Testimony re: SB 174
Senate Public Health and Welfare Committee
Presented by Michelle Knowles, APRN, FNP-BC, FAANP
on behalf of
Kansas Advanced Practice Nurses Association
February 18, 2021

Mister Chairman and Members of the Committee:

Thank you for the opportunity to speak to you today. My name is Michelle Knowles and I have been a family nurse practitioner in western Kansas for 26 years. I worked for 12 years at the Hays VA. I support SB 174.

Access to effective primary care is the goal of this legislation. Effective primary care improves the quality of care, patient outcomes, contains costs, reduces unnecessary utilization of emergency departments for non-emergency conditions and promotes proper use of health care resources.

A few years ago, the Department of Veteran's Affairs (VA) recognized the need to improve access to primary care for veterans. The VA provides primary care and other health services to about 87,000 veterans across Kansas. The VA removed collaborative practice agreement contracts in 2016 and APRNs have worked under their own licenses since, which is referred to as Full Practice Authority. The APRN scope of practice did not change. The APRN patient outcomes remained comparable to the physician patient outcomes after the regulation change. Access to care was improved for veterans and delays in care were reduced. As an example, diagnostic tests that I ordered came directly to me and were not diverted to a third party who may or may not know the patient. Prescriptions and renewals came directly to me so that patients received medications quickly and the pharmacists didn't have to guess where to send refill requests.

The VA, the Bureau of Indian Affairs and the Department of Defense do not require collaborative practice agreements for APRNs to manage patient care. There are more than 20 such Federal health clinics and 3 VA hospitals across Kansas that have APRNs already providing patient care exclusively under their own license through the Board of Nursing. In Kansas, these clinics are located in: Fort Riley, Fort Leavenworth, Wichita, Topeka, Overland Park, Chanute, Dodge City, Fort Scott, Garnett, Hays, Hutchison, Junction City, Lawrence, Liberal, Paola, Parsons, Salina, Shawnee, Kansas City, White Cloud and Horton. It is relevant to note that APRNs in these clinics are providing care without a physician-signed agreement and are regulated by the Board of Nursing, a clear demonstration of safe quality care with trustworthy regulation.

Twenty-three states have removed collaborative practice agreements. It is important to note that NONE of these states have gone back to remove or add restrictions to those statutes. Many of the states are in the Midwest and had the same worsening access to care issues that we have. **Access to healthcare statewide was increased at no additional cost in those states when restrictions were lifted.** Here are a few examples. Within two years of removing the CPA contracts, Nebraska increased their number of primary care NPs by 40% and twenty of their underserved counties had increased numbers of NPs working in them. Arizona saw a 52% increase in the number of APRNs moving into their state over the 5 years after removing restrictions, that increased to 73% a few years later. Nevada had a 33.4% increase over 2 years following removal of restrictions.

We must remember that we are competing for our future workforce. It is very easy for APRNs educated in Kansas to chose to go to a neighboring state with fewer restrictions.

SB 174 has been proven to work in the VA, Dept. of Defense, Bureau of Indian Affairs and 23 other states. I have included studies with the testimony you received from me. Look at what the studies show. Two examples are: APRNs are more likely to work in underserved areas and care for Medicaid, Medicare and uninsured patients. Also, populations in states with restricted practice of NPs had significantly less geographic access to primary care. Removing restrictions on NPs helps to remedy the primary care shortage and improve public health.

Hundreds of studies confirm there are equal or better patient outcomes when the collaborative practice agreement requirement is removed. This is not a new concept and is already working in VA, tribal and military clinics across Kansas. The rest of our Kansas citizens need to benefit from the provisions of SB 174.

Please review the following excerpts from the many studies.

Thank you for allowing me to testify and I will be happy to address questions.

