

## Legislative Commission on Primary Care Workforce Issues

October 26, 2017 2:00-4:00pm at the NH Medical Society Conference Room, Concord

### Call in information:

866-939-8416

Participant Code: 1075916

### Agenda

- |             |  |
|-------------|--|
| 2:00 - 2:10 | <b>Introductions &amp; Minutes</b>   |
| 2:10 - 2:50 | <b>LSR 18-2033 - relative to regulation of assistant physicians –</b><br>Rep. William Marsh and Sen. James Gray  |
| 2:50 – 3:15 | <b>Lamprey NP Fellowship Program –</b> Paula Smith – Southern<br>NH AHEC, Rosemary Smith and Niki Watson – Lamprey<br>Health Center                          |
| 3:15 – 3:45 | <b>UNH HRSA Behavioral Health grant presentation –</b> R.<br>William Lusenhop, MSW, Ph.D., LICSW, Clinical Assistant<br>Professor, Department of Social Work |
| 3:45 – 4:00 | <b>Create a small work group to discuss next steps for the<br/>Commission</b>  |

**Next meeting: Thursday November 30 2:00-4:00pm**

**State of New Hampshire**  
**COMMISSION ON PRIMARY CARE WORKFORCE ISSUES**

DATE: October 26, 2017

TIME: 2:00 – 4:00pm

LOCATION: New Hampshire Medical Society

**Meeting Minutes**

**TO:** Members of the Commission and Guests

**FROM:** Danielle Weiss

**MEETING DATE:** October 26, 2017

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**Members of the Commission:**

Laurie Harding – Chair

Rep. John Fothergill, NH House of Representatives

Alisa Druzba, Administrator, Rural Health and Primary Care Section – Vice-Chair

Mike Auerbach, New Hampshire Dental Society

Mary Bidgood-Wilson, ARNP, NH Nurse Practitioner Association

Kristina Fjeld-Sparks, Director, NH AHEC

Jeanne Ryer, NH Citizens Health Initiative

Trinidad Tellez, M.D., Office of Health Equity

Tyler Brannen, Dept. of Insurance

**Guests:**

Danielle Weiss, Program Manager, Rural Health and Primary Care Section

Paula Smith, SNH AHEC

Paula Minnehan, NH Hospital Association

Nancy Frank, Executive Director, NNH AHEC, IDN 7

Douglas Southard, Program Director, Master of Physician Assistant Studies, Franklin Pierce

John Bunker, representing UNH & CHHS

Peter Mason, Geisel School of Medicine, IDN Region 1

Guy Defeo, MD, Associate Dean for Clinical Education, UNE

Anne Marie Mercuri, QI Nurse, Maternal and Child Health Section

Roxie Severance, Health Sector Partnership

Kristine Stoddard, Bi-State Primary Care Association

Rep. William Marsh

Sen. James Gray

Mike Barr, Board of Medicine Chair

Joe Shoemaker, Dir. Division of Health Professions, Office of Professional Licensure and Certification

Claire Reed, MD, Chief Medical Officer, Mid-State Health Center

Will Lusenhop, UNH

Valerie Acres, Medical Society

Geoff Vercauteren, Dir. Workforce Development, Catholic Medical Center

Krista Morris, DPHS Legislative Liaison

Mandi Gingras, Bi-State Primary Care Association

**Meeting Discussion:**

2:00 - 2:10      **Introductions & Minutes**

- Paula's presentation on Lamprey NP Fellowship Program is rescheduled for next month
- September's minutes were accepted in their original form

2:10 - 2:50      **LSR 18-2033 - Relative to Regulation of Assistant Physicians** – Rep. William Marsh and Sen. James Gray

- What prompted the LSR and why they're here
  - o Sen. Gray received email from Rep. Marsh concerning graduates who don't match for residency and the dearth of providers
    - Clarification that the AAMC reports that the vast majority of med students are matched and those who are not either aren't interested in residency and clinical practice or have fellowship/practicum opportunities and match within the next 6 years
  - o Sen. Gray believes these Assistant Physicians or "APs" would be a viable provider type to mitigate the shortage, comparable to NPs and even residents that are brand new
  - o Rep. Marsh believes the number of those unmatched is substantial and that there's been an increase in those graduating from med school without an increase in residency matches
  - o They understand some of the ideas within the LSR aren't popular and want to address these points
- Bill is in 3 parts
  - o 1 - Establishes the regulation and licensure of "APs" by the Board of Medicine
    - Borrowed from the PA practice statute to apply to "APs"
      - To practice only under supervision
  - o 2 – Regulates their practice through "AP" collaborative practice arrangements
    - It's a voluntary program and no one can be required by contract to participate
  - o 3 – Establishes a grant program in DHHS to provide matching funds for primary care clinics in medically underserved areas utilizing "APs"
    - Completely unfunded
  - o Pipeline to full physician practice
    - Intends for the Board of Medicine to create a test for those who have worked successfully for 5 years to be licensed as a physician
    - Although the training is intended to be modeled after PA training, PAs are selected and trained to be team members, which is very different from physician training
- Residency expansion concerns
  - o Q - Would the program deter the addition of residency programs?
    - Legislators believe it will be a mechanism to shine light on the greater need for residency expansion and funding to do so
  - o Q - Would there be a cap on number accepted?
    - Limit of 3 per supervising physician so it's dependent on the availability of physician supervisors
  - o Q - Can't these resources go to another residency?
    - Challenge is money for a startup
      - Portsmouth is talking about launching a family practice residency
      - UNE is looking at a family based residency across NH, VT, and ME
      - No Graduate Medical Education funds for 7 years but still a budget line item
    - Legislators believe that this program will motivate legislature to put funds in for residencies or they'll find other ways around it
- Safety/Quality of care concerns
  - o Q - How much time would providers spend alone as opposed to supervised?
    - Intending for "APs" to work alongside physicians
    - Supervisory requirements mandated within the bill
      - However, outside of that, agreements will be reached between provider and supervising physicians with the understanding that physicians are liable for all those they're supervising

- Remaining concerns that there are physicians who would make a lot of money from exploiting these providers and not providing the supervision needed
  - Open to additional language and restrictions in the bill to ensure safety and quality
    - Looking to place those who would've made a match if there was one additional residency
  - National Committee for Quality Assurance (NCQA) and malpractice insurance
    - No experience with the former but the latter could be surmountable because MO did it – albeit there were issues at first
- Reimbursement concerns
  - CMS is not flexible with medical student supervision reimbursement so much so that preceptors can be difficult to find because of the time burden and meager reimbursements
    - The vision is for it to run like the PA program and have the same allowances
- The State Loan Repayment Program exists to combat the provider shortage
  - The State Loan Repayment Program (SLRP) is flexible and is modified to meet the needs of practices, like Critical Access Hospitals, in underserved areas
    - SLRP could be expanded to meet the growing needs addressed here but there's not enough funding
      - Suggestion to put money into the SLRP instead to bolster it
- Sustainability
  - Sustainability depends on the educational piece developed
    - If the Board of Medicine creates a quality piece that develops skills and licensure through the alternative pathway, the congressmen believe it could be a long-term solution for NH
  - It's unlikely that a pathway could be built so these providers could transition to a residency
    - The ACGME would need a mechanism for advancing this
      - Usually providers move from one residency to another
- AK, KS, UT have brought legislation forward but haven't implemented any comparable program

3:15 – 3:45      **UNH HRSA Behavioral Health grant presentation** – R. William Lusenhop, MSW, Ph.D., LICSW, Clinical Assistant Professor, Department of Social Work  
 Refer to handout “Behavioral Health Workforce Development Grant.”

- Clarifications
  - Funding
    - \$10k in stipends but not to put towards tuition - only for cost of living
    - There is no money to support the sites, only the students
    - The IDNs have funds to use in creative ways
      - The program may be able to expand using these funds
  - Proposing to make clinical placements available to these students
    - Will encourage partners to welcome them
  - Supervision
    - There's more flexibility for social workers to conduct supervision offsite
  - Curriculum
    - Intend to use off the shelf curriculum, not reinvent the wheel
      - Will refer to APA materials but will also bring the medical side in and BH (motivational interviewing and SBIRT, etc.)
    - Working with collaborators like Antioch
  - Program integration and certification
    - Fits within master's program
    - Substance abuse certificate program for graduates
    - Dual licensure won't be necessary as long as students have a substance use disorder placement
    - Grant allows for flexible interpretation of BH providers and settings
  - OT contribution
    - Novel part of submission – but work with physician and mental debilities/devastations
    - Similar background in training to social worker and history of being a part of the BH world

- Interpersonal training

3:45 – 4:00      **Create a small work group to discuss next steps for the Commission**

- Same issues that were described in the Citizens Health Report from 2008
  - Targeted issues to tackle - Graduate Medical Education and residency and pipeline, BH representation
- Appoint someone from NPA and a substance use disorder provider

**Next meeting: Thursday November 30 2:00-4:00pm**

# Pathways to Behavioral Health Careers (PBHC): Integrated Health Care Model

University of New Hampshire / College of Health and Human Services  
Departments of Social Work and Occupational Therapy

## Project Background and Description

The UNH Departments of Social Work and Occupational Therapy with grant writing assistance from the Department of Nursing and the Institute on Disabilities has received a 1.8 million, four-year, Health Resources Services Administration (HRSA) Behavioral Health Workforce Development Grant (BHWET). The project is designed to increase access to high quality integrated primary care and behavioral health (PCBH) care for individuals in rural areas and medically underserved populations in New Hampshire. The PCBH will enhance and expand interprofessional education (IPE) and field experiences for UNH Master's level Social Work and Occupational students to work in primary care and behavioral health settings with an emphasis on the integration of these services. The project addresses the behavioral health workforce needs in New Hampshire noted in the "Cherokee Report" of 2014 and from the New Hampshire Primary Care Behavioral Health Workforce Development Plan of 2017.

