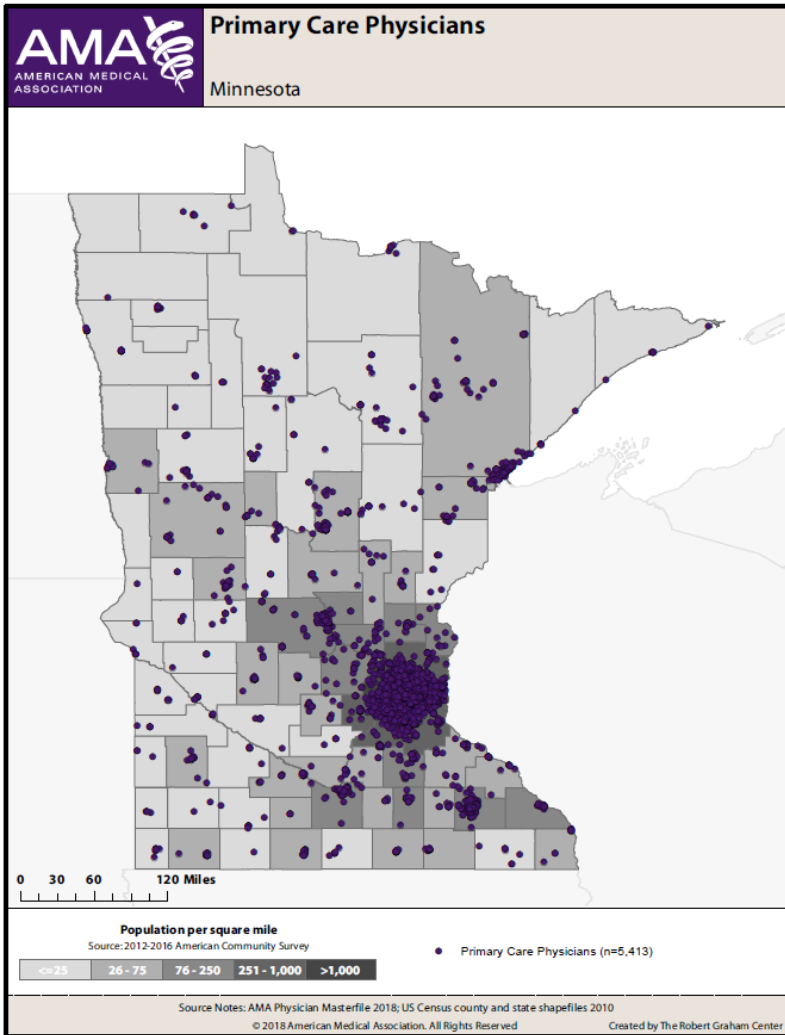
INFO TO SHARE WITH LEGISLATORS: AMA MAPS CONTINUED



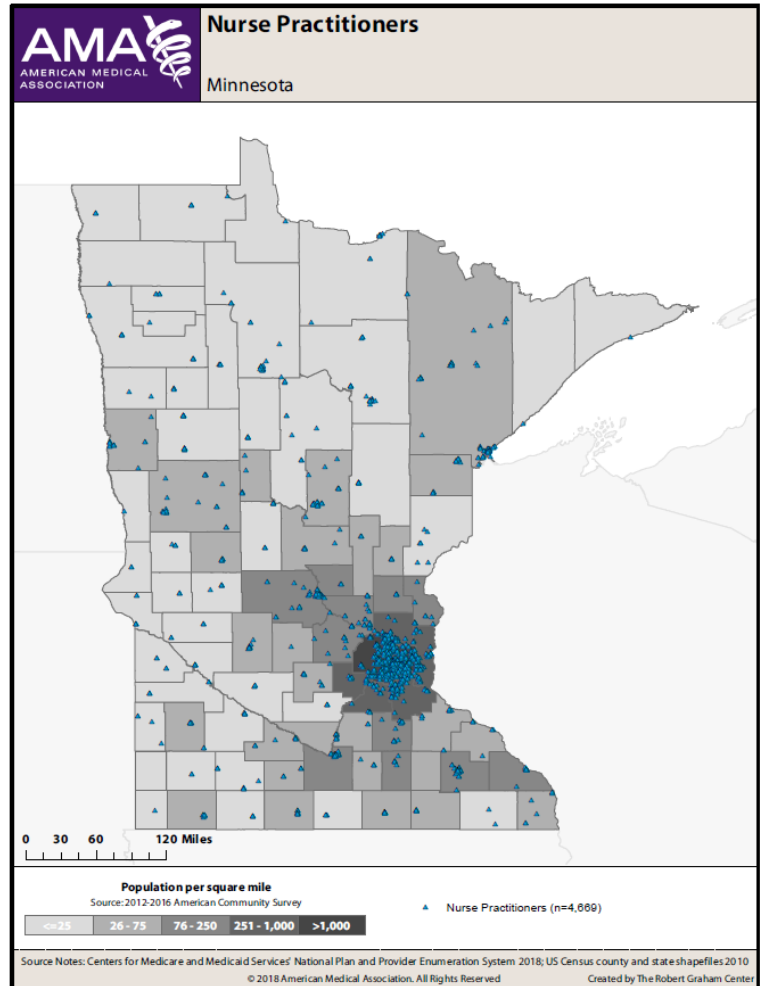
COLORADO



INFO TO SHARE WITH LEGISLATORS: AMA MAPS CONTINUED



MINNESOTA



CLAIM VS. FACT



CLAIM

Independent Nurse Practitioners will solve the shortage of Primary Care in Rural/Underserved Areas

