Housekeeping

- All attendees are muted during the webinar
- We like to get through our presentations in about 45 minutes, offering time at the end for questions to the presenter
- If you have a question for the presenter, please type it into the question section of your GOTO webinar control panel. We will cover it at the end.
- This event is being recorded. You will receive an email before the end of the day with a link to the recording.
FIRST ANNUAL
RURAL PROVIDER COMPENSATION SURVEY
AGENDA

Current Compensation Market

Compensation Packages for Recruitment

Provider Compensation Survey

Review of Initial Findings: Primary Care

Review of Initial Findings: Specialty Care

Q&A
CURRENT COMPENSATION MARKET
FORCES INFLUENCING COMPENSATION

• Regulatory changes, COVID-19 impacts and the transition to value-based care intensify existing challenges with provider supply (shortages) and demand (increasing need), which directly influence compensation.

• Factors to the right affect compensation within the industry. Rural hospitals are also affected by:
  • Difficulty recruiting
  • Lack of access to specialists

• Provider compensation must be attuned to present and evolving market forces that impact the healthcare system and organizational goals.

Upward Pressures
- Physician Supply & Demand
- COVID-19
- CMS Physician Fee Schedule
- Over-reliance on Surveys

Downward Pressures
- Scarcity of Resources
- “Fair Market Value”

Neutral (Model Impacts)
- Value-Based Care
- Stark Law Changes
LIMITATIONS TO SURVEY DATA

- Survey data typically publishes total cash compensation for professional services.
- What is in cash compensation?
  - W-2 wages
  - K-1 compensation
  - Medical director stipends
  - Research income
  - Call compensation
  - APP Supervision stipends
- Not many rural respondents (servicing populations of less than 49,999)
  - General Surgery, OB/GYN, and Orthopedics are the only surgical specialties represented with more than 50 total providers
  - Primary care data represents 1,130 providers

Source: MGMA 2023 Provider Compensation and Productivity Survey (Based on 2022 Data)
COMPENSATION PACKAGES - WHAT IS INCLUDED

• **Base Salary**
  • Tied to what long-term productivity expectations would be for a provider
  • Share with provider proforma and discuss the assumptions
    • Total patient volumes
    • Plan for the ramp-up period
  • 1–2-year guarantee

• **Productivity Incentives**
  • Productivity metrics need to be consistently measurable
  • Options:
    • % of net professional collections (atypical and significantly gone away)
    • wRVUs
    • Encounters
    • Panel size

• **Quality Compensation**
OTHER KEY COMPENSATION FACTORS

• Call Compensation
  • Call burden – call rotation, volume & frequency, acuity of care, and restricted vs. unrestricted
  • Specialty
  • Other payments are being made to the provider
  • Who is billing for the services
  • Concurrent call coverage
• Problematic Compensation
  • Making up for “lost income”
  • Aggregate payments are disproportionately high relative to regular practice income
  • Double-counting compensation

• Medical Directorship
  • Entities must at minimum:
    • Ensure that medical directorship arrangements are in writing, compensate the physician at fair market value, and outline the services the physician is to perform, as well as the compensation for such services
    • Maintain descriptive documentation of services the medical director performs, such as time logs with activity detail or other accounts
      • Time logs are necessary when administrative FTE is less than 0.5 FTE
      • Median-level medical directorship is 8 hours per week with a median stipend of $25,000
WHAT ABOUT APPS?

- Provider compensation for APP collaboration
  - What is collaboration? Oversight? Training? Team-based goals?
- Distinguishing pay based on the skills, experience, and license of the APP
- State and payer restrictions on APP utilization are critical considerations

- How do you compensate APPs?
  - Aligning with the work they do with physicians
  - 65% of organizations have APPs in leadership positions
  - 33% have incentives tied to team-based performance
- Expectations for APPs are mimicking physicians
  - 52% of organizations now adjust APPs’ compensation based on wRVU data

Source: SullivanCotter 2021 Advanced Practice Provider Compensation Survey
PROVIDER COMPENSATION SURVEY
SCOPE AND PURPOSE