## Project Scope

- Grant Period: October 2017 – August 2021
- Training for 116 Master's Level Social Work and Occupational Therapy students
- \$10,000 stipends to support the costs associated with completing field work training.

## Project Objectives

- Student Recruitment including: (from rural and medically underserved areas)
- Establish a graduate certificate program in Behavioral Health and Healthcare
- Development and support new training sites across the state, in rural and underserved areas
- Coordinate with partners to (re) train existing workforce in primary care and behavioral health
- Through evaluation of program process measures and outcomes.

## Collaboration

This project will seek to align with and leverage resources through collaborations with, but not limited to: Manchester Community College and Plymouth State (both HRSA/BHWET grantees); the seven Integrated Delivery Networks (IDN's); NH Behavioral Health Integration Learning Collaborative (BHILC) facilitated by the UNH Institute for Health Policy and Practice (IHPP); Institute on Disabilities; Behavioral Health Institute at Antioch University of New England; Endowment for Health; and the many health and behavioral health organizations that take part in this training.

### Contact:

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Section 1 Header

2018 SESSION

18-2033.0  
10/03

HOUSE BILL            ***[bill number]***  
AN ACT                relative to regulation of assistant physicians.  
SPONSORS:            [sponsors]  
COMMITTEE:           [committee]

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ANALYSIS

This bill:

- I. Establishes the regulation and licensure of assistant physicians by the board of medicine.
- II. Regulates their practice through assistant physician collaborative practice arrangements.
- III. Establishes a grant program in the department of health and human services to provide matching funds for primary care clinics in medically underserved areas utilizing assistant physicians.

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Explanation:        Matter added to current law appears in ***bold italics***.  
                          Matter removed from current law appears [~~in brackets and struck through.~~]  
                          Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.



Section 3 Header

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1 chapter.

2 III. Except as provided in RSA 328-K:15, persons licensed under this chapter shall be  
3 authorized to receive reimbursement from the Centers for Medicare and Medicaid Services (CMS)  
4 and other insurers as if they were licensed under RSA 329.

5 328-K:3 Conditions for Licensure.

6 I. To apply for licensure by the board as an assistant physician, an applicant shall file a  
7 written application on forms provided by the board and pay an application fee. The applicant to be  
8 licensed shall:

9 (a) Fulfill the requirements for physician licensure established by RSA 329:12 except for  
10 RSA 329:12, I(d)(5) and RSA 329:12, I(d)(6);

11 (b) Have successfully completed Step 1 and Step 2 of the United States Medical  
12 Licensing Examination or the equivalent of such steps of any other board-approved medical  
13 licensing examination;

14 (c) Have proficiency in the English language; and

15 (d) Submit a complete set of fingerprints and a notarized criminal history record release  
16 form pursuant to RSA 328-K:4.

17 II. Circumstances that exist which would be grounds for disciplinary action under RSA 328-  
18 K:7 may be grounds for denial of a license.

19 328-K:4 Criminal History Record Checks.

20 I. Every applicant for initial permanent licensure or reinstatement shall submit to the  
21 board a notarized criminal history record release form, as provided by the New Hampshire division  
22 of state police, which authorizes the release of his or her criminal history record, if any, to the  
23 board.

24 II. The applicant shall submit with the release form a complete set of fingerprints taken by  
25 a qualified law enforcement agency or an authorized employee of the department of safety. In the  
26 event that the first set of fingerprints is invalid due to insufficient pattern, a second set of  
27 fingerprints shall be necessary in order to complete the criminal history records check. If, after 2  
28 attempts, a set of fingerprints is invalid due to insufficient pattern, the board may, in lieu of the  
29 criminal history records check, accept police clearances from every city, town, or county where the  
30 person has lived during the past 5 years.

31 III. The board shall submit the criminal history records release form and fingerprint form  
32 to the division of state police which shall conduct a criminal history records check through its  
33 records and through the Federal Bureau of Investigation. Upon completion of the records check,  
34 the division of state police shall release copies of the criminal history records to the board.

35 IV. The board shall review the criminal record information prior to making a licensing  
36 decision and shall maintain the confidentiality of all criminal history records received pursuant to  
37 this section.

38 V. The applicant shall bear the cost of a criminal history record check.

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1       328-K:5 Renewal of Licenses. Every person licensed to practice under this chapter shall apply  
2 to the board for annual renewal of license on forms provided by the board and shall pay a renewal  
3 fee as established by the board. A license issued under this chapter shall not expire until the board  
4 has taken final action upon the application for renewal.

5       328-K:6 Failure to Renew; Lapse.

6           I. Any licensee who fails to apply for renewal under RSA 328-K:5 shall pay double the  
7 renewal fee, provided the licensee applies and pays the renewal fee no later than 90 days after the  
8 expiration date. Any licensee who fails to apply for renewal of his or her license within the 90-day  
9 period after expiration, shall have his or her license lapse. A lapsed license shall be reinstated only  
10 upon payment of a reinstatement fee as established by the board, and upon showing evidence of  
11 professional competence as the board may reasonably require.