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Studies show removing CPA is safe for patients AND Increases Access to Care

Evidence that it is safe to remove restrictions on APRNs comes from an annual review of state laws and regulations governing APRNs that now includes malpractice claims in its analysis. The 2010 Pearson Report documents no increase in claims registered in the Healthcare Integrity and Protection Data Bank in states where APRNs have full authority to practice and prescribe independently. **[Institute of Medicine, 2011]**

A 2018 study of the Department of Health & Human Services' Medical Expenditure Panel Survey data file found that **APRN Full Practice Authority has increases the frequency of routine check-ups, improves quality of care, and decreases emergency room use.** Specifically, individuals living in states with Full Practice Authority were 1.3% less likely to visit the ER, 4.8% more likely to receive a routine checkup, and 3.1% more likely to receive care when sick. Additionally, researchers did not find this increased access to care was a result of APRN's replacing others as physicians in these states saw a reduced administrative burden of approximately 1.3% while increasing their patient care by 3%. **[Journal of Health Economics, 2018]**

A study estimates **adults are 11 percent more likely to receive a routine physical exam in states that expanded practice authority, while the rate of emergency room visits fell by more than 21 percent.** As we all know by now, having access to a regular source of care that is not an emergency room is better for our health, and better for our wallets. [Census Bureau and the University of Hawaii]

Primary care — annual checkups and vaccinations — **is usually our first line of defense against chronic health problems. Public-health experts say it's incredibly important, and the medical literature points to a strong relationship between access to primary care and good health outcomes.** Studies also show that in many cases, it can save money since good primary care means catching and treating ailments before they become chronic, and costly. [Freakonomics 2019]

State-level NP scope-of-practice restrictions do not 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 care.** Some physicians and **certain 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. We found no evidence to support their claim**. [AEI 2018]

"Relative to primary care physicians, **APRNs are more likely to practice in underserved areas and care for large numbers of minority patients, Medicaid beneficiaries, and uninsured patients**." [Policy perspectives: Competition and the regulation of advanced practice nurses, Federal Trade Commission]

The primary care access challenge impacts rural as well as urban and suburban communities **… nearly as many urban and suburban residents live in a county with a primary care physician shortage as rural residents (21 million vs. 23 million)**. [United Health Group, 2018]

Researchers at the University of Rochester found **the number of nurse practitioners serving areas suffering from primary care shortages increased 30 percent in states providing full practice authority**.

After Arizona enacted reforms to grant **nurse practitioners full practice authority, the number of nurses serving rural communities increased 73 percent.**

In 2016 the Department of Veterans Affairs granted Full Practice Authority to Advanced Practice Registered Nurses in order to reduce barriers to access to care. This has resulted in reduced wait times for appointments for our veterans seeking care. [U.S. Department of Veterans Affairs]

What's more, **patients seeing nurse practitioners were also found to have higher levels of satisfaction with their care.** Studies found that nurse practitioners do better than physicians on measures related to patient follow up; time spent in consultations; and provision of screening, assessment, and counseling services. **[Robert Wood Johnson Foundation, 2012]**

Numerous Federal Agencies recognize the safety and quality of care that Advanced Practice Registered Nurses provide when authorized to practice to the top of their education and preparation including: the Federal Trade Commission, U.S. Department of Veterans Affairs, Indian Health Service, U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor.

The diabetes nurse practitioners' interventions lowered hemoglobin A1C and glucose to a greater degree than physician colleagues. In the nurse practitioner managed group patients' weight was stable… Blood pressure remained equal among nurse practitioner and physician providers. Diabetes patient education was initiated, documented, and offered throughout the continuum of care more consistently by the nurse practitioner than physicians. [Primary Health Care, 2010]

Under a broader definition of primary care provider that includes NPs, **if all states were to allow NPs to practice to the full extent of their graduate education, advanced clinical training, and national certification: The number of U.S. residents living in a county with a primary care shortage would decline from 44 million to fewer than 13 million** – a 70 percent reduction. The number of rural residents living in a county with a primary care shortage would decline from 23 million to 8 million – a 65 percent reduction. [United Health Group, 2018]