• This presentation is based on the 2023 Provider Compensation Survey issued by Stroudwater Associates in January 2023
• The survey's purpose is to provide insight into rural hospitals and promote more informed decisions when considering physician and advanced practice provider compensation
• Respondents ranged from independent hospitals that reported fewer than 10 staffed beds and system-affiliated hospitals with more than 150 staffed beds
  • No independent respondent reported more than 150 staffed beds

<table>
<thead>
<tr>
<th>Total Surveys</th>
<th>156</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health System Respondents</td>
<td>43</td>
</tr>
<tr>
<td>Independent Hospital Respondents</td>
<td>109</td>
</tr>
<tr>
<td>No Response – System Status</td>
<td>4</td>
</tr>
</tbody>
</table>
PHYSICIANS REPRESENTED

• Based on respondent feedback, this survey represents, at minimum, approximately 4,234 physicians
  • Responses showed that independent hospitals represented 2,897 (68%) of the total physicians
• A large majority of physicians from hospitals that identify as independent are consulting/contracted physicians, whereas respondents that identified as systems mostly employ physicians

<table>
<thead>
<tr>
<th></th>
<th>Reported as System</th>
<th>Reported as Independent</th>
<th>Nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Physicians Represented*</td>
<td>1,337</td>
<td>2,897</td>
<td>4,234</td>
</tr>
<tr>
<td>Employed Physicians (W-2)</td>
<td>533</td>
<td>830</td>
<td>1,363</td>
</tr>
<tr>
<td>Independent Physicians (1099)</td>
<td>269</td>
<td>607</td>
<td>876</td>
</tr>
<tr>
<td>Consulting/Contracted Physicians</td>
<td>417</td>
<td>1,281</td>
<td>1,698</td>
</tr>
<tr>
<td>Locums</td>
<td>118</td>
<td>179</td>
<td>297</td>
</tr>
</tbody>
</table>
ADVANCED PRACTICE PROVIDERS REPRESENTED

- Based on respondent feedback this survey represents, at minimum, approximately 1,833 advanced practice providers (APPs)
  - Based on feedback Independent hospitals represented 1,198 (65%) of the total APPs
  - System APPs represent 635 (35%) of the physicians in this survey
- Most respondents report that their APPs are employed (W-2 rather than 1099)

<table>
<thead>
<tr>
<th></th>
<th>Reported as System</th>
<th>Reported as Independent</th>
<th>Nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum APPs Represented*</td>
<td>635</td>
<td>1,198</td>
<td>1,833</td>
</tr>
<tr>
<td>Employed APPs (W-2)</td>
<td>428</td>
<td>660</td>
<td>1,088</td>
</tr>
<tr>
<td>Independent APPs (1099)</td>
<td>77</td>
<td>250</td>
<td>327</td>
</tr>
<tr>
<td>Consulting/Contracted APPs</td>
<td>70</td>
<td>207</td>
<td>277</td>
</tr>
<tr>
<td>Locums</td>
<td>60</td>
<td>81</td>
<td>141</td>
</tr>
</tbody>
</table>
NOSORH REGIONAL RESPONDENTS

- Respondents represent 42 out of 50 states
- 5 of 5 (100%) National Organization of State Offices of Rural Health (NOSORH) regions had at least one respondent
NOSORH REGIONAL RESPONDENTS (CONT.)

• NOSORH Regional Response Detail
  • Region C accounted for 36.54% of surveys returned
  • Region A was the only region with a higher percentage of health system respondents than independent respondents
  • Region D had the highest percentage of independent respondents
• Overall, independent hospitals accounted for approximately 70% of total survey responses
  • Health systems were asked to respond based on their total medical staff across their rural hospitals and likely represent multiple rural hospitals; response rates are consistent with the overall composition of the 2,008 rural hospitals in the US