FACT

Another argument advanced by the supporters of this bill is that nurse practitioners will effectively solve, or significantly improve, the shortage of primary care providers in rural and underserved areas. This argument is purely speculative, and the data is inconclusive at best. First, from a common sense standpoint, one has to wonder why a nurse practitioner would be any more inclined to live in a rural area than a physician would. Certainly factors such as family, career opportunities for a spouse/partner, and education options for children would come into play just as much for a nurse practitioner as a physician when deciding where to practice. This logic IS supported by data, as states such as Oregon and Arizona have allowed independent practice of nurse practitioners for years. Yet, according to Dr. James Madara, the American Medical Association Executive Vice President, "in Oregon, there is no measurable shift of nurse practitioners to the rural areas." Perhaps even more telling is that in a 2014 80-page report prepared for the Arizona Area Health Education Centers program, entitled "The Supply of Physician Assistants, Nurse Practitioners, and Certified Nurse Midwives in Arizona," the authors found that only 11% of physician assistants, nurse practitioners, and CNM's work in rural areas. Last, even a study funded by the American Nurses Association, titled "Understanding Advanced Practice Registered Nurse Distribution in Urban and Rural Areas of the United States Using National Provider Identifier Data" refutes the proponents' argument. Specifically, when looking at the likelihood of nurse practitioners working in a rural area, the investigators found there was no statistical significance between nurse practitioners in states with the most autonomous practice regulations compared with states requiring physician delegation or supervision." In sum, both common sense, as well as empirical studies, raise doubt that nurse practitioners, whether autonomous or not, will gravitate to rural areas any more than physicians do.

SOURCE

1 O'Reilly, K. Three big reasons why letting Nurse Practitioners practice independently is a bad idea. September 14, 2020. AMA-ASSN.org.

2 Tabor, J. Jennings, N., Degnan, B Derksen, D., Campos-Outcalt, D., and Eng H.(2014). The supply of physician assistants, nurse practitioners, and certified nurse midwives in Arizona. A report prepared for the Arizona Area Health Education Centers Program.

3 Skillman, S.M., Kaplan, L., Fordyce, M.A., McMenamin, P.D., and Doescher, M.P. (2012). Understanding Advanced Practice Registered Nurse Distribution in Urban and Rural Areas of the United States Using National Provider Identifier Data. Final Report #137. (Study funded through a contract with the American Nurses Association). University of Washington School of Medicine. Department of Family Medicine.

CLAIM VS. FACT



CLAIM

This bill only removes the collaborative practice agreement and these independently practicing nurse practitioners will only work “within their scope of practice” so they should not fall under the Louisiana State Medical Board Examiners’ regulation

FACT

Allowing someone to engage in the independent practice of medicine without being subject to the examination and regulation of the Louisiana State Board of Medical Examiners is a clear violation of La. R.S. 37:1270.

The statute uses the word SHALL. There's nothing optional about it. It's mandatory.

When you get rid of the Collaborative Practice Agreement, you eliminate the need for physician-led healthcare teams. Thus, this legislation is NOT about a single piece of paper, as Representative Ivey claims. Rather, this bill allows complete independent practice of medicine by nurse practitioners. We heard numerous times in the House debate that just because you get rid of the CPA, that doesn't mean that you CAN'T collaborate anymore. But that is not at all the point. Of course it doesn't mean you HAVE TO practice independently without collaboration, but it does mean that you have the RIGHT to. And once you have the RIGHT to practice medicine independently, you are now subject to La. R.S. 37:1270.

During the House Floor debate, Representative Stagni pointed out that other groups, such as psychologists and chiropractors, are NOT regulated by the LSBME. However, these groups do NOT practice MEDICINE. There's an easy distinction there and his analogy simply doesn't hold up. By removing the collaboration, you are essentially equating an independent nurse practitioner (who will be called “Dr” and wear a long white coat) to a family practice physician (also called “Dr” and wearing a long white coat). Are they not then practicing medicine at this point? Both the physician and the independent nurse practitioner will be treating, for example, hypertension. If they are diagnosing and treating the same diseases as physicians, shouldn't they be held to the same standards of care as physicians? There are very clear practice guidelines on diagnosis and treatment of such diseases and besides distracting our patients with the same titles and uniforms, this is one area where the waters should NOT be muddied. Anyone engaging in the practice of medicine needs to be regulated by the well-established LSBME. Physicians do not want to compromise on this point, but patients should not want to either.

If two individuals with different training and different degrees are examining, diagnosing and treating the exact same diseases, why would they NOT be regulated by the same board and subject to the same standards of care?