Testimony in Support of HB 2066 Updating APRN Statutes
House Health and Human Services Committee
February 11, 2019

Chairman Landwehr and members of the Health Committee:

Thank you for allowing time to discuss this important issue affecting Kansans every day. My name is Michelle Knowles and I live in Hays, Kansas. I have been a registered nurse for 38 years and a nurse practitioner for 23 years. For the last 10 years, I have worked for the Department of Veteran's Affairs (VA). Just a quick disclaimer, I am not here as a spokesperson for the VA. I am a primary care nurse practitioner in a community-based outreach clinic in western Kansas. I lead a patient-aligned care team providing primary care for about 900 patients. Passage of HB 2066 will not change my scope of practice or that of my colleagues across the state. Passage of this bill will allow APRNs to practice under their own license issued solely by the Board of Nursing, referred to as "Full Practice Authority" and remove unnecessary regulations standing in the way between APRNs and taking care of patients.

The intent of this bill is three fold. It will increase accountability of APRNs by requiring all new APRNs to pass a national certification exam. Currently, Kansas is only one of 3 states that does not require national certification for nurse practitioners and we feel this needs to change. This bill will also require all APRNs to carry malpractice insurance. Currently, certified nurse midwives and certified registered nurse anesthetists require malpractice insurance. Although it is rare to find a nurse practitioner without malpractice insurance or national certification, we feel it is important to maintain high professional standards and offer this consumer protection. Finally, this bill will retire the mandatory written protocol requirement that is to be signed by a physician each year. This antiquated practice has decreased patient access to care and raised health care costs. Finding physicians to sign this requirement is getting more difficult. The number of primary care physicians is dropping in the rural and underserved areas. According to KDHE, we had a net loss of 364 physicians from the underserved communities from 2010-2015. This required signed protocol does not improve care or safeguard the public. It does stand in the way of providing care if a physician moves, retires or dies. The inability to rapidly secure a new signed protocol leaves patients without a provider. According to the

Bipartisan Policy Center, physician oversight of work that can be performed autonomously by other professionals can lead to unnecessary repetition of orders, office visits and services, thus increasing total costs without any additional benefit to patients.

There are many research studies and considerable data over the last 20 years to support the high quality of care provided by APRNs and the lack of patient benefit from a signed collaborative agreement. Twenty-two states and DC have removed practice barriers and changed APRN practice to full practice authority. You have a copy of this map in my testimony. Two of these states are Nebraska and Colorado, which border Kansas and are in competition for our workforce. You will also notice that the majority of these states are rural. There are hundreds of studies that have supported the high quality of care delivered by APRNs, the cost savings of APRN care and the increase in access to care when legislative barriers are removed. We have a sampling of those studies with us today. All studies indicate APRN care is safe.

As I mentioned earlier, I work for the VA. Two years ago, the VA moved to full practice authority for most APRNs across the country. Now nurse practitioners, clinical nurse specialists and certified nurse midwives work solely under their own advance nursing license. The change has already improved access to care for veterans. There is no longer a delay in receiving diagnostic results, because they come directly to me. The prescriptions I write are managed more efficiently because they are under my name. In the past, diagnostic tests and prescriptions were delayed getting to patients because they also went to the collaborating physician, sometimes only to the collaborating physician, who may or may not know who the patient is. Furthermore, the administrative burden has been removed for physicians and now they can see more patients and can focus on more complex patients. Professional collaboration continues and involves many physicians depending on the needs of the patient.

Most importantly, my patient outcomes have remained the same. My outcomes, along with my APRN colleagues' outcomes are comparable to the physician outcomes. Quality of care has not changed at all. Patient care has become more streamlined and efficient, and has remained high - quality.

Prescribing also hasn't changed over the last 2 years since changing to full practice. I have prescribed medications for almost 20 years. The only trend is a decrease in the number of narcotic prescriptions written and a decrease in the dose of narcotics, with a goal of trying to use other methods of pain relief instead of narcotics.

My patients are spread out over the northwest part of the state and they have a choice to either come to our clinic or receive care locally. Most choose to continue to come to the VA for care because of the consistency of care. Many report their community has lost their physician or physicians have changed. They are frustrated with the uncertainty and chose to drive to Hays for their health care. Some drive over 150 miles.

