AMA
AMERICAN MEDICAL ASSOCIATION

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February 17, 2021

The Honorable Richard Hilderbrand
Chairman
Senate Public Health and Welfare Committee
Kansas State Senate
300 SW 10th Street, Room 445-S
Topeka, KS 66612

Re: **AMA Opposition to S.B. 174**

Dear Chair Hilderbrand:

On behalf of the American Medical Association (AMA) and our physician and student members, I am writing to express our **strong opposition to Senate Bill (S.B.) 174**, which would allow all advanced practice registered nurses (APRNs) the ability to provide medical care without any physician involvement and allow more prescribers of controlled substances. This legislation also sets a dangerous precedent by allowing APRNs to act as the collaborating provider for newly graduated APRNs who have practiced less than 4,000 hours. The AMA is concerned S.B. 174 will not improve access to care in rural areas, will result in increased costs, and will threaten the health and safety of patients in Kansas. We strongly encourage you to oppose S.B. 174.

First, the AMA is concerned S.B. 174 threatens the health and safety of patients in Kansas by allowing APRNs the ability to provide medical care without any physician collaboration or oversight. While all health care professionals play a critical role in providing care to patients and all APRNs are important members of the care team, their skillsets are not interchangeable with that of fully trained physicians. This is fundamentally evident based on the difference in education and training. Physicians complete four years of medical school plus a three-to seven-year residency program, including 10,000-16,000 hours of clinical training. By contrast, nurse practitioners, one type of APRN, complete only two to three years of education, have no residency requirement, and complete only 500-720 hours of clinical training. Certified registered nurse anesthetists, another type of APRN, have only two to three years of education, no residency requirement, and approximately 2,500 hours of clinical practice.

But it is more than just the vast difference in hours of education and training—it is also the difference in rigor and standardization between medical school/residency and APRN programs. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological, and behavioral aspects of the human condition. This period of intense study is supplemented by two years of patient care rotations through different specialties, during which medical students assist licensed physicians in the care of patients. During clinical rotations, medical students continue to develop their clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine. Following graduation, students must then pass a series of examinations to assess a physician's readiness for licensure. At this point, medical students "match" into a three- to seven-year residency program during which they provide care in a select surgical or medical specialty under the supervision of experienced

physician faculty. As resident physicians gain experience and demonstrate growth in their ability to care for patients, they are given greater responsibility and independence. **Nurse practitioner programs, in addition to other APRN programs, do not have similar time-tested standardizations. Critically, it needs to be noted that APRNs are <u>not</u> trained to practice independently**. Patients in Kansas deserve to have physicians leading their health care team.

Additionally, the AMA believes S.B. 174 takes Kansas's health care in a dangerous direction by allowing APRNs to serve as the collaborating/consulting provider for other APRNs. There are four types of APRNs: nurse practitioners, certified registered nurse anesthetists, nurse midwives, and clinical nurse specialists. Each has a separate and unique focus and different path for education, training, and certification. It is unclear if S.B. 174 would limit APRNs to collaborate with only APRNs in their same role. For example, as drafted S.B. 174 could allow nurse midwives to serve as a collaborating authority for CRNAs. Yet, the education and training of nurse midwives, which focuses on primary care for women and childbirth, is entirely different from the education and training from CRNAs, which focuses on anesthesia services. APRNs do not have the education and training to practice without physician supervision themselves and certainly do not have the education and training to supervise other APRNs beyond their own education and training.

APRNs are integral members of the care team, but the skills and acumen obtained by physicians throughout their extensive education and training make them uniquely qualified to oversee and supervise patients' care. Physician-led team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients.

Patients agree—four out of five patients want a physician leading their health care team. All members of the health care team serve an important role in health care and are valuable members of the care team, but they are not a replacement for physicians.