<table>
<thead>
<tr>
<th>Survey Responses by NOSORH Region</th>
<th>All</th>
<th>System</th>
<th>Independent</th>
<th>No Response</th>
<th>% of System Respondents</th>
<th>% of Independent Respondents</th>
<th>% No Response</th>
<th>Total Response Rate (of surveys returned)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>24</td>
<td>13</td>
<td>11</td>
<td></td>
<td>54.17%</td>
<td>45.83%</td>
<td>0.00%</td>
<td>15.38%</td>
</tr>
<tr>
<td>B</td>
<td>17</td>
<td>7</td>
<td>10</td>
<td></td>
<td>41.18%</td>
<td>58.82%</td>
<td>0.00%</td>
<td>10.90%</td>
</tr>
<tr>
<td>C</td>
<td>57</td>
<td>11</td>
<td>43</td>
<td>3</td>
<td>19.30%</td>
<td>75.44%</td>
<td>5.26%</td>
<td>36.54%</td>
</tr>
<tr>
<td>D</td>
<td>35</td>
<td>6</td>
<td>29</td>
<td>3</td>
<td>17.14%</td>
<td>82.86%</td>
<td>0.00%</td>
<td>22.44%</td>
</tr>
<tr>
<td>E</td>
<td>20</td>
<td>5</td>
<td>14</td>
<td>1</td>
<td>25.00%</td>
<td>70.00%</td>
<td>5.00%</td>
<td>12.82%</td>
</tr>
<tr>
<td>Total</td>
<td>153</td>
<td>42</td>
<td>107</td>
<td>4</td>
<td>27.45%</td>
<td>69.93%</td>
<td>2.61%</td>
<td>98.08%</td>
</tr>
</tbody>
</table>
## STUDY PROCESS

<table>
<thead>
<tr>
<th>Measures</th>
<th>Sources</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Compensation Range:</strong> <em>Total</em> compensation paid within a calendar year (consistent with MGMA’s definition of total compensation)</td>
<td>• Stroudwater Associates Physician Compensation survey, 156 responses reflective of 42 of 50 states</td>
<td>• First year conducting survey – no historical data or expectations</td>
</tr>
<tr>
<td>• Number of providers by specialty</td>
<td>• AANP State Practice Environment map</td>
<td>• Data is self-reported by organizations without validation</td>
</tr>
<tr>
<td>• <strong>Provider employment status:</strong> Providers were identified as W-2, contracted (1099) or locums</td>
<td>• Rural organizations were contacted through NRHA, NOSORH, and individual State Offices of Rural Health</td>
<td>• Data collected was based on compensation ranges and not the inclusion of specific individual compensation</td>
</tr>
</tbody>
</table>
TYPES OF COMPENSATION

- In response to what types of compensation are provided to your employed providers, 56% of respondents pay providers entirely on a straight salary
- 37% of respondents provide some form of incentive compensation
- Additional compensation provided:
  - 125 respondents provide relocation stipends (over half of which exceed $5,000)
  - 121 respondents provide student loan repayment (over half pay less than $45K per provider per year)
  - 91 respondents provide sign-on bonuses (58% pay less than $5K in sign-on per provider)

<table>
<thead>
<tr>
<th>Types of Incentive Comp</th>
<th>% of Those Providing</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVU/RVU Based</td>
<td>30.6%</td>
</tr>
<tr>
<td>Net Collections</td>
<td>10.0%</td>
</tr>
<tr>
<td>Gross Billing</td>
<td>9.4%</td>
</tr>
<tr>
<td>Patient Encounter/Visits</td>
<td>18.9%</td>
</tr>
<tr>
<td>Patient Panel Size</td>
<td>8.9%</td>
</tr>
<tr>
<td>Quality</td>
<td>22.2%</td>
</tr>
</tbody>
</table>
NATIONAL SUMMARY – PRIMARY CARE PHYSICIANS

- 156 respondents specifically representing the rural United States
  - Over 6,000 providers represented compared to 2,632 rural providers in MGMA data
  - This represents at least 4,234 physicians and 1,833 APPs
- 43 health system respondents ranging from 10 or fewer staffed beds to upwards of 150+ staffed beds
- Majority of family medicine physicians make less than $300K