When the VA was moving to full practice authority, the greatest hurdle was the belief from organized medicine that APRNs were practicing medicine. We are not. We practice advanced nursing. All professions have overlap. We are taught to diagnose in our advanced nursing programs and are identified as diagnosticians by the National Academy of Medicine (formerly the Institute of Medicine).

In conclusion, this bill will bring Kansas up to national standards and move us into a position to keep our workforce in Kansas and improve access to care for patients. I urge you to support HB 2066.

Thank you.

Respectfully,

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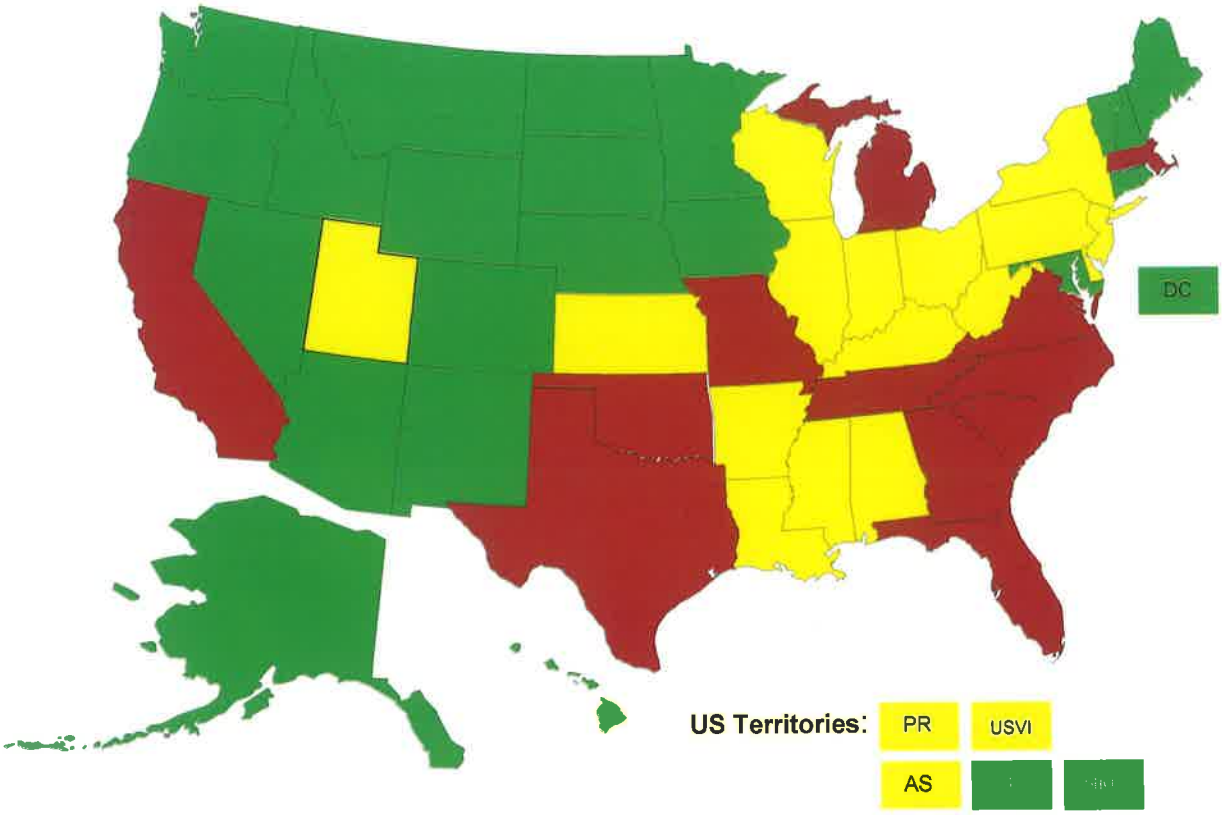
2018 Nurse Practitioner State Practice Environment



Full Practice
State practice and licensure laws provide for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications and controlled substances—under the exclusive licensure authority of the of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine and National Council of State Boards of Nursing.

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

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

Source: State Nurse State Practice Acts
And Administration Rules, 2017

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