12          II. If a license expires or lapses as a result of a licensee being ordered to active duty with  
13 the armed services, the licensee shall have 90 days from the date of discharge or release from the  
14 armed service to apply for renewal and all late fees shall be waived.

15       328-K:7 Grounds for Discipline. The board, after hearing under RSA 329:18-a, may take action  
16 against any person licensed under this chapter upon finding that the licensee:

17           I. Has knowingly provided false information on any application for professional licensure,  
18 whether by making any affirmative statement which was false at the time it was made or by failing  
19 to disclose any fact material to the application.

20           II. Is a habitual user of drugs or intoxicants or is afflicted with a physical disability,  
21 insanity, psychiatric disorders, or other disease deemed dangerous to the public health.

22           III. Has displayed a pattern of behavior which is incompatible with the basic knowledge  
23 and competence expected of persons in the practice of his or her profession.

24           IV. Has engaged in dishonest or unprofessional conduct or has been grossly or repeatedly  
25 negligent in practicing his or her profession or in performing activities ancillary to the practice of  
26 his or her profession or any particular aspect or specialty thereof, or has intentionally injured a  
27 patient while practicing his or her profession or performing such ancillary activities.

28           V. Has undertaken to practice independent of the referral or prescription, direction, or  
29 supervision of a physician licensed under RSA 329.

30           VI. Has failed to provide adequate safeguards with regard to aseptic techniques or radiation  
31 techniques.

32           VII. Has included in advertising any statement of a character tending to deceive or mislead  
33 the public or any statement claiming professional superiority.

34           VIII. Has advertised the use of any drug or medicine of an unknown formula or any system  
35 of anesthetic that is unnamed, misnamed, misrepresented, or not in reality used.

36           IX. Has willfully or repeatedly violated any provision of this chapter or any substantive rule  
37 of the board.

38           X. Has been convicted of a felony under the laws of the United States or any state.

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1 XI. Has failed to maintain adequate medical record documentation on diagnostic and  
2 therapeutic treatment provided or has unreasonably delayed medical record transfer, or violated  
3 RSA 332-I.

4 328-K:8 Disciplinary Action. The board, upon making an affirmative finding under RSA 328-  
5 K:7, may take disciplinary action in any one or more of the following ways:

6 I. Administer a public or private reprimand.

7 II. Revoke, suspend, limit, or otherwise restrict a license.

8 III. Require the assistant physician to submit to the care, counseling, or treatment of a  
9 physician, counseling service, health care facility, professional assistance program, or any  
10 combination thereof which is acceptable to the board.

11 IV. Place the assistant physician on probation.

12 V. Require the assistant physician to participate in a program of continuing education in  
13 the area or areas in which he or she has been found deficient.

14 VI. Assess administrative fines in amounts established by the board which shall not exceed  
15 \$3,000 per offense, or, in the case of continuing offenses, \$300 for each day that the violation  
16 continues, whichever is greater.

17 328-K:9 Appeals. Disciplinary action taken by the board under RSA 328-K:8 may be appealed  
18 to the supreme court under RSA 541.

19 328-K:10 Rulemaking.

20 I. Unless the board elects to follow RSA 328-K:10, III, the board shall adopt rules under  
21 RSA 541-A relative to:

22 (a) The scope of practice for a licensed assistant physician.

23 (b) Form and content of the application for licensure.

24 (c) Application procedures.

25 (d) Conduct of hearings under RSA 328-K:7.

26 (e) Standards for assistant physician education and training.

27 (f) Supervision of assistant physicians.

28 (g) Notification of changes in employment.

29 (h) Definition of supervision.

30 (i) Manner of recordkeeping under RSA 328-K:11.

31 (j) Except as provided in paragraph II, any other matter which is consistent with the  
32 legislative intent of this chapter and which is necessary to the administration of this chapter.

33 II. Unless the board elects to follow paragraph III, the board, in consultation with the New  
34 Hampshire pharmacy board, shall adopt rules under RSA 541-A relative to the prescriptions to be  
35 issued by a assistant physician.

36 III. The board may elect to make all rules applicable to physician assistants under RSA 328-  
37 D:10 apply to assistant physicians under this chapter.

38 328-K:11 Recordkeeping. The board shall keep a record of its proceedings under this chapter

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1 and a register of all persons licensed under it. The register shall list the name, last known business  
2 address, and last known residence address of each living licensee, and the date and number of the  
3 license of each licensed assistant physician. The board shall maintain and publish a list of licensed  
4 assistant physicians once a year.

5 328-K:12 Physician Liability. This chapter shall not be construed to relieve the responsible  
6 physician of professional or legal responsibility for the care and treatment of his or her patients.

7 328-K:13 Penalty.

8 I. Any person who, not being licensed or otherwise authorized according to the law of this  
9 state, shall advertise oneself or hold oneself out as an assistant physician, or any person who does  
10 such act after receiving notice that such person's license has been revoked, shall be guilty of a  
11 misdemeanor.