<table>
<thead>
<tr>
<th>Compensation: Family Medicine Physician (with OB)</th>
<th>% of compensation in this range, per survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $260,000</td>
<td>59.6%</td>
</tr>
<tr>
<td>$260,000-$325,000</td>
<td>24.6%</td>
</tr>
<tr>
<td>$325,000-$390,000</td>
<td>15.8%</td>
</tr>
<tr>
<td>$390,000-$455,000</td>
<td>0.0%</td>
</tr>
<tr>
<td>Greater than $455,000</td>
<td>0.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Compensation: Family Medicine Physician (without OB)</th>
<th>% of compensation in this range, per survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $234,000</td>
<td>38.8%</td>
</tr>
<tr>
<td>$234,000-$305,500</td>
<td>43.5%</td>
</tr>
<tr>
<td>$305,500-$377,000</td>
<td>16.5%</td>
</tr>
<tr>
<td>$377,000-$442,000</td>
<td>1.2%</td>
</tr>
<tr>
<td>Greater than $442,000</td>
<td>0.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Majority of Family Medicine NPs make less than $150K per year, regardless of state of licensure or scope of service.

This translates to $72 per hour in a time when, based on a survey by Kaufman Hall, contract nurses are averaging $132 per hour in 2022. 

Source: The cost of hospital contract labor in 22 numbers (beckershospitalreview.com)
PRIMARY CARE PHYSICIANS (WITHOUT OB)

- Organizations report paying Family Medicine Physicians less in Regions A and B.
- Region E is the sole region with organizations reporting paying primary care physicians more than $377K based on survey responses.
PRIMARY CARE PHYSICIANS (WITH OB)

- Organizations report paying Family Medicine Physicians less in Regions A, B, and D.
- Both Regions C and E had respondents who reported paying primary care physicians who provide OB services more than $390K.
RESTRICTED PRACTICE STATES

- Region B has the highest rate of restricted practice states
- Region B is also one of the lowest-paying regions for APP compensation
- This has far-reaching implications regarding APP recruitment, retention, and alignment in reduced and restricted practice states

Please see the Appendix for the full state practice environment map
• Regions A and B have no respondents, regardless of system status, who report compensating NPs (without OB) more than $156K
  • Only 6% of respondents from Region B reported paying between $130K-156K for primary care NPs (without OB)
• Regions D and C are the only regions with respondents that report compensating NPs (without OB) at a rate higher than $208K annually
• Region E reported no primary care NPs (without OB) being compensated at a rate less than $104K
• Region B has no respondents, regardless of system status, who report compensating NPs who provide OB services more than $149.5K
  • 20% of respondents from Region B report paying between $130K-149.5K for primary care NPs (with OB)
• Regions C and E are the only regions where respondents reported compensating NPs (with OB) at a rate higher than $188.5K annually
• Region A indicated no primary care NPs (with OB) being compensated at a rate less than $110.5K
PRIMARY CARE PHYSICIAN ASSISTANT (WITHOUT OB)

- Region B has no respondents, regardless of system status, who report compensating PAs (without OB) more than $149.5K
  - 8% of respondents from Region B reports paying between $130K-$149.5K for primary care PAs (without OB)
- Regions C and D are the only regions with reports of compensating PAs (without OB) at a rate higher than $188.5K annually
- Most primary care PAs (without OB) are reported to be compensated between $104K and $149.5K annually

<table>
<thead>
<tr>
<th>Average total compensation per Family Medicine PA (without OB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ \text{Less than$104,000}$</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Less than $104,000$</td>
</tr>
<tr>
<td>$104,000$-$130,000$</td>
</tr>
<tr>
<td>$130,000$-$149,500$</td>
</tr>
<tr>
<td>$149,500$-$169,000$</td>
</tr>
<tr>
<td>$169,000$-$188,500$</td>
</tr>
<tr>
<td>Greater than $188,500$</td>
</tr>
</tbody>
</table>
• Regions B and D have no reported respondents, regardless of system status, compensating PAs who provide OB care more than $143K

• Regions A and E are the only regions reporting that PAs (with OB) are compensated between $156-169K

• Most primary care PAs (with OB) are reportedly being compensated less than $130K annually
REVIEW OF INITIAL FINDINGS:
SPECIALTY CARE
Regardless of system affiliation status, 53% of respondents indicated they have professional service agreements in place with providers.

