Written testimony in Support of HB 2066 Updating APRN Statutes
House Health & Human Services Committee
February 11, 2019

Chairman Landwehr and committee members,

My name is Merilyn Douglass. I am a family nurse practitioner and have been working in Garden City for the past 21 years. I am proud to be the President of Kansas Advanced Practice Nurses Association, a professional organization of nurse practitioners, nurse anesthetists, nurse midwives and clinical nurse specialists. KAPN members are passionate advocates of access to primary care for Kansans, strong supporters of this bill.

Primary care is a crucial component of American health care.

Primary care is the answer. Dr. Gordon Moore wrote in the Journal of the American Medical Association, 1991: "Primary care is the most affordable safety net we can offer our citizens." Primary care is a crucial component of American health care. Having an established trusted relationship with a provider who is screening for health-related conditions, coaching wellness, fitness, providing vaccinations, being accessible for sickness results in lower health care costs, decreases emergency department visits and hospitalizations and lowers mortality. Kansas really could use a dose of improved health care. In the past 9 years, Kansas has ranked 23rd to 25th in health status as measured by indicators evaluated by the United Health Foundation (America's health rankings.org 2017. https://www.americashealthrankings.org/learn/reports/2017-annual-report/findings-state-rankings)

Most Kansas counties are designated primary care provider and mental health provider shortage areas. Despite efforts to attract physicians into the primary care programs, the need is growing, and the supply is not keeping up.

Thankfully, there is a solution that you can be a part of. HB 2066 is that opportunity to grow primary care in Kansas by utilizing the affordable, readily-available and trustworthy profession of advanced practice nurses.

Only 12.6% of 2018 medical school students or graduates chose family medicine residency

60% of NPs choose family health- primary care

In contrast to physicians, most nurse practitioners are trained to provide primary care. American Association of Nurse Practitioners (AANP) reports that 60% of nurse practitioners are in family health, 21% in the care of adults and geriatrics, 4.6% care for pediatrics and 3.4% care for women's health. American Association of Family Practitioners (AAFP) reports that 12.6% of the 2018 medical school students or graduates (National Resident Matching Program and American Osteopath Association) chose family medicine residency positions. While the residency match results continue a decade-long trend of increasing numbers of positions offered, filled, and filled with U.S. seniors and graduates in family medicine, the pace needs to exceed dramatically to reach 25% of all residency positions in the Match filling with U.S. seniors and graduates in family medicine. The U.S. medical education system is far from delivering the medical workforce needed in the country it serves, and whose taxpayers fund it. Substantial increases in the family medicine and primary care workforce are needed to improve the

health of Americans and the sustainability of the health care system. (AAFP 2019 https://www.aafp.org/medical-school-residency/program-directors/nrmp.html.)

NPs do not hesitate to care for underserved populations

Primary care nurse practitioners do not hesitate to care for the underserved populations. This is established by research performed by Dr. Buerhaus in a study of Medicare claims. Nurse practitioners cared for populations with characteristics of being female, younger, American Indian, nonwhite, dually eligible for Medicare and Medicaid (an important proxy for poverty) and qualified for Medicare due to a disability. (Buerhaus, 2018. American Enterprise Institute. *Nurse Practitioners A solution to America's Primary Care Crisis*, Sept. 2018)

NP-directed cares cost 11-29% less than physician directed cares

The cost of care provided by primary care nurse practitioners to Medicare populations is less than primary care physicians. It is anticipated that as baby boomers enroll in Medicare, total spending will increase substantially in the years ahead. It makes sense to utilize access to health care without bankrupting the Medicare program. In a study of 12 months of Medicare data, a comparison of primary care nurse practitioners to primary care physicians demonstrated that the cost of primary care nurse practitioner-directed care ranged between 11 percent and 29 percent less than the cost of primary care physician directed care. The largest gap in cost was for basic evaluation and management services which composes 80 percent of claims that are filed to Medicare. Beneficiaries treated by primary care nurse practitioners who received such services cost Medicare 29 percent less than beneficiaries who received their primary care from physicians. The large differences in costs between primary care nurse practitioners and primary care physicians persisted even after considering that Medicare pays NPs at 85 percent of the rate of physicians for the same services. (Buerhaus, 2018)

Over 100 research studies have concluded that APRN care is comparable to physician directed care. Nurse practitioners (NPs) provide high-quality primary, acute and specialty health care services across the lifespan and in diverse settings, including patients' homes, community-based clinics, schools, colleges, prisons, hospitals and long-term care facilities. NPs have graduate education, with master's or doctoral degrees, and they bring a unique perspective to health services in that they emphasize both care and cure.

