Ohio State Medical Association

Bringing physicians together for a healthier Ohio

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

Opponent Testimony: House Bill 177

Presented by Monica Hueckel, Senior Director, Government Relations

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Chairman Merrin, 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 about 16,000 Ohio physicians, medical residents and medical students.

I am here today on behalf of the OSMA in opposition to House Bill 177, which would terminate the current relationship through which physicians and APRNs work safely and efficiently to deliver high-quality, coordinated care by eliminating the standard care arrangement. I first want to make it clear that the OSMA truly respects the contributions of APRNs to patient care teams and believes they represent an important part of the physician-led, team-based care model. We emphasize; however, that the current collaborative model is the evidence-based choice for high-quality patient outcomes. 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.

The physicians testifying after me today are here to provide their own thoughts as well as more specific clinical perspective on HB 177. I would like take some time to respond to some of the claims presented to the committee previously by the proponents of this bill, as the OSMA has some concerns about the information given.

One of the main points made by those in favor of HB 177 is 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 of safe way to do so. Studies conducted by the American Medical Association find that midlevel providers like APRNs obtaining full unsupervised practice authority does not provide incentive to locate to rural or underserved areas. At the heart of this issue are Ohio's patients and patient care, and 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.

The proponents of HB 177 have stated that many APRNs are currently distributed across rural areas. As you can see in the map included with my testimony, workforce data compiled by the American Medical Association actually suggests that the distribution of APRNs across the state continues to mirror that of physicians, with APRNs concentrated in highly-populated, urban areas and clustered most evidently around the Columbus, Cleveland, and Cincinnati areas.

It is important to consider that 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. In addition, in response to claims from the APRNs that they had difficulty finding physicians to collaborate with, we agreed to an increase in the number of APRNs a physician can simultaneously collaborate with from 3 to 5 as part of a multi-pronged compromise regarding HB 216, originally introduced as a similar bill to HB 177 in the 131st General Assembly.

The proponent testimony offered for this bill stated that more than half of the U.S. and the District of Columbia currently do not require the standard care arrangement between APRNs and physicians, but this is not the case - it is actually less than half of the U.S., or 22 states and D.C., that have granted full unsupervised practice to APRNs.

The current standard care arrangement between an APRN and a collaborating physician contains limited criteria regarding patient care provided by the APRN. This includes criteria for referral of a patient to the collaborating physician, the process by which to consult with the collaborating physician, a plan for coverage in instances of emergency or planned absences of either the APRN or physician, the procedure for review of the care outcomes for the patients seen by the APRN, the process for resolution of disagreements, and the policy for the care of infants up to age one. The standard care arrangement is not approved by either the Board of Nursing or the Medical Board, nor is it even filed with either of the boards. It is merely required to be kept on site where the APRN practices, and it must be made available to the regulatory board upon request.

I want to clarify another point that arose in testimony from the proponents, which compared the workforce quantity and distribution of APRNs versus physicians in Ohio, stating that there are over 1,000 more nurse practitioners in the state than physicians. The Ohio Physician Workforce Profile compiled by the Association of American Medical Colleges and released in 2017 reports that Ohio had 33,621 total active physicians. According to the 2017 Advanced Practice Registered Nurse Ohio Workforce Data Summary Report, the most recent report of its kind released by the Ohio Board of Nursing, there were 16,760 APRNs, including certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and certified nurse-midwives in Ohio. “APRN” is an umbrella term under which all of these types of NP are housed. We are confused by the numbers given by the proponents, since the nursing board’s

own data suggests that the number of APRNs in Ohio is less than half of the number of physicians.

The testimony also stated that 48% of these NPs specialize in primary care, but the same board of nursing report I just mentioned lists the specialty practice areas of the APRNs in Ohio, with 2,511 reported to be focused in primary care. This means that about 15% of the total population of APRNs in Ohio specialize in primary care. Going back to the 2017 Ohio Physician Workforce Profile from the AAMC, the reported number of primary care physicians in primary care in Ohio is 10,842, or about 32% of the total number of Ohio physicians.

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 merely presides over the care administered by the APRN and acts as a resource when a more complex care need or a question arises. They are able to review the care records of the APRN and ensure that appropriate diagnosis and treatment is underway. An APRN currently has extensive freedoms in a standard care arrangement that include working to diagnose medical conditions, prescribing authority, the ability to order tests and imaging, 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.

The APRNs have said that with HB 177, the intent is not to try to be physicians, but it is with this legislation that APRNs would fill a role that would otherwise be occupied by a physician, practicing with full autonomy and no supervision. The OSMA remains concerned as the current scope of practice of an APRN is defined in Ohio law as contained within the standard care arrangement. By virtue of removing the standard care arrangement and allowing an APRN to practice unsupervised, HB 177 represents a distinct increase to scope of practice. We believe that the current approach with use of the standard care arrangement helps to make sure patients are safe and receive the best care possible.

