



**Statement of the Ohio State Medical Association
to the House Health Committee**

**Opponent Testimony
Substitute HB 177 – Advanced Practice Registered Nurses**

**Presented Monica Hueckel, Senior Director, Government Relations Group
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Chairman Lipps, Vice Chairman Manning, Ranking Member Boyd, and members of the House Health Committee, good morning. My name is Monica Hueckel and I am the Senior Director of Government Relations for the Ohio State Medical Association (OSMA), the state's largest professional organization representing physicians, medical residents and medical students.

I am here today on behalf of the OSMA in opposition to substitute House Bill 177. Over the course of proceedings on this issue over the past several years, the OSMA has continued to emphasize that physicians truly respect the contributions of APRNs to patient care teams and believe they represent an important part of the physician-led, team-based care model. The current collaborative model is the evidence-based choice for high-quality patient outcomes and is highly preferred by patients. Working together in a collaborative model with the experience and education of a physician leading the team is the best way to coordinate treatment effectively and take advantage of the skills and training of each member of the team.

Substitute HB 177 is largely similar to its predecessor, and is still an independent practice bill. The only major difference is that it adds a stipulation that in order to gain independent practice authority, an APRN must complete 2,000 hours of "clinical practice." The term "clinical practice" is not clearly defined in the bill, but it does state that these hours are to be completed in a standard care arrangement with a licensed health care practitioner. This means that for roughly the equivalent of one year, an APRN would be required to be in a standard care arrangement, but notably, it does not have to be with a physician. Under this substitute version of HB 177, this arrangement could be with another APRN, and again, is only for a period of about one year. After this is completed, the APRN would be able to practice independently. The bill still does away with requiring any collaboration with or supervision by a physician entirely.

Substitute HB 177 continues to go against the team-based care model by terminating the current relationship through which physicians and APRNs work safely and efficiently to deliver high-quality, coordinated care. It is essential that we work together to ensure all Ohioans are provided with high-quality primary care. Currently, patients already see both physicians and APRNs to receive such care. The overseeing physician that collaborates with each APRN acts as a resource when a more complex care need or a question arises, and they are able to review the care records of the APRN to ensure that appropriate diagnosis and treatment is underway.

An APRN has extensive freedoms in a standard care arrangement that include working to diagnose specific conditions, prescribing authority, the ability to order tests, and more. A physician serves as a safety buffer and limited oversight to APRNs, providing insight based on a vast difference in clinical training hours and breadth of education. This helps to keep the patient safe and avoid some unnecessary health care costs incurred by erroneous testing orders or misdiagnosis, for example.