Over 100 research studies conclude that APRN-directed care is comparable to physician - directed care

Patient outcomes, and not clinical hours, are the yardstick of educational effectiveness. Patient outcomes are defined as the condition of a patient at the end of therapy or a disease process, including the degree of wellness and the need for continuing care, medication, support, counseling, or education. Examples of patient outcomes are indicators of safe care such as readmissions to hospital within 30 days; patient satisfaction. Effectiveness of care outcomes include compliance with professional guidelines in diabetes care, heart disease, and pregnancy.

Educational preparation for physicians and NPs does differ. Although different, there is no evidence to suggest one is superior to the other in terms of patient outcomes, safety and quality of care provided.

One example of the 100 research articles is a review of 37 research articles comparing outcomes for NPs compared to MDs, or teams without NPs. A high level of evidence

indicated better cholesterol levels in patients cared for by NPs in primary care settings. A high level of evidence also indicated patient outcomes on satisfaction with care, health status, functional status, number of emergency department visits and hospitalizations, blood sugar, blood pressure, and mortality are similar for NPs and MDs. (Stanik-Hutt, J. et al, 2013).

Potentially preventable hospitalizations of Medicare beneficiaries with a diagnosis of diabetes were analyzed between patients of physicians and NPs. Several statistical methods demonstrated that receipt of care from NPs decreased the risk of potentially preventable hospitalizations. These findings suggest that NPs are exceptionally effective at treating diabetic patients. Kuo, Y., Chen, N., Baillargeon, J., Raji, M. A. & Goodwin, J. S. (2015). Potentially Preventable Hospitalizations in Medicare Patients with Diabetes: A Comparison of Primary Care Provided by Nurse Practitioners Versus Physicians.

The National Health Care Workforce Commission chaired by Dr. Buerhaus provided questions, analysis and a forecast of the primary care workforce (physicians, NPs and physician assistants [PAs]) supply and location.

Key findings:

Primary care NPs are more likely to practice in rural areas

- Rural areas throughout the country had the highest numbers of uninsured people, particularly in non-Medicaid expanding states
- Primary care nurse practitioners are more likely to practice in rural areas, physicians were more likely to be concentrated in urban areas

Strong indications that NP workforce will increase 6.8% annually.

- People that live in states that do not restrict NP scope-of-practice had significantly greater geographic access to primary care. In nonrestrictive states 63 percent of the people had geographic access to counties with a higher capacity of primary care clinicians compared to 34 percent of people living in restricted NP scope-of-practice.
- Results also showed that states with restricted NP scope-of-practice had 40 percent fewer NPs compared to those without. These findings suggest that lifting state-level scope-of-practice restrictions on NPs would, over time, increase access to primary care, particularly in rural areas.

Removing state-level NP restrictions would, over time, increase access to primary care

- Between 2016 and 2030, the size of the NP workforce will increase dramatically, growing 6.8 per cent annually, compared to 1.1 per cent growth of the physician workforce.
- The number of physicians practicing in rural areas has been decreasing since 2000, and this decline will continue through 2030 while rural populations age and need more health care.

No difference in the quality of care that Medicare beneficiaries received between states that reduced or restricted NP scope of practice

<u>State level restrictions do not increase quality of care</u>. Studies assessed the quality care indicators of primary care nurse practitioners of states with no restrictions, reduced and restricted states. Higher-quality care in reduced and restricted states would suggest that restrictions do protect quality of care- a position that some physician groups advocate.

Review of the studies on Medicare data included hospitalization rates, hospital readmissions within 30 days, emergency department visits and low-value care. Using the AANP classification system, results provided no evidence that state-level scope-of-practice restrictions were related in any consistent or discernable way to the quality of care that primary care nurse practitioners provide. There was no difference in the quality of care that Medicare beneficiaries received between states that reduced or restricted NP scope-of-practice and states that did not restrict NP scope-of-practice.

Further, in full practice states, both primary care nurse practitioners and primary care physicians utilized outpatient services, lower rates of hospitalization, readmission and emergency department use. These findings provide further evidence that beneficiaries living in full scope-of-practice states have greater access to care.

Why removing restrictions on NPs helps remedy the primary care shortage

- It is unrealistic to rely on or expect the physician workforce alone to provide the primary care Americans need. Significant time, effort, and resources have been spent over many decades on various public and private policies to increase the supply and geographic reach of primary care physicians, yet today there is a growing national shortage of such physicians and continued uneven geographic distribution of primary care. Hit particularly hard are people in the rural and underserved areas, who are generally older, less educated, poorer and sicker-the very populations who need primary care the most.
- Large numbers of primary care physicians retire over the next decade, demand for primary care will increase, shortages will worsen and fewer physicians will practice in rural areas.
- In contrast, the numbers of primary care nurse practitioners have been growing at a faster rate than physicians. Primary care nurse practitioners are more likely to practice in rural areas, where the need is greatest.
- Populations with reduced or restricted practice of NPs had significantly less geographic access to primary care nurse practitioners. The studies described in this report consistently show that primary care nurse practitioners are significantly more likely to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualified for Medicare as a disability, and dual-eligible are all more likely to receive primary care from primary care nurse practitioners than from primary care physicians.
- After controlling for differences in patient severity and sociodemographic factors, the cost of care provided to Medicare beneficiaries by primary care nurse practitioners was significantly lower than primary care provided by primary care physicians.
- In these studies, Medicare beneficiaries who received their primary care from primary care nurse practitioners consistently received significantly higher-quality care than physicians' patients with respect to decreasing hospital admissions, readmissions, emergency department use and ordering of low-value care (specifically MRI images for low back pain). While beneficiaries treated by

