AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Kent Haden
Chair, Healthcare Reform Committee
Missouri House of Representatives
201 W. Capitol Ave., Rm. 311
Jefferson City, MO 65101

Re: AMA Opposition to Missouri House Bill 271 and House Bill 329

Dear Chair Haden:

On behalf of the American Medical Association (AMA) and our physician and student members, I am writing to express **our strong opposition to House Bill 271 (HB 271) and House Bill 329 (HB 329),** which would allow advanced practice registered nurses the authority to provide medical care, including prescribing medications, without any physician involvement and allow certified registered nurse anesthetists to provide anesthesia care without any physician involvement. The AMA has and will continue to stand up for patients who have said time and again they want and expect physicians leading their health care team. In a recent survey of U.S. voters, 95 percent say it is important for a physician to be involved in their diagnosis and treatment decisions and 63 percent opposed allowing nurse anesthetists to perform anesthesia without physician oversight. HB 271 and HB 329, however, effectively remove physicians from the care team and set Missouri on a crash course toward worsening health outcomes and higher costs—all without improving access to care in rural areas as confirmed by multiple studies. Simply put, the education and training of advanced practice registered nurses does not equip them with the skills necessary to independently diagnose, prescribe medications, or provide anesthesia care to patients. The current collaboration requirements in Missouri law protect the health and safety of patients and ensure all patients have access to physician-led care. These commonsense requirements, which are already in Missouri law, are what patients deserve. We strongly encourage you to oppose both HB 271 and HB 329.

Education matters: Patients want physicians involved in their diagnosis and treatment decisions.

The AMA is deeply concerned that HB 271 and HB 329 threaten the health and safety of patients in Missouri by allowing all advanced practice registered nurses to prescribe and nurse anesthetists to administer anesthesia—without any physician collaboration or oversight—immediately after graduation. While all health care professionals play a critical role in providing care to patients, and advanced practice registered nurses are important members of the care team, their skillsets are not interchangeable with that of fully trained physicians. This is fundamentally evident upon review of the difference in education and training between the two distinct professions. 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, the most common type of advanced practice registered nurse, complete only two to

three years of education, have no residency requirement, and complete a mere 500-720 hours of clinical training.

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 and residency and nurse practitioner programs that matter and must be assessed. 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 do not have similar time-tested standardizations resulting in much variation among students' didactic and clinical experiences. For example, in 2019, 60 percent of nurse practitioner programs were offered mostly or completely online, meaning less in-person instruction and hands-on clinical experience.** Plus, many of these nursing programs require nursing students to find their own preceptor to meet their practice hours requirement, resulting in a wide variation in the training and skills acquired by nurse practitioners during their clinical training and leaving many nurse practitioner students with a lack of confidence in their preparation and ability to practice independently upon graduation.[1] Importantly, this includes prescribing medications to patients.

Notably, a recent study in the *Journal of Nursing Regulation* found that family nurse practitioner students have very little experience in basic tasks like performing a comprehensive physical examination and prescribing medications during their clinical training.[2] For example, the study found that 15 percent of newly graduated family nurse practitioner students prescribed medications to an adult patient only 1-2 times during their entire clinical training and 5.5 percent indicated they never prescribed medications to a pediatric patient. Similarly, only 64.9 percent of family nurse practitioner students surveyed said they performed a comprehensive physical examination on an adult patient more than 10 times, with 10.6 percent stating they performed a comprehensive physical exam only 1-2 times during their clinical training. These findings demonstrate the severe gaps in nurse practitioner education and training and should cause deep concern in and of themselves. These findings are especially important when one considers that family physicians must complete more than 10,000 hours in clinical training throughout medical school and residency programs and that such programs, based on standards set forth by the Accreditation Council for Graduate Medical Education, must adhere to strict guidelines on the number of encounters by type, patient population, and facility.

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[1] Hart AM, Bowen A. New nurse practitioners' perceptions of preparedness for and transition into practice. *The Journal for Nurse Practitioners*, 2016; 12(8), 545–552; Nicoteri J. Meeting FNP students' and faculty clinical needs: Two perspectives. *Journal of the American Association of Nurse Practitioners,* 2020*;* 32(10), 676–681; Taylor I, Bing-Jonsson P, Wangensteen S, et al. The self-assessment of clinical competence and the need for further training: A cross-sectional survey of advanced practice nursing students. *Journal of Clinical Nursing*, 2020; 29(3–4), 545–555.

[2] McNelis AM, Dreifuerst T, Beebe S, et al. Types, Frequency, and Depth of Direct Patient Care Experiences of Family Nurse Practitioner Students in the United States, *Journal of Nursing Regulation*, 2021; 12(1), 19-27.

The bottom line is this: nurse practitioner education programs fall short in providing the training and skills necessary to provide care to patients immediately upon graduation without any physician involvement—as HB 271 and HB 329 would allow. Patients in Missouri deserve better—they deserve and have a right to have physicians leading their health care team.