There is also strong evidence that S.B. 174 will result in increased health care costs due to overprescribing and overutilization of diagnostic imaging and other services by APRNs. This should give legislators great pause as studies have shown nurse practitioners tend to prescribe more opioids than physicians, particularly in states that allow nurse practitioners to prescribe without physician involvement. Specifically, a 2020 study published in the *Journal of General Internal Medicine* found that 3.8% of physicians (MDs/DOs) compared to 8.0% of nurse practitioners met at least one definition of overprescribing opioids and 1.3% of physicians compared to 6.3% of nurse practitioners prescribed an opioid to at least 50% of patients.[1] **The study further found, in states that allow independent prescribing, nurse practitioners were <u>20 times</u> more likely to overprescribe opioids than those in prescription-restricted states.**[2] Before removing physicians from the care team and simultaneously removing the written protocol for prescribing, we encourage legislators to carefully review these studies. We believe the results are startling and will not only have an impact on both the health and well-being of patients in Kansas, but also the cost of health care in Kansas.

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[1]MJ Lozada, MA Raji, JS Goodwin, YF Kuo, "Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns." *Journal of General Internal Medicine*. 2020; 35(9):2584-2592.
[2] Id.

Multiple studies have also shown that nurse practitioners order more diagnostic imaging than physicians, which increases health care costs and threatens patient safety by exposing patients to unnecessary radiation. For example, a study in the *Journal of the American College of Radiology*, which analyzed skeletal x-ray utilization for Medicare beneficiaries from 2003 to 2015, found ordering increased substantially—**more than 400%**—by non-physicians, primarily nurse practitioners and physician assistants during this time frame.[3] A separate study published in *JAMA Internal Medicine* found nurse practitioners ordered more diagnostic imaging than primary care physicians following an outpatient visit. The study controlled for imaging claims that occurred after a referral to a specialist.[4] **The authors opined this increased utilization may have important ramifications on costs, safety, and quality of care. They further found greater coordination in health care teams may produce better outcomes than merely expanding nurse practitioner scope of practice alone.**

Proponents of S.B. 174 have argued this legislation is necessary to expand access to care. This promise of expanded access has been made in many other states, but it has not proven true. **In reviewing the actual practice locations of primary care physicians compared to nurse practitioners and other APRNs, it is clear that physicians and APRNs tend to practice in the same areas of the state.** This is true even in those states where nurse practitioners can practice without physician involvement. The Graduate Nurse Demonstration Project (GND Project), conducted by the Centers for Medicare & Medicaid Services, confirmed this as well. One goal of the GND Project was to determine whether increased funding for APRN programs would increase the number of APRNs practicing in rural areas. Not surprisingly, the GND Project concluded that this did not happen. In fact, only 9% of alumni from the program went on to work in rural areas.

Moreover, workforce studies in various states have shown a growing number of nurse practitioners are not entering primary care. For example, the Oregon Center for Nursing found only 25% of nurse practitioners practice primary care. Similarly, the Center for Health Workforce Studies conducted a study on the nurse practitioner workforce in New York and found that, "[w]hile the vast majority of NPs report a primary care specialty certification, about one-third of active NPs are considered primary care NPs, which is based on both NP specialty certification and practice setting." In addition, the study found newly graduated nurse practitioners were more likely to enter specialty or subspecialty care rather than primary care. In short, the evidence is clear that expanding scope for APRNs will not necessarily lead to better access to care in rural Kansas.

Rather than support an unproven path forward, legislators should consider proven solutions to increase access to care, including supporting physician-led team-based care. Evidence shows, states that require physician-led team-based care have seen a greater overall increase in the number of nurse practitioners compared to states that allow independent practice. Other proven reforms include rural physician scholarship programs and telehealth expansion. These proven solutions will ensure all patients in Kansas have access to high quality health care.

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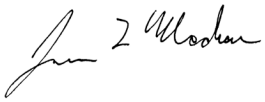
[3] D.J. Mizrahi, et.al. "National Trends in the Utilization of Skeletal Radiography," *Journal of the American College of Radiology* 2018; 1408-1414.

[4] D.R. Hughes, et al., A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA Internal Med*. 2014;175(1):101-07.

For all the reasons above, we strongly encourage you to protect the health and safety of patients in Kansas and oppose S.B. 174. Thank you for the opportunity to provide these comments. If you have any questions, please contact Kimberly Horvath, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at kimberly.horvath@ama-assn.org.

Sincerely,



James L. Madara, MD

cc: Kansas Medical Society