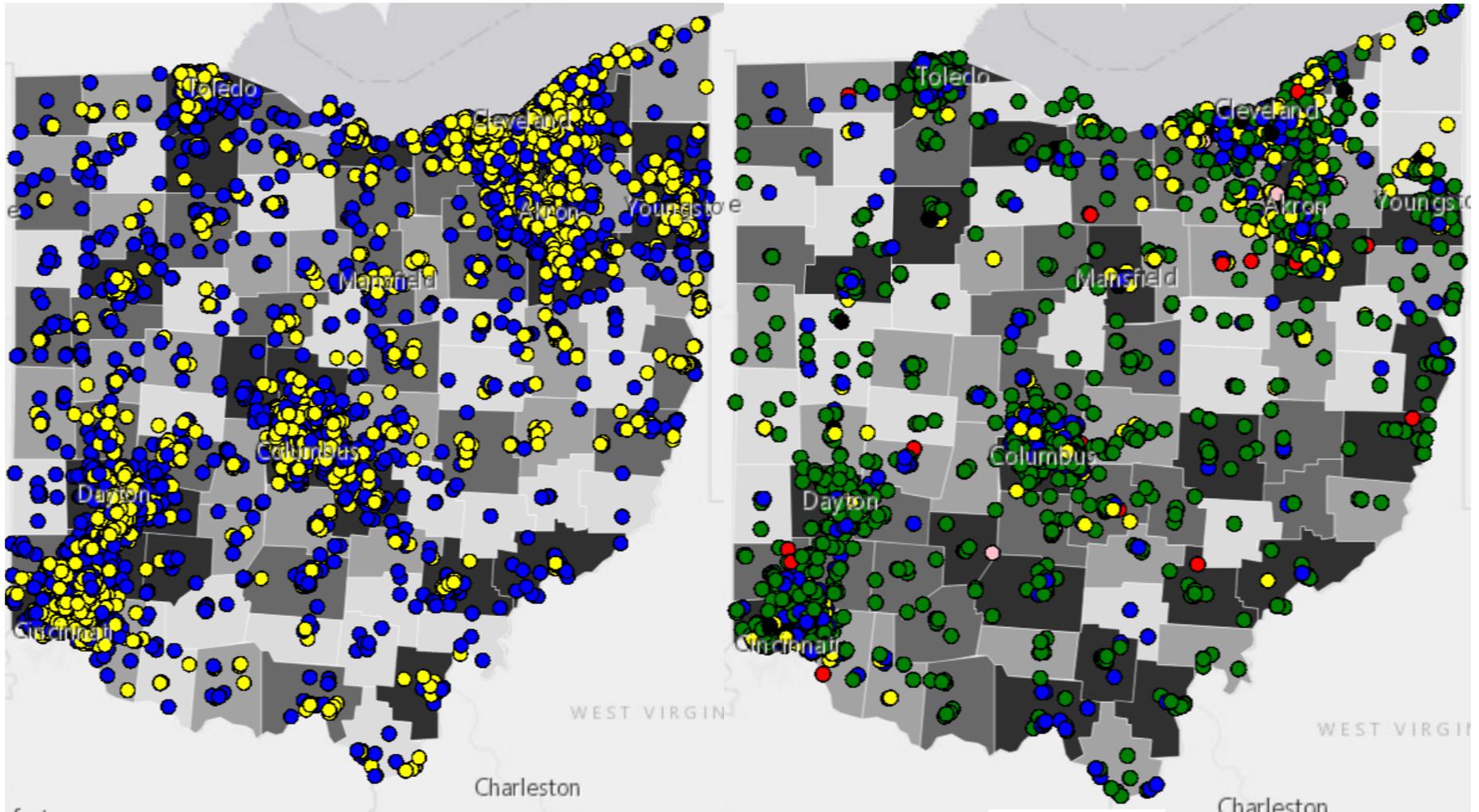
One of the major arguments in favor of substitute HB 177 has been that it would increase access to care for Ohioans, most particularly in rural areas of the state. Increasing access to care is an important priority for the OSMA as well, but we do not believe that allowing APRNs to practice without the standard care arrangement is an effective or safe way to do so. Substitute HB 177 changes nothing about current APRN access in rural areas of Ohio. An APRN is already able to practice in a rural area and collaborate with a physician anywhere in the state. Ohio does not require the collaborating physician to be within any certain distance of the APRN.

Studies conducted by the American Medical Association (AMA) find that midlevel providers like APRNs obtaining full unsupervised practice authority does not provide incentive to locate to rural or underserved areas. As you might recall from our testimony in the spring on this legislation, workforce data compiled by the AMA and from Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System (NPPES) suggests that more physicians are working in rural areas of Ohio than APRNs. APRNs are largely concentrated in highly-populated, urban areas and clustered most evidently around the Columbus, Cleveland, and Cincinnati areas. I have included map graphics with my testimony that illustrate this distribution.

At the heart of this issue, though, are Ohio's patients and patient care. We want to stress that our main focus is what is best for patients. Complete elimination of physician oversight on patient care delivered by APRNs could have serious implications on patient safety and health outcomes. The current model of physician-led, team-based care works by allowing a balance and cooperation amongst all involved in patient diagnosis and treatment.

Chairman Lipps, that concludes my testimony today and I would like to thank the committee for the opportunity to present these comments on behalf of the members of the OSMA. I would be happy to answer any questions.

APRNs are not going to rural areas, even though they may do so under the current rules for collaboration. Most practice in urban areas like Columbus, Cleveland, and Cincinnati and that will not change if HB 177 is enacted.



Primary Care Physicians

APRNs