12 II. Any person who shall practice or attempt to practice as an assistant physician in this  
13 state without a license shall be guilty of a class A misdemeanor if a natural person or guilty of a  
14 felony if any other person.

15 328-K:14 Limitation on Action. A person, licensed or authorized to practice as an assistant  
16 physician under this chapter or under the laws of any other state, who, in good faith, renders  
17 emergency care at the scene of an emergency, shall not be liable for any civil damages as a result of  
18 acts or omissions by such person in rendering such emergency care, or as a result of any act or  
19 failure to act to provide or arrange for further medical treatment or care, as long as such person  
20 receives no direct compensation for the care from or on behalf of the person cared for.

21 328-K:15 Rural Health Clinics. When working in a rural health clinic under the federal Rural  
22 Health Clinic Services Act of 1977, Public Law 95-210, as amended:

23 I. An assistant physician shall be considered a physician assistant for purposes of  
24 regulations of the Centers for Medicare and Medicaid Services (CMS); and

25 II. No supervision requirements in addition to the minimum federal law shall be required.

26 328-K:16 Assistant Physician Collaborative Practice Arrangements.

27 I. A physician may enter into collaborative practice arrangements with assistant  
28 physicians. Collaborative practice arrangements shall be in the form of written agreements, jointly  
29 agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative  
30 practice arrangements, which shall be in writing, may delegate to an assistant physician the  
31 authority to administer or dispense drugs and provide treatment as long as the delivery of such  
32 health care services is within the scope of practice of the assistant physician and is consistent with  
33 that assistant physician's skill, training, and competence and the skill and training of the  
34 collaborating physician. Collaborative practice arrangements shall provide for assistant physicians  
35 to practice in medically underserved areas pursuant to funding under RSA 126-A:18-c.

36 II. The written collaborative practice arrangement shall contain at least the following  
37 provisions:

38 (a) Complete names, home and business addresses, zip codes, and telephone numbers of

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1 the collaborating physician and the assistant physician;

2 (b) A list of all other offices or locations besides those listed in subparagraph (a) where  
3 the collaborating physician authorized the assistant physician to prescribe;

4 (c) A requirement that there shall be posted at every office where the assistant  
5 physician is authorized to prescribe, in collaboration with a physician, a prominently displayed  
6 disclosure statement informing patients that they may be seen by an assistant physician and have  
7 the right to see the collaborating physician;

8 (d) All specialty or board certifications of the collaborating physician and all  
9 certifications of the assistant physician;

10 (e) The manner of collaboration between the collaborating physician and the assistant  
11 physician, including how the collaborating physician and the assistant physician shall:

12 (1) Engage in collaborative practice consistent with each professional's skill,  
13 training, education, and competence;

14 (2) Maintain geographic proximity; except, the collaborative practice arrangement  
15 may allow for geographic proximity to be waived for a maximum of 28 days per calendar year for  
16 rural health clinics under RSA 328-K:15, as long as the collaborative practice arrangement includes  
17 alternative plans as required in subparagraph (3). Such exception to geographic proximity shall  
18 apply only to independent rural health clinics, provider-based rural health clinics if the provider is  
19 a critical access hospital as provided in 42 U.S.C. section 1395i-4, and provider-based rural health  
20 clinics if the main location of the hospital sponsor is greater than 50 miles from the clinic. The  
21 collaborating physician shall maintain documentation related to such requirement and present it to  
22 the board of medicine when requested; and

23 (3) Provide coverage during absence, incapacity, infirmity, or emergency by the  
24 collaborating physician;

25 (f) A description of the assistant physician's controlled substance prescriptive authority  
26 in collaboration with the physician, including a list of the controlled substances the physician  
27 authorizes the assistant physician to prescribe and documentation that it is consistent with each  
28 professional's education, knowledge, skill, and competence;

29 (g) A list of all other written practice agreements of the collaborating physician and the  
30 assistant physician;

31 (h) The duration of the written practice agreement between the collaborating physician  
32 and the assistant physician; and

33 (i) A description of the time and manner of the collaborating physician's review of the  
34 assistant physician's delivery of health care services. The description shall include provisions that  
35 the assistant physician shall submit a minimum of 10 percent of the charts documenting the  
36 assistant physician's delivery of health care services to the collaborating physician for review by the  
37 collaborating physician, or any other physician designated in the collaborative practice  
38 arrangement, every 14 days.

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1           III. The collaborating physician, or any other physician designated in the collaborative  
2 practice arrangement, shall review every 14 days a minimum of 20 percent of the charts in which  
3 the assistant physician prescribes controlled substances. The charts reviewed under this paragraph  
4 may be counted in the number of charts required to be reviewed under subparagraph II(i).