Increasing scope of practice of advanced practice registered nurses can lead to increased health care costs and lower quality of care.

There is strong evidence that advanced practice registered nurses, practicing without any physician involvement, results in worse patient outcomes while also increasing costs due to overprescribing and overutilization of diagnostic imaging and other services. Directly on point is a new 2022 high-quality economic analysis of care provided by nurse practitioners practicing independently in emergency departments (ED) within the Veterans Administration, which found that nurse practitioners used more resources than physicians including x-rays, CT scans, and formal consults.[3] The study found that nurse practitioners increased the cost of ED care by 7 percent—about $66 per patient compared to physicians. This study further estimated that continuing the current staffing allocation of nurse practitioners in the ED would result in a net cost of $74 million per year compared to staffing the ED with only physicians. **The study also confirmed that removing physicians from the care team is associated with lower quality of care, finding that nurse practitioners demonstrated lower levels of skill than physicians and achieved worse outcomes, despite using more resources.** Furthermore, the study found that nurse practitioners raise 30-day preventable hospitalizations by 20 percent, which the authors suggest may reflect poorer decision-making over whom to admit to the hospital or that nurse practitioners produce lower quality of care conditional on admitting decisions compared to physicians. **The study also found that nurse practitioners prescribing patterns are consistent with lower levels of skill compared to physicians.** While nurse practitioners are a valuable member of the health care team, this study reinforces that they are not a replacement for a physician.

Similarly, a study conducted by Hattiesburg Clinic (the Clinic), a leading Accountable Care Organization (ACO) in Mississippi, found that allowing non-physicians, including nurse practitioners, to have their own primary care panel of patients led to higher costs, more referrals, higher emergency department use, and lower patient satisfaction than care provided by physicians. Based on Medicare cost data, the Clinic found the Medicare ACO patients spend was nearly $43 higher per member per month for patients with a non-physician as their primary care provider compared to those with a physician.[4] These costs could have translated to an additional $10.3 million in spending annually for the clinic. Adjusting for patient complexity, this number jumped to over $119 in extra costs per member per month or $28.5 million in additional costs annually.

Other studies have also found that nurse practitioners tend to prescribe more frequently compared to physicians. For example, a 2020 study published in the *Journal of Internal Medicine* found 3.8 percent of physicians compared to 8 percent of nurse practitioners met at least one definition of overprescribing opioids and 1.3 percent of physicians compared to 6.3 percent of nurse practitioners prescribed an opioid

[3] Chan DC, Chen Y. The Productivity of Professions: Evidence from the Emergency Department, *National Bureau of Economic Research*, Nov. 2022.

[4] Batson BN, Crosby SN, Fitzpatrick J. Targeting Value-Based Care with Physician-Led Care Teams. *Journal of the Mississippi State Medical Association.* Jan. 2022.

to at least 50 percent of patients.[5] **The study further found that in states that allow independent prescribing, nurse practitioners were 20 times more likely to overprescribe opioids than those in prescription-restricted states.[6]**

Nurse practitioners also tend to prescribe more antibiotics compared to physicians. A study from *Infection Control and Hospital Epidemiology* found inappropriate antimicrobial prescribing among nurse practitioners and other advanced practice providers in ambulatory practices.[7] The study collected data on patients presenting with common upper respiratory conditions that should not require antibiotics and included visits to urgent care, family medicine, internal medicine, and pediatric providers. **The study found that adult patients seen by non-physicians were 15 percent more likely to receive an antibiotic than those seen by a physician.** The rate of prescribing for pediatric patients was similar. Similarly, a brief report by the Infectious Diseases Society of America found that **ambulatory visits involving nurse practitioners and physician assistants more frequently resulted in an antibiotic prescription compared with physician visits**.[8] The authors noted that their findings were consistent with several previous studies.[9]

The findings are clear: nurse practitioners tend to prescribe more opioids than physicians, overprescribe antibiotics, and order more diagnostic imaging and other testing than physicians—all which increase health care costs and threaten patient safety. Additionally, studies have shown nurse practitioners practicing independently has led to worse patient outcomes. Before allowing advanced practice registered nurses, including those newly licensed, to prescribe without any physician involvement, we encourage lawmakers to carefully review these studies. We believe you will agree that the results are startling and have a significant impact on the assessment of risk to the health and welfare of Missouri patients, as well as the impact on the cost of health care in Missouri.

Scope expansions have not proven to increase access to care in rural areas.

