Testimony Presented to the Senate Public Health Committee in Opposition to HB2205/SB218

February 18, 2015

I respectfully submit testimony in opposition to HB2205 and SB218. It is a volatile time in health care and these two bills are severe, unsubstantiated overreaches in governance to the practice of nurse practitioners and to the Kansas Board of Nursing without any associated evidence. The languages within these bills are an overreach which leaves significant uncertainty for nurse practitioners, patients and my practice in particular.

My name is Karen K. Trees a family nurse practitioner, women's health care nurse practitioner and certified nurse midwife. (What I am not is a mid-level provider, a physician extender nor a physician-want-to-be). I am not trying to be anything other than a nurse practitioner that wants to practice to the fullest extent of my education and training as supported by the Institute of Medicine (IOM) and my governing bodies. It is all in the hope of supporting and providing care to the medically insured, underinsured and uninsured citizens of Kansas. "Health professions have overlapping scopes and no single discipline "owns" an aspect of care. Simply because two professions provide the same service does not mean that one professional is practicing the other's trade or should share the same oversight structure" (NCSBN, 2015).

I am currently co-owner of a suburban area nurse practitioner owned and led clinic that provides care to the citizens of Kansas. We specialize in family practice and women's health with opportunities for walk-in clinic and same day appointments. This clinic was founded by my business partner and me after several years in the emergency department settings and after years of caring for patient's dependent on the ER for their primary care. My partner and I set out to respond to what we perceived was a need to increase and improve healthcare access for patients. All too often when patients were queried in the ER as to whether or not they called their primary care provider (PCP) or clinic before presenting, we were informed that the wait was 3 weeks or more just to be seen, even for some of the most simplified of health concerns. Another subset of population stated they did not have a PCP. Therefore, it was our position that we needed to do something that would assist in alleviating the physician shortage and need for improved access.

We opened our clinic three years ago and this year alone have amassed greater than 1000 patients. That is one thousand patients without a medical home or patients seeking the care of a nurse practitioners. Through our practice we have improved patient access, paid taxes and hired citizens of Kansas helping to offset unemployment. We have also made many patient referrals this year to area physician specialty groups, approximately 29 different specialists, in the Kansas City area. That occurred not because of a mandated collaborative agreement but because those patients healthcare needs required specialized care or were patients that fell outside the scope of NP practice.

My concern is that these bills are far too restrictive, could create massive bureaucratic changes in the regulatory process and dramatically revise the independent role and sole governing authority of the KSBN. Such a shift in regulatory oversight would not improve access to health care for Kansans but instead, would create further barriers to APRNs ability to function to the fullest extent of their education, training, and competencies as defined by the KSBN/APRN scope of practice. According to the bills, a joint authoritative board would now redefine "…the APRN functions and the differing degrees of

collaboration, direction or supervision…" in addition to determining practice conditions, limitations, and restrictions.

The Board of Healing Arts has a history of setting precedence's by placing limitations on other healthcare entities that they preside over, such as the restrictions imposed upon physician assistants (PAs) mandating that one physician may only supervise two physician's assistants (PAs) and limiting PA development and ownership in a corporation as evidenced by regulation 100-28A-18.

In reference to the statue:

> **100-28a-17. Limitation on number of physician assistants supervised.**
> a. A responsible physician shall not provide direction and supervision to more than two physician assistants without the board's prior approval.
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> **"100-28a-18. Physician assistant; ownership of corporation or company.**
> a. Licensed physician assistants shall not hold more than 49 percent of the total number of shares issued by a professional corporation that is organized to render the professional services of a physician, surgeon or doctor of medicine, or osteopathic physician or surgeon.
> b. Licensed physician assistants shall not contribute more than 49 percent of the total amount of capital to a professional liability company that is organized to render the professional services of a physician, surgeon or doctor of medicine, or osteopathic physician or surgeon."

For our practice such a change would mean potential closure since it is 100% NP owned and operated and a displacement of several hundred patients who selected NP care to begin with, in an already deprived primary care physician era. It would limit support of free market or trade and ignore the FTC's (March 2014) vigorous statement that health care needs competition and that competition leads to creative measures for improving healthcare, reducing cost while enhancing safety and quality of care. My practice is one example of that creative environment that they discussed towards augmenting health care access. The success of our practice and practices like mine are certainly indicated.

Other organizations affected by such a limitation would be the "quick care" and "urgent care" facilities within our communities. These settings are home to many NPs working hard to provide and improve community access during off business hours. Often one physician may collaborate with several NPs located at various sites. And often those NPs are practicing in clinic settings with no physical physician presence, working off their skill, education and training. A limitation of nurse practitioners to physician collaboratives would adversely affect businesses and corporations in Kansas. These businesses would be either mandated to hire more physicians or to lay-off nurse practitioners, thus incurring greater costs to companies. This would only serve to enhance the physician role and minimizing the role of the nurse practitioner while again limiting health care access for patients.