5           IV. The board under RSA 541-A shall adopt rules regulating the use of collaborative  
6 practice arrangements for assistant physicians. Such rules shall specify:

7               (a) Geographic areas to be covered;

8               (b) The methods of treatment that may be covered by collaborative practice  
9 arrangements;

10              (c) In conjunction with the commissioner of the department of health and human  
11 services, or designee and deans of medical schools and primary care residency program directors in  
12 the state, or adjacent states, the development and implementation of educational methods and  
13 programs undertaken during the collaborative practice service which shall facilitate the  
14 advancement of the assistant physician's medical knowledge and capabilities, and which may lead  
15 to credit toward a future residency program for programs that deem such documented educational  
16 achievements acceptable; as well as a means to certify completion of such a program, to be used  
17 according to RSA 329:12, III;

18              (d) Within 5 years of the effective date of this chapter, in conjunction with the  
19 commissioner or designee, the adoption of an existing test equivalent to Part 3 of the United States  
20 Medical Licensing Examination, or the development and implementation of such a test, which shall  
21 be used as an alternative path for licensure under RSA 329:12, III; and

22              (e) The requirements for review of services provided under collaborative practice  
23 arrangements, including delegating authority to prescribe controlled substances. Any rules relating  
24 to dispensing or distribution of medications or devices or controlled substances by prescription or  
25 prescription drug orders under this section shall be subject to the approval of the state board of  
26 pharmacy. The board shall adopt rules applicable to assistant physicians that shall be consistent  
27 with guidelines for federally funded clinics.

28           V. The board shall not deny, revoke, suspend, or otherwise take disciplinary action against  
29 a collaborating physician for health care services delegated to an assistant physician provided the  
30 provisions of this section and the rules adopted thereunder are satisfied.

31           VI. Within 30 days of any change and on each renewal, the board shall require every  
32 physician to identify whether the physician is engaged in any collaborative practice arrangement,  
33 including collaborative practice arrangements delegating the authority to prescribe controlled  
34 substances, and also report to the board the name of each assistant physician with whom the  
35 physician has entered into such arrangement. The board may make such information available to  
36 the public. The board shall track the reported information and may routinely conduct random  
37 reviews of such arrangements to ensure that arrangements are carried out for compliance under  
38 this chapter.

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1 VII. A collaborating physician shall not enter into a collaborative practice arrangement  
2 with more than 3 full-time equivalent assistant physicians. Such limitation shall not apply to  
3 collaborative arrangements of hospital employees providing inpatient care service in hospitals or  
4 population-based public health services.

5 VIII. The collaborating physician shall determine and document the completion of at least a  
6 one-month period of time during which the assistant physician shall practice with the collaborating  
7 physician continuously present before practicing in a setting where the collaborating physician is  
8 not continuously present. Such limitation shall not apply to collaborative arrangements of  
9 providers of population-based public health services.

10 IX. An agreement made under this section may govern hospital medication orders under  
11 protocols and standing orders for the purpose of delivering inpatient or emergency care within a  
12 hospital if such protocols or standing orders have been approved by the hospital's medical staff and  
13 pharmaceutical therapeutics committee.

14 X. No contract or other agreement shall require a physician to act as a collaborating  
15 physician for an assistant physician against the physician's will. A physician shall have the right to  
16 refuse to act as a collaborating physician, without penalty, for a particular assistant physician. No  
17 contract or other agreement shall limit the collaborating physician's ultimate authority over any  
18 protocols or standing orders or in the delegation of the physician's authority to any assistant  
19 physician, but such requirement shall not authorize a physician in implementing such protocols,  
20 standing orders, or delegation to violate applicable standards for safe medical practice established  
21 by a hospital's medical staff.

22 XI. No contract or other agreement shall require any assistant physician to serve as a  
23 collaborating assistant physician for any collaborating physician against the assistant physician's  
24 will. An assistant physician shall have the right to refuse to collaborate, without penalty, with a  
25 particular physician.

26 XII. All collaborating physicians and assistant physicians in collaborative practice  
27 arrangements shall wear identification badges while acting within the scope of their collaborative  
28 practice arrangement. The identification badges shall prominently display the licensure status of  
29 such collaborating physicians and assistant physicians.

30 XIII. An assistant physician may prescribe any controlled substance listed in Drug  
31 Enforcement Administration (DEA) schedule III, IV, or V and may have restricted authority in  
32 schedule II, when delegated the authority to prescribe controlled substances in a collaborative  
33 practice arrangement. Prescriptions for schedule II medications prescribed by an assistant  
34 physician are restricted to only those medications containing hydrocodone. Such authority shall be  
35 filed with the board. The collaborating physician shall maintain the right to limit a specific  
36 scheduled drug or scheduled drug category that the assistant physician is permitted to prescribe.  
37 Any limitations shall be listed in the collaborative practice arrangement. Assistant physicians shall  
38 not prescribe controlled substances for themselves or members of their families. Schedule III

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1 controlled substances and schedule II hydrocodone prescriptions shall be limited use in an inpatient  
2 hospital setting or to a 5-day supply without refill. Assistant physicians who are authorized to  
3 prescribe controlled substances under this section shall register with the federal Drug Enforcement  
4 Administration and shall include the Drug Enforcement Administration registration number on  
5 prescriptions for controlled substances.