While nothing in HB 271 or HB 329 require advanced practice registered nurses or certified registered nurse anesthetists to practice in primary care or in shortage areas, proponents of these bills have argued it is necessary in order to increase access to care. **This promise 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, it is clear that physicians and nurse practitioners tend to practice in the same areas of the state.** This is true even in those states where nurse practitioners can practice without any physician involvement. As an example, see attached maps which show the practice location of nurse practitioners and primary care physicians in Oregon, a state in which nurse practitioners can practice without any physician involvement. While the number of nurse practitioners increased from 2018 to 2022, nurse practitioners continued to practice in the same highly populated areas of the state over this point in time—not the rural areas. The Graduate Nurse Demonstration Project (the Project), conducted by

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

[6] *Id.*

[7] Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. *Infection Control & Hospital Epidemiology*. 2018:1-9.

[8] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. *Open Forum Infectious Diseases*. 2016:1-4.

[9] Grijalva CG, Nuorti JP, Griffin MR. Antibiotic prescription rates for acute respiratory tract infections in US ambulatory settings. *JAMA* 2009; 302:758–66.

the Centers for Medicare & Medicaid Services, confirmed this as well.[10] One goal of the Project was to determine whether increased funding for advanced practice registered nurse programs would increase the number of advanced practice registered nurses practicing in rural areas. The results found that this did not happen. In fact, only 9 percent 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 percent of nurse practitioners practice primary care. Similarly, the Center for Health Workforce Studies conducted a study on the nurse practitioner workforce in New York that found, "[w]hile the vast majority of nurse practitioners report a primary care specialty certification, about one-third of active nurse practitioners are considered primary care nurse practitioners, which is based on both nurse practitioner specialty certification and practice setting." **So, while a large number of nurse practitioners are certified in primary care—far fewer practice in primary care. The study also found that newly graduated nurse practitioners were more likely to enter specialty or subspecialty care rather than primary care.[11] In short, the evidence is clear that expanding the scope of practice for advanced practice registered nurses will not necessarily lead to better access to primary care. The data show that this is nothing more than an empty promise.**

Rather than support an unproven path forward, legislators should consider proven solutions to increase access to care and reduce health care costs, including supporting physician-led team-based care. Evidence shows that states that require physician-led care have seen a greater overall increase in the number of nurse practitioners compared to states that allow independent practice. In addition, Missouri should consider other proven solutions to increase access to care including expanding coverage and payment for high-quality telehealth, and state funding for graduate medical education to increase the physician workforce. If you are interested, the AMA stands ready, alongside the Missouri State Medical Association, to explore these proven solutions further.

Preserving safe anesthesia care makes sense.

We are also deeply concerned with the language in HB 271 and HB 329 that would allow nurses to provide anesthesia care without any physician involvement. Anesthesia care is the practice of medicine. It is a highly time-dependent critical care-like service that demands the immediate availability of a physician's medical decision-making skills. Physician supervision of anesthesia care is critically important to preserve the health and safety of patients. Moreover, there is no literature to support the safety of eliminating physician clinical oversight of anesthesia. To the contrary, independent literature points to the risk to patients of anesthesia without appropriate physician clinical oversight. This includes research finding that patients having general surgery or orthopaedic surgery are more likely to die if the anesthesia for their procedure is not provided by an anesthesiologist.[12] Several studies also show that physician-led care for anesthesia reduces overall costs and results in improved patient outcomes.[13]

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[10] The Graduate Nurse Education Demonstration Project: Final Evaluation Report, Centers for Medicare and Medicaid Services. August 2019. https://innovation.cms.gov/files/reports/gne-final-eval-rpt.pdf.

[11] Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners, 2017. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; October 2017.

[12] Silber JH, Kennedy SK, Even-Shoshan O, et al. Anesthesiologist direction and patient outcomes. *Anesthesiology*. 2000;93(1):152-163.

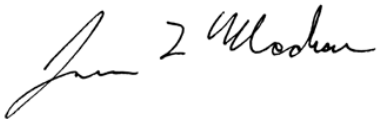
[13] Abenstein JP, Long KH, McGlinch BP, Dietz NM. Is physician anesthesia cost-effective?. *Anesth Analg.* 2004;98(3); Wicklund RA, Rosenbaum SH. Anesthesiology. *New England Journal of Medicine*. 1997;337:1132-1141; Ohsfeldt RL, Miller TR, Schneider JE, Scheibling CM. Cost impact of unexpected disposition after orthopedic ambulatory surgery associated with category of anesthesia provider. *Journal of Clinical Anesthesiology.* 2016;35:157-162.

Removing direct physician involvement from anesthesia in surgery lowers the standard of care and jeopardizes patients' lives and as such, we urge you to reject this language.

Given all of the reasons cited above, we strongly encourage you to keep your commonsense laws in place and protect the health and safety of patients in Missouri by **opposing both HB 271 and HB 329.**

Thank you for the opportunity to provide these comments. If you have any questions, please contact Kimberly Horvath, JD, Senior Attorney, AMA Advocacy Resource Center, at kimberly.horvath@ama-assn.org.

Sincerely,



James L. Madara, MD

cc: Members of the House Healthcare Reform Committee
Missouri State Medical Association
Attachments