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Senate Public Health and Welfare Committee - SB 69
House Health and Human Services Committee - HB 2122
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I am a nurse practitioner and a lifetime Kansas resident, having lived in Plains, Pratt, and now my birthplace of Wichita.

I am contacting you in support of the proposed changes to the Kansas APRN Statutes per **SB 69** that would lift the outdated and ineffective requirement that nurse practitioners have a collaborative supervisory agreement with a physician.

In 1997, I was board certified as a family nurse practitioner and began work in an orthopedic surgery practice. In 2006 I was one of the first nurse practitioners in the USA to obtain the specialty certification of orthopedic nurse practitioner. After 12 years in orthopedic practice in southwest and south central Kansas, I moved to Wichita where I work in orthopedics and long-term care. I am also an Assistant Professor at Georgetown University where I teach nurse practitioner students, and I consult as an expert witness in nurse malpractice cases.

I offer four points for your consideration in support of SB 69/HB 2122:

1. The practical realities of 'collaboration' and 'supervision' are not central concepts in the daily clinical practice of nurse practitioners.

In the reality of everyday clinical practice over the past 18 years, my 'supervising' physicians are not closely involved with me or my patients because of the scope of my education, experience, and training. Whenever I collaborate with any healthcare provider (not just my MD), I do so from my commitment to professional ethical standards, my professional knowledge, and from my knowledge of my own limitations, not because the law says I must collaborate. I have always enjoyed a mutually trusting relationship with MDs and never hesitated to confer with them. The concept of 'supervision' is nebulous at best. It is impossible for our MD partners to review all our patients and 'supervise' our daily work. In fact, we were hired to alleviate their patient burden, not to add to it. Our MDs don't review many patients with us very often, nor is the MD normally present at the APRN-patient encounter. For the public to think that MDs 'supervise' us in the generally understood sense of the word just does not play out in everyday practice. Thus, these strict legal ideas of 'supervision' and 'collaboration' are elusive at best, and are not a prominent reality of the APRN's daily clinical practice like the proponents of the current law would argue.

So you see, what the law requires in terms of 'supervision' and 'collaboration', and what it accomplishes in real daily practice are actually two very different things. The law is impotent to ensure 'patient safety' or 'positive health outcomes' through a written statement between the APRN and MD about

'supervision' and 'collaboration', because good patient outcomes hinge on the integrity and ability of the practitioner, which at it's core, is an ethical and educational issue, not a supervisory issue. Removing the restrictive 'supervision' and 'collaborative' language from the Kansas statute governing nurse practitioners is an important step to ensuring nurse practitioners have their rightful privilege of full practice authority within their professional education and ethical boundaries as set forth by the American Nurses Association.

2. The Kansas mandate for supervisory collaborative agreements is detrimental to full APRN practice authority.

The current law ties the hands of both the nurse practitioner and the MD, because it artificially constrains APRN practice authority to a level less than what was entailed in our education, training, certification, and licensure, and unfairly restricts APRNs from creating innovative health delivery models. My patients have good outcomes not because I am restrained by the law to be 'supervised' or compelled to 'collaborate', but my patients have good outcomes because I, as an ethical professional who abides by the American Nurses Association Code of Ethics, conduct my daily practice with integrity and clinical expertise within the scope and authority of my education and training. Also, from a legal perspective, it is not logical that a physician should be liable for someone who practices in a different profession. I carry my own liability insurance and am liable for my own professional actions. Supervisory language in the statute is powerless to negate, mitigate, or prevent me from committing malpractice, and such language is therefore unnecessary.

3. Consensus exists among American agencies that supervisory collaborative agreements are detrimental to the public welfare.

The Federal Trade Commission (2014), the National Governor's Association , and the Institute of Medicine all agree that supervisory collaboration agreements between MDs and APRNs restrict the public's access to health care by decreasing the number and types of health care providers, decreases effective market competition, and decreases innovation in health care delivery. The FTC concluded,

> *We (FTC) have also conducted our own reviews of pertinent literature and considered stakeholder input. Based on our research, the kinds of supervision requirements examined in FTC staff's APRN advocacies do not appear to be justified by legitimate health and safety concerns. Specifically, our research did not identify significant evidentiary support for either the claim that independent APRN practice gives rise to significant safety concerns, or the claim that mandatory supervision requirements redress such concerns...*
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> *...Similarly, we have not seen research suggesting that the safety or quality of primary care services declines when APRN supervision or collaborative practice requirements are lessened or eliminated...*
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> *...Empirical research and on-the-ground experience demonstrate that APRNs provide safe and effective care within the scope of their training, certification, and licensure. Moreover, effective and beneficial collaboration among healthcare providers can, and typically does, occur even without mandatory physician supervision of APRNs. (pgs. 36-38)*

4. The purpose of SB 69/HB 2122 is to rightly enable APRNS for full practice authority.

It is critical to understand that the proposed amendments do not expand the scope of professional practice by APRNs, as is claimed by some physicians. Rather, the purpose of the SB 69 amendments is to

unfetter the unnecessary restraints of the current law so APRNs can work within the full practice authority of their education, training, and experience, for the benefit of Kansas residents of all ages.

I encourage our legislature to fully support SB 69/HB 2122. I ask that Senator Pilcher-Cook, committee chair of the Senate Public Health and Welfare Committee, and Representative Hawkins, committee chair of the House Health and Human Services Committee, to hold public hearings on this matter. I am available to talk to legislators in person or by phone any time.

For your review, I have attached the Federal Trade Commission's (2014) *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses,* the National Governor's Association (2012) paper, *The role of nurse practitioners meeting increasing demand for primary care,* and a policy brief from the American Association of Nurse Practitioners, *Issues at a Glance: Full Practice Authority.*

Sincerely yours,

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