6 XIV. The collaborating physician shall be responsible to determine and document the  
7 completion of at least 124 hours in a 4-month period by the assistant physician during which the  
8 assistant physician shall practice with the collaborating physician onsite prior to prescribing  
9 controlled substances when the collaborating physician is not onsite. Such limitation shall not  
10 apply to assistant physicians of population-based public health services.

11 2 New Paragraph; Physicians; Alternative for Licensure. Amend RSA 329:12 by inserting after  
12 paragraph II the following new paragraph:

13 III. As an alternative to paragraph I, upon approval of the board applicants for licensure  
14 may:

15 (a) Fulfill all the requirements of RSA 329:12, I(a), (b), (c), and (1) through (4) of (d).

16 (b) Have been licensed in this state and practiced continuously under RSA 328-K for 5  
17 or more consecutive years without any disciplinary action.

18 (c) Have successfully completed the educational component implemented pursuant to  
19 RSA 328-K:16, IV(c).

20 (d) Have passed Parts 1 and 2 of the United States Medical Licensing Examination or  
21 equivalent.

22 (e) Have passed the test adopted pursuant to RSA 328-K:16, IV(d).

23 3 New Paragraph; Physicians; Person Excepted. Amend RSA 329:21 by inserting after  
24 paragraph XVI the following new paragraph:

25 XVII. To such assistant physicians as have been licensed under RSA 328-K while acting  
26 under the terms of that chapter.

27 4 Professionals Health Program; Assistant Physicians Added. Amend RSA 329:13-b to read as  
28 follows:

29 329:13-b Professionals' Health Program.

30 I. Any peer review committee may report relevant facts to the board relating to the acts of  
31 any physician [ø], physician assistant, *or assistant physician* in this state if it has knowledge  
32 relating to the physician [ø], physician assistant, *or assistant physician* which, in the opinion of  
33 the peer review committee, might provide grounds for disciplinary action as specified in RSA  
34 329:17.

35 II. Any committee of a professional society comprised primarily of physicians, its staff, or  
36 any district or local intervenor participating in a program established to aid physicians impaired or  
37 potentially impaired by mental or physical illness including substance abuse or disruptive behavior  
38 may report in writing to the board the name of a physician whose ability to practice medicine safely

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1 is impaired or could reasonably be expected to become impaired if the condition is allowed to  
2 progress together with the pertinent information relating to the physician's impairment. The board  
3 may report to any committee of such professional society or the society's designated staff  
4 information which it may receive with regard to any physician who may be impaired by a mental or  
5 physical illness including substance abuse or disruptive behavior. In this chapter, "disruptive  
6 behavior" means any abusive conduct, including sexual or other forms of harassment, or other  
7 forms of verbal or nonverbal conduct that harms or intimidates others to the extent that quality of  
8 care of patient safety could be compromised.

9 III. Notwithstanding the provisions of RSA 91-A, the records and proceedings of the board,  
10 compiled in conjunction with a peer review committee, shall be confidential and are not to be  
11 considered open records unless the affected physician so requests; provided, however, the board  
12 may disclose this confidential information only:

13 (a) In a disciplinary hearing before the board or in a subsequent trial or appeal of a  
14 board action or order;

15 (b) To the physician licensing or disciplinary authorities of other jurisdictions; or

16 (c) Pursuant to an order of a court of competent jurisdiction.

17 IV.(a) No employee or member of the board, peer review committee member, medical  
18 organization committee member, medical organization district or local intervenor furnishing in good  
19 faith information, data, reports, or records for the purpose of aiding the impaired physician ~~[or]~~,  
20 physician assistant, **or assistant physician** shall by reason of furnishing such information be  
21 liable for damages to any person.

22 (b) No employee or member of the board or such committee, staff, or intervenor program  
23 shall be liable for damages to any person for any action taken or recommendations made by such  
24 board, committee, or staff unless the person is found to have acted recklessly or wantonly.

25 V.(a) The board may contract with other organizations to operate the professionals' health  
26 program for physicians ~~[and]~~, physician assistants, **and assistant physicians** who are impaired or  
27 potentially impaired because of mental or physical illness including substance abuse or disruptive  
28 behavior. This program shall be available to all physicians ~~[and]~~, physician assistants, **and**  
29 **assistant physicians** licensed in this state, all physicians ~~[and]~~, physician assistants, **and**  
30 **assistant physicians** seeking licensure in this state, and all resident physicians in training, and  
31 shall include, but shall not be limited to, education, intervention, ongoing care or treatment, and  
32 post-treatment monitoring.

33 (b) [Repealed.]

34 VI. Upon a determination by the board that a report submitted by a peer review committee  
35 or professional society committee is without merit, the report shall be expunged from the  
36 physician's ~~[or]~~, physician assistant's, **or assistant physician's** individual record in the board's  
37 office. A physician, ~~[or]~~, physician assistant, **or assistant physician**, or authorized representative  
38 shall be entitled on request to examine the peer review or the organization committee report

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1 submitted to the board and to place into the record a statement of reasonable length of the  
2 physician's [ø], physician assistant's, *or assistant physician's* view with respect to any  
3 information existing in the report.