Region C reported the most professional service agreements while Region B reported the least.
When broken down by system versus independent status, the results remain consistent regardless of status.

- Of the system respondents there is a higher rate of “unsure” responses, potentially indicating provider contracting is being handled at the system level rather than at the rural affiliate.
PROFESSIONAL SERVICE AGREEMENTS BY SPECIALTY

- Regardless of system affiliation status, general surgery and diagnostic radiology are reported to be the most established specialties for professional service agreements.
  - As indicated in the prior slides, Region C has the most professional service agreements.
  - 81 respondents report utilizing PSAs.
    - Majority of respondents indicate having multiple PSAs.
  - Only 21 respondents indicated having access to psychiatrists.

- The chart shows the number of professional service agreements by specialty and region for specific specialties such as Surgery (General), Radiologist (Diagnostic), Orthopedic Surgery, Anesthesiology, Urologist, Psychiatry (General), Family Medicine, Neurology, Cardiology, Gastroenterology, OB-GYN (General), Internal Medicine, Urgent Care, and Pediatrician (General).
When analyzed by system versus independent status, no system status respondents reported a professional service agreement with internal medicine.

Additionally, where independent respondents report more professional service agreements in the general surgery and orthopedic specialties, system respondents report those as less common than radiology and anesthesiology.
SPECIALTY CARE PHYSICIANS – FURTHER ANALYSIS

**Anesthesiologist Total Compensation:** All regions, regardless of system affiliation status, pay less than $520,000 for anesthesiology physicians; MGMA median is $498,954.

**Cardiology Total Compensation:** Low response rates from health system respondents; independent status respondents report 55% of cardiology physicians being compensated between $325,000–$520,000; MGMA median for noninvasive Cardiology is $559,107.

**Gastroenterology:** All regions, regardless of system affiliation status, pay less than $585,000 for gastroenterology physicians; MGMA median is $556,675.

**Neurology:** All respondents paying less than $422,500; MGMA median is $347,348.

**OB/GYN:** Low rate of response amongst system status respondents. Independent respondents indicated OB/GYNs in Region D generally are compensated at a higher rate than their Region A and Region B colleagues. MGMA median is $369,179.

**Orthopedic Surgery:** Low response rate amongst system status respondents; independent respondents indicate Region B is compensating orthopedic physicians at a lower rate than most of the other regions. MGMA median is $639,741.
SPECIALTY CARE APPS – ANESTHESIOLOGY

- **Anesthesiology Total Compensation**: 48% of respondents, regardless of affiliation status, report paying employed CRNAs more than $188.5K annually and reported 35% of non-employed CRNAs earning less than $234K regardless of organization affiliation status.

<table>
<thead>
<tr>
<th>Employed CRNA Compensation</th>
<th>National % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $110,500</td>
<td>24%</td>
</tr>
<tr>
<td>$110,500-$130,000</td>
<td>11%</td>
</tr>
<tr>
<td>$130,000-$149,500</td>
<td>4%</td>
</tr>
<tr>
<td>$149,500-$169,000</td>
<td>4%</td>
</tr>
<tr>
<td>$169,000-$188,500</td>
<td>9%</td>
</tr>
<tr>
<td>Greater than $188,500</td>
<td>48%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PSA per CRNA FTE Coverage</th>
<th>National % of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $234,000</td>
<td>35%</td>
</tr>
<tr>
<td>$234,000-$260,000</td>
<td>23%</td>
</tr>
<tr>
<td>$260,000-$286,000</td>
<td>11%</td>
</tr>
<tr>
<td>$286,000-$312,000</td>
<td>11%</td>
</tr>
<tr>
<td>$312,000-$338,000</td>
<td>15%</td>
</tr>
<tr>
<td>Greater than $338,000</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
WHAT’S NEXT?