In some cases, **the costs imposed on independent APRNs seeking collaborative practice agreements may be prohibitive, destroying the economic viability of an existing APRN practice or deterring entry by others.** The viability of an APRN practice also may be compromised by uncertainty or instability in states where APRNs must obtain collaborative agreements in order to practice, but physicians retain the power to terminate agreements at will and without cause, or may simply refuse to renew them. [Federal Trade Commission, 2014]

APCs and physicians provided an equivalent amount of low-value health services, dispelling physicians' perceptions that APCs provide lower-value care than physicians for these common conditions. **[Annals of Internal Medicine, 2016]**

In an ambulatory care situation in which patients were randomly assigned to either nurse practitioners or physicians, and where nurse practitioners had the same authority, responsibilities, productivity and administrative requirements, and patient population as primary care physicians, patients' outcomes were comparable. [Journal of the American Medical Association, 2000]

The main argument against allowing NPs to practice independently is that they have less training than physicians. But **there's a mountain of empirical evidence from randomized trials, case studies, systematic reviews, and analyses of malpractice claims in states where similar legislation has already passed that all points to the same thing: when it comes to primary care, NPs are just as safe and effective as doctors.** [Freakonomics, 2019]

Within the Kansas City region, the range for the combined health factors and health outcomes was first in the Overland Park ZIP code of 66224 and 650th in the Kansas City neighborhood of Armourdale. These two communities are separated by a distance of 13 miles. **The disparities in health and social factors between the two neighboring counties are dramatic, with Johnson County containing each of the top five healthiest ZIP codes in the state, while Wyandotte County has five of the state's 25 least-healthy ZIP codes.** [KHI ZipCode Health Rankings].

NP independence increases the frequency of routine checkups, improves care quality, and decreases emergency room use by patients with ambulatory care sensitive conditions. These effects come from decreases

in administrative costs for physicians and NPs and patients' indirect costs of accessing medical care. **[Journal of Health Economics, 2018]**

The Washington State Department of Labor and Industries provided **claim and medical billing data for 29,949 injured workers…The distributions of injury type and severity/complexity indicators were similar across provider types. The likelihood of any time loss was lower for NP claims, but duration of lost work time and medical costs did not significantly differ by provider type.** [Medical Care, 2007]

Comparable controlled BP rates were observed among patients with hypertension receiving care from an NP vs a comparison group receiving care from a physician; the groups had similar baseline characteristics. Our findings support the increasingly important role of NPs in primary care. [American Journal of Managed Care, 2011]

Randomized controlled trials and prospective observational studies **comparing nurse practitioners and doctors providing care at first point of contact for patients with undifferentiated health problems in a primary care setting … No differences in health status were found. … No differences were found in prescriptions, return consultations, or referrals. Quality of care was in some ways better for nurse practitioner consultations**. [British Medical Journal, 2002]

A study of NPs as primary care providers in long term nursing facilities found that care provided by NPs reduced unnecessary hospitalizations and improved health outcomes of residents. "**The utilization of NPs in long-term care settings should be encouraged to improve access to care, decrease hospitalizations and enhance quality of care."** [The Impact of Nurse Practitioners on Hospitalizations and Discharges from Long-term Nursing Facilities: A Systematic Review, Healthcare MDP]

This study looked at Medicare and Medicare-Medicaid beneficiaries and found that **"states with full practice of nurse practitioners have lower hospitalization rates in all examined groups and improved health outcomes in their communities.** Results indicate that obstacles to full scope of APRN practice have the potential to negatively impact our nation's health." [Impact of nurse practitioners on health outcomes of Medicare and Medicaid patients, Nursing Outlook]

Study report results of the 2-year follow-up phase of a randomized study comparing outcomes of patients assigned to a nurse practitioner or a physician primary care practice. In the sample of 406 adults, no differences were found between the groups in health status, disease-specific physiologic measures, satisfaction or use of specialist, emergency room or inpatient services [Medical Care Research and Review, 2004]

