AMERICAN COLLEGE of NURSE-MIDWIVES
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February 17, 2015

Senator Mary Pilcher-Cook
Kansas State Capitol
300 SW 10th Street, Room 441-E
Topeka, Kansas 66612

Re: Opposition to Senate Bill 218– An Act Concerning Advanced Practice Registered Nurses

Dear Senator Pilcher-Cook and Esteemed Members of the Public Health and Welfare Committee:

I am writing on behalf of the American College of Nurse-Midwives (ACNM), the national professional organization representing the interests of certified nurse-midwives (CNM) and certified midwives (CM) practicing in the United States, in regards to Senate Bill 218, which proposes significant amendments to the current regulation of advanced practice registered nurses (APRNs) in Kansas. Certified nurse-midwives are regulated as a category of APRN in Kansas.

The proposals contained within S.218 are contrary to national recommendations for ideal regulation of APRNs and, if enacted, would have a negative effect on the ability of Kansans to access much needed health care. For this reason, ACNM is opposed to the bill. We believe that the interests of all stakeholders can best be served by continued discussions between the Board of Nursing and the Board of Healing Arts with the goal of jointly crafting legislative language amendable to both parties. We firmly believe that there is a path to consensus that can be achieved through good faith negotiations. It is unfortunate that S.218 does not lay the groundwork for this path. It is not the result of collaborative compromise and, moreover, it fails to incorporate sound policy recommendations that have been proven to increase access to care, protect patient safety, and reduce health care expenditures.

S.218 proposes joint regulation of APRN practice by the Boards of Nursing and Healing Arts. This regulatory model has not been supported as a best practice for decades. Indeed, the National Council of State Boards of Nursing's Consensus Model for APRN Regulation, which has been endorsed by the Institute of Medicine and the National Governor's Association, among others, recommends that advanced practice nurses be self-regulating.[1] The Board of Nursing should be the sole regulatory authority for APRNs.

While proponents of joint regulation of nursing practice frequently suggest that it is necessary for protecting patient safety, this assertion is not supported by outcome studies. Decades of research indicate that services provided by nurse-midwives compare favorably to those provided by

[1] For additional information on the Consensus Model, including full text of the recommended regulatory model, see https://www.ncsbn.org/736.htm.

physicians. For example, in a recent systematic review of studies comparing midwifery care to physician care, researchers concluded that women cared for by CNMs compared to women of the same risk status cared for by physicians had lower rates of cesarean birth, lower rates of labor induction and augmentation, a significant reduction in the incidence of third and fourth degree perineal tears, and higher rates of breastfeeding. Moreover, a 2012 meta-analysis of midwifery outcomes as compared to labor and delivery care provided by physicians concluded that there was no difference in CNM versus MD care and, for some variables, that midwifery care demonstrated better outcomes.[2] Midwifery outcomes are constant across regulatory structures and are the result of the midwifery model of care, not state-mandated interaction with or oversight by physician collaborators.

A 2014 report by the Federal Trade Commission asserted that "it may be in the economic self-interest" of physicians to support proposals for joint regulation of advanced practice nurses.[3] Joint regulation and its corresponding preference for restricted practice environments significantly limits the ability of advanced practice nurses to practice to the full extent of their education and training, a reality that, perhaps not unintentionally, also hampers their ability to be a competitive threat to physicians. Proposals for joint regulation of nursing practice are designed to protect the existing status quo in health care delivery systems, not to serve the needs and interests of patients struggling to obtain safe and accessible health care services.

S.218 would continue to require "a collaborative practice agreement or protocol with physicians" for selected, unspecified services. This proposal is contrary to the regulatory frame outlined in the APRN-supported bill, S.69, and is out of step with national trends in APRN practice. It is a continuation of an unnecessary and outmoded restriction. The FTC has determined that, contrary to ensuring communication and collaboration between health care professionals, statutory collaborative practice requirements are "inconsistent with a truly collaborative and team-based approach to health care." Such requirements merely serve to "exacerbate existing and projected health care workforce shortages by limiting the ability of APRNs to fill gaps in patients' access" to health care.[4]

This has serious implications for the delivery of women's health care services in Kansas, where 77 out of 105 counties lack access to an obstetrician-gynecologist.[5] Nurse-midwives can be instrumental in overcoming this shortage, but to do so regulation must enable CNMs to practice to the full extent of their education and training. S.218 would hinder the ability of nurse-midwives to meet this need and, importantly, the regulatory structure proposed by the bill would not even be supported by our closest collaborators. The American Congress of Obstetricians and Gynecologists (ACOG) recognizes CNMs as "independent providers" who are "experts" in their

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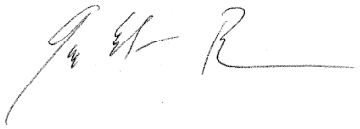
[2] Johantgen M et al. Comparison of Labor and Delivery Care Provided by Certified Nurse-Midwives and Physicians: A Systematic Review, 1990 to 2008. *Women's Health Issues* 22-1 (2012) e73–e81.
[3] Federal Trade Commission, Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses, March 2014, p. 14.
[4] Ibid, p. 20.
[5] American Congress of Obstetricians and Gynecologists. 2014 ACOG Workforce Fact Sheet: Kansas. http://www.acog.org/~/media/Departments/Government%20Relations%20and%20Outreach/WF2011KS.pdf?dmc=1&ts=20131107T0512532758. Accessed February 16, 2015.

field of practice.[6] Statutory requirements for formal collaborative agreements are not necessary for the provision of collaborative midwifery care. There is no evidence that such requirements improve patient outcomes. There is, however, ample evidence that these requirements restrict access to care and hinder the development of an APRN workforce large enough to respond to patient care needs.[7]

Both the APRN and the physician communities desire a system of regulation that can protect patient safety and be responsive to the growing and complex health care needs of Kansans. ACNM would respectfully argue that the regulatory structure outlined in S.218 would exacerbate existing difficulties in efficient health care delivery rather than alleviate them. There is simply a better way forward for Kansas. I hope you will join us in our opposition to S.218.

Respectfully,



Jesse Bushman
Director, Advocacy and Government Affairs

[6] American College of Nurse-Midwives and American Congress of Obstetricians and Gynecologists. Joint Statement of Practice Relations between Obstetricians-Gynecologists and Certified Nurse-Midwives/Certified Midwives. March 2011.

[7] See for example Eugene Declerq et al, "State Regulation, Payment Policies, and Nurse-Midwife Services," *Health Affairs* 17 (1998): 190-200.