• Stroudwater and NRHA will be hosting a webinar on October 10th reviewing the survey for those that missed the conference

• Stroudwater plans to update and distribute this survey annually. 2024’s survey will continue to build upon the information already obtained.
  • Questions already requested:

• Action Requested
  • If you receive this survey, please respond and complete all questions to help us continually improve and provide value to rural healthcare providers
  • If you have feedback on ways to improve the survey or items you would like to see included in future presentations, please contact Opal Greenway at ogreenway@stroudwater.com
THANK YOU

Opal Greenway, Principal
ogreenway@Stroudwater.com
207.221.8281
www.stroudwater.com

Cameron Smith, Consultant
csmith@Stroudwater.com
207.221.8253
www.stroudwater.com
Increasing demand for physicians continues to outpace growth in supply

The Association for American Medical Colleges projected the following shortages by 2034, based on 2019 data assuming physician supply and demand were in equilibrium:

- 37,800 to 124,000 total physicians
- 17,800 to 48,000 in primary care
- 21,000 to 77,000 in specialty care

COVID-19 has raised awareness of disparities in health and access to care by minorities, people living in rural communities, and people without health insurance.

- If these populations had healthcare patterns of like populations with fewer barriers, the national shortage ranges from 102,400 to 180,400

Changes are made annually to the Medicare Physician Fee Schedule (“PFS”) to address revised CPT codes and corresponding work RVUs (“wRVUs”); quarterly changes also apply, but are generally less significant.

On December 2nd, 2020, CMS published the final rule for 2021.

- Most significantly, CMS overhauled the office and outpatient evaluation and management (“E&M”) codes 99201–99205 (new patients) and 99211 – 99215 (established patients).
- Changes were intended to address the ongoing documentation burden on physicians and the undervaluation of time and effort involved in these services.
- Most compensation models are based on wRVUs and, therefore, without intervention, compensation would increase significantly for certain specialties.

On November 2nd, 2021, CMS published the final rule for the 2022 PFS which includes a conversion factor of $33.59, a 7% decrease from 2021’s conversion factor of $34.89.

- No material change in wRVUs based on 2021 PFS applied.
- The impact of the 2021 and 2022 PFS changes: Potentially higher provider compensation with lower reimbursement.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>% Change in Total wRVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>24.4%</td>
</tr>
<tr>
<td>Family Medicine (w/o OB)</td>
<td>19.3%</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>17.4%</td>
</tr>
<tr>
<td>Internal Medicine: General</td>
<td>17.4%</td>
</tr>
<tr>
<td>Pediatrics: General</td>
<td>13.5%</td>
</tr>
<tr>
<td>Cardiology: Noninvasive</td>
<td>8.4%</td>
</tr>
<tr>
<td>Orthopedic Surgery: General</td>
<td>6.3%</td>
</tr>
<tr>
<td>OB/GYN: General</td>
<td>3.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>3.8%</td>
</tr>
<tr>
<td>Surgery: General</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

Note: 99201 was eliminated (historically used for nurse visits).

Source: Gallagher/Integrated Healthcare Strategies, Based on MGMA procedural profile.
PFS CHANGE – NO ONE IMPLEMENTED UNIFORMLY

• Over a third of MGMA respondents have not gone live on the 2021 PFS!
• Only 12% allowed for providers to access a full increase in compensation resulting from changes in wRVU values

Source: American Association of Provider Compensation Professionals – “Physician Fee Schedule wRVUs and Billing Rules – This Changes Everything You Know About Provider Data”
SCARCITY HITTING RURAL

According to the Bipartisan Policy Center, 441 rural hospitals are at risk of closure
PRACTICE ENVIRONMENT DEFINITIONS

- **Full Practice**
  - State practice and licensure laws permit all NPs to evaluate patients; diagnose, order, and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing.

- **Reduced Practice**
  - State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.

- **Restricted Practice**
  - State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation, or team management by another health provider for the NP to provide patient care.

Source - https://www.aanp.org/advocacy/state/state-practice-environment