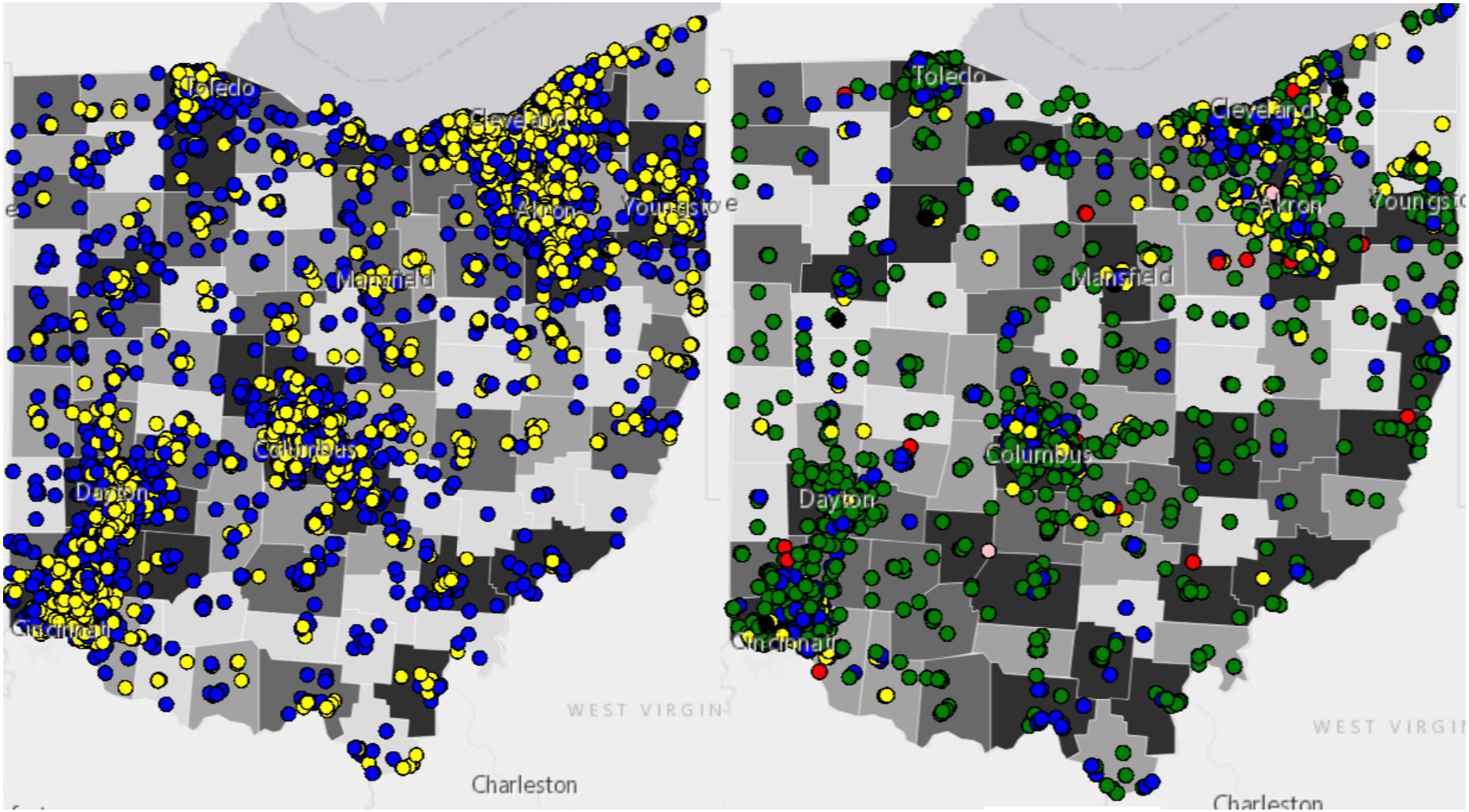
Before I turn my statement over to the next testifying witness today, I also want to briefly address several provisions in the bill that seem to diverge into separate topics and have caused our members additional confusion and concern. HB 177 also contains provisions that appear to alter the required procedures regarding evaluation of student athletes for concussions, as well prohibit a physician from prescribing schedule II drugs out of a convenience care clinic. These provisions have been inserted into this legislation with little to no explanation, leaving many questions unanswered.

In conclusion, the OSMA would like to reiterate that APRNs currently represent an important part of the care team, but that it is safer and more appropriate to work to increase access to care in ways that preserve the physician-led, team-based care model, such as increasing access to telemedicine, or providing incentive for more medical students and residents to remain in

Ohio to practice as physicians. This care model is evidence-based and patient-preferred. Allowing APRNs to practice fully unsupervised is not the answer.

Chairman Merrin, 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 at the conclusion of testimonies today.

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 chance if HB 177 is enacted.



Primary Care Physicians **APRNs**