Unrealistic to rely on physician workforce alone to provide primary care

Primary care NP numbers are increasing; do not mind working in rural areas

NPs are most likely to care for underserved populations

Cost of NP directed cares lower than physician directed cares

NPs provide quality care comparable to physicians in studies of hospital admissions, readmissions, emergency department use, ordering low-value MRI

physicians received slightly more services involved in managing chronic diseases than those receiving primary care from primary care nurse practitioners, the differences were marginal. When populations were analyzed separately, the differences in quality of chronic disease management between primary care nurse practitioners and physicians narrowed considerably, and some disappeared. These results align with the findings of many other studies conducted over the past four decades.

No evidence that states with imposed NP restrictions receive better quality of care

Physician professional groups will tell you that state-level NP scope-of-practice restrictions help protect the public from subpar health care. Analysis of different classifications of state-level scope-of-practice restrictions provided no evidence that Medicare beneficiaries living in states that imposed restrictions received better quality of care. Some physicians and professional medical associations have justified their support for state regulations to limit NP scope-of-practice on the grounds that they are necessary to protect the public from low-quality providers and to assert that physicians must be the leaders of the health care team. There is no evidence to support their claim.

The opioid crisis is not a licensure crisis; it happens in multiple professions.

You may also hear some false statements that the opioid crisis started when nurse practitioners began prescribing. According to the IMS Institute for Healthcare Informatics National Prescription Audit of 2012, the states with reduced and restricted NP practices have the highest number of pain prescriptions per 100 people- AK, LA, MI, MS, and WV. The states with full practice authority have the lowest pain pill prescriptions per 100 people- CT, HI, ID, MN, OR, and NV. See the attached maps for reference. The opioid crisis is not a licensure crisis, as it happens in multiple professions. It is a problem that we should all work together to educate within our professions, educate our patients, pay attention to legislative activity, participate in development of evidence-based health policy and evaluate the outcomes.

HHS members: Do your part to improve Kansas health care access.

Policymakers: Do your part to improve Kansas health care. HB 2066 is a commonsense solution to the primary care workforce-supply problem with minimal cost to the state. APRNs are the appropriate profession to provide primary care. Remove APRN scope-of-practice restrictions. The evidence presented suggests that scope-of-practice restrictions do not help keep patients safe. They actually decrease quality of care overall and leave vulnerable people without access to primary care.

I appreciate your time and attention to this matter. Thank you for serving the people of Kansas and please extend my appreciation to your families as well for their support of your work. Please feel free to contact me if you have any questions.

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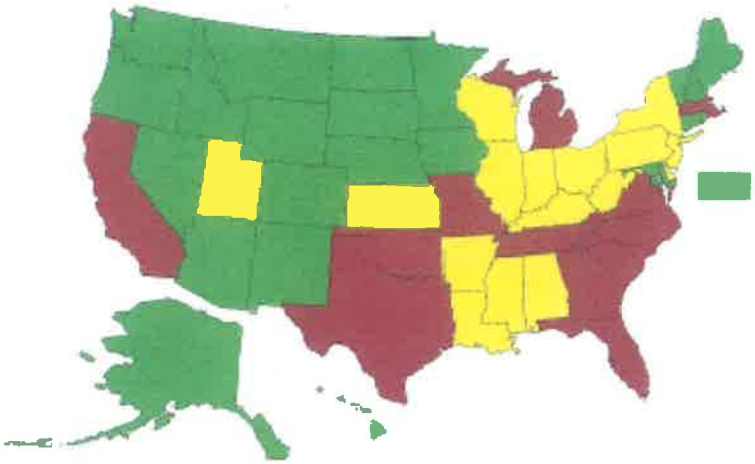
The Opioid Crisis is NOT a Licensure Crisis



Pain Medication Prescriptions per 100 people

- 52 - 71
- 72 - 82.1
- 82.2 - 96
- 96 - 143

Full Practice Authority

Reduced Practice Authority

Restricted Practice Authority

ated with data from CDC Vital Signs: Opioid Painkiller Prescribing. July 2014.
tp://www.cdc.gov/Vitalsigns/opioid-prescribing/infographic.html#map