4 5 Board of Medicine; Hearings Panel. Amend RSA 329:18-a, I to read as follows:

5 I. Allegations of misconduct or lack of professional qualifications which are not settled  
6 informally shall be heard by the board or a panel of the board, with a minimum of 3 members  
7 appointed by the president of the board. The panel for a hearing on a physician-licensee shall  
8 consist of a minimum of 2 physicians and one public member. The panel for a hearing on a  
9 physician assistant-licensee shall consist of a minimum of one physician, one physician assistant,  
10 and one public member. *The panel for a hearing on an assistant physician licensee shall*  
11 *consist of a minimum of one physician, one assistant physician, and one public member.*  
12 Such hearing shall be an open public hearing. Any member of the board, or other person qualified  
13 to act as a hearing officer and duly designated by the board, shall have the authority to preside at  
14 such a hearing and to issue oaths or affirmations to witnesses.

15 6 New Section; Health and Human Services; Medically Underserved Areas. Amend RSA 126-A  
16 by inserting after section 18-b the following new section:

17 126-A:18-c Medically Underserved Areas.

18 I. The department shall establish and administer a program to increase the number of  
19 medical clinics in medically underserved areas as defined in RSA 328-K:1. A not-for-profit or  
20 nonprofit entity in this state that includes a medically underserved area may establish a medical  
21 clinic in the medically underserved area by contributing start-up money for the medical clinic and  
22 having such contribution matched wholly or partly by grant moneys from the medical clinics in  
23 medically underserved areas fund established in paragraph IV. An existing clinic which the not-for-  
24 profit or nonprofit entity has not been able to recruit a physician or APRN to provide needed  
25 primary care services despite reasonable effort for a period of one or more years shall also be  
26 considered an eligible clinic under this section. The department shall seek all available moneys  
27 from any source whatsoever, including but not limited to healthcare foundations, insurance  
28 companies, pharmaceutical companies and hospitals to assist in funding the program. The  
29 legislature may appropriate general fund moneys or moneys raised under RSA 84-A for this fund.

30 II. A participating not-for-profit or nonprofit entity that includes a medically underserved  
31 area may provide start-up money for a medical clinic over a 2-year period. The department shall  
32 not provide more than \$100,000 per clinic in a fiscal year unless the department makes a specific  
33 finding of need in the medically underserved area.

34 III. The department shall establish priorities so that the neediest medically underserved  
35 areas eligible for assistance under this section are prioritized.

36 IV. There is established a nonlapsing fund to be known as the medical clinics in medically  
37 underserved areas fund administered and expended by the commissioner of health and human  
38 services, or designee. The fund shall be expended for the purposes of paragraph I. The fund shall

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1 be continually appropriated to the department of health and human services for the purposes of this  
2 section. The fund shall consist of:

3 (a) Revenue from appropriations or other moneys authorized from the general fund or  
4 from tax receipts under RSA 84-A.

5 (b) Funds from public or private sources, including, but not limited to gifts, grants,  
6 donations, rebates, and settlements received by the state specifically designated to be credited to the  
7 fund.

8 (c) Funds repaid per paragraph VI.

9 V. To be eligible to receive a matching grant from the department, a not-for-profit or  
10 nonprofit entity that includes a medically underserved area shall:

11 (a) Apply for the matching grant; and

12 (b) Provide evidence satisfactory to the department that it has entered into an  
13 agreement or combination of agreements with a collaborating physician or physicians for the  
14 collaborating physician or physicians and assistant physician or assistant physicians in accordance  
15 with a collaborative practice arrangement under RSA 328-K:16 to provide primary care in the  
16 medically underserved area for at least 2 years.

17 VI. The department shall adopt rules under RSA 541-A necessary for the implementation of  
18 this section, including rules addressing:

19 (a) Eligibility criteria for a medically underserved area; and for existing clinics in a  
20 medically underserved area which have not been able to recruit physicians or APRNs;

21 (b) A requirement that a medical clinic utilize an assistant physician in a collaborative  
22 practice arrangement under RSA 328-K:16;

23 (c) Minimum and maximum contributions to the start-up money for a medical clinic to  
24 be matched with grant moneys from the state;

25 (d) Conditions under which grant moneys shall be repaid for failure to comply with the  
26 requirements for receipt of such grant moneys;

27 (e) Procedures for disbursement of grant moneys by the department;

28 (f) The form and manner in which start-up money shall be contributed; and

29 (g) Requirements for the not-for-profit or nonprofit entity to retain interest in any  
30 property, equipment, or durable goods for 7 years including, but not limited to, the criteria for a not-  
31 for-profit or nonprofit entity to be excused from such retention requirement.

32 7 New Paragraph; Application of Receipts. Amend RSA 6:12, I(b) by inserting after  
33 subparagraph (339) the following new subparagraph:

34 (340) The medical clinics in medically underserved areas fund established in RSA  
35 126-A:18-c.

36 8 Effective Date. This act shall take effect July 1, 2018.