Previous studies have demonstrated that APRNs deliver care that is of equal quality to the care provided by their physician counterparts. **Our own review of the literature demonstrates that granting APRNs full practice authority would likely increase access to health-care services for Ohioans with possible increases in quality and no clear increase in costs.** [Rand 2015 Ohio Study]

Five studies on 588 adults and children were included concerning nurse-led care versus physician-led care…**There was no statistically significant difference in the number of asthma exacerbations and asthma severity after treatment (duration of follow-up from six months to two years)**. [Cochrane Database of Systematic Reviews, 2013]

The 2008 Medicare Payment Advisory Commission (MedPAC) beneficiary survey found that **28 percent of beneficiaries without a primary care physician reported a problem finding such a physician.** [Health Affairs, 2010]

The time it takes to schedule a new patient physician appointment in 15 major metropolitan areas has increased by 30 percent since 2014… "Physician appointment wait times are the longest they have been since we began

conducting the survey," said Mark Smith, president of Merritt Hawkins. "Growing physician appointment wait times are significant indicator that the nation is experiencing a shortage of physicians." [Merritt Hawkins, 2017] **We find clinics with more non-physician clinicians are associated with better access for Medicaid patients and lower prices for office visits; however, these relationships are only found in states granting full practice autonomy to these providers.** [Health Economics, Policy, and Law; 2016]

More expansive NP practice privileges in states are associated with higher [breast cancer screening] utilization, and may help reduce rural disparities. [Journal of Racial and Ethnic Health Disparities, 2017]

Compared with the most restrictive NP states, states with independent practice had 19.2% lower odds (p = .001) of a greater than 30-min drive to the closest primary care provider.[Nursing Outlook, 2018]

47 percent of survey respondents with a known history of at least one risk factor for heart disease or stroke, had not had their cholesterol checked within the past year… Research suggests even modestly elevated cholesterol levels can lead to heart disease later in life, but these survey results show an alarming lack of communication between healthcare providers and those most at risk for cardiovascular disease [American Heart Association, 2017]

Allowing NPs to practice to the full extent of their education and training represents a meaningful, timely opportunity to increase primary care capacity in the U.S. NPs are qualified to independently deliver high-quality primary care and already do so in 22 States. However, in many States, existing laws limit the ability of NPs to close gaps in primary care access. [United Health Group, 2018]

"Thirty-nine percent of patients say that they're only somewhat knowledgeable at best about how to effectively manage their chronic conditions." Seventy-five percent of their providers agreed, stating that their patients are lacking the knowledge necessary for self-management. However, patients said lacking provider support is driving their limited health knowledge. Seventy percent of patients said they need their providers to supply them with more educational resources teaching them how to manage their chronic diseases. [Patient Engagement HIT, 2017]

When additional and unnecessary restrictions are imposed on APRNs, access problems are more likely to be exacerbated, with patients deprived of basic care. [Federal Trade Commission, 2014]

We continue to project that physician demand will grow faster than supply, leading to a projected total physician shortfall of between 42,600 and 121,300 physicians by 2030. [Association of American Medical Colleges, 2018]

As the committee considered how the additional 32 million people covered by health insurance under the ACA would receive care in the coming years**, it identified as a serious barrier overly restrictive scope-of-practice regulations for APRNs that vary by state.** [Institute of Medicine, 2011]

In the absence of efforts to ease the SOP restrictions and other barriers, states may find it difficult to meet the growing demand for health care. [US Department of Health and Human Services, 2015]

The U.S. population is expected to rise by 18% during the next two decades, with the population over 65 increasing at over three times this rate … between 2005 and 2025, the workload of primary care physicians serving adults will increase by 29% but their supply will only rise by 7% during that time period. [University of Washington School of Medicine, 2010]

14.4% of physicians indicated they will retire in the next one to three years, up from 9.4% in 2012. Should they do so, approximately 115,000 physicians would be removed from the workforce. During that same three year

period, about 81,000 physicians will complete residency and enter the workforce [The Physicians Foundation, 2016]