Ohio House of Representatives

Representative Tom Brinkman
Ohio's 27th House District

Thank you Chairman Merrin, Vice Chair Manning, Ranking Member Boyd and members of the Health Committee. It is my pleasure to testify before you today in regard to H.B. 177.

This legislation seeks to remove an unnecessary regulatory burden that acts as an impediment to APRN practice. HB 177 will reduce bureaucratic hoops and increase access to care by eliminating mandatory collaborative contracts between physicians and Certified Nurse Practioners, Certified Nurse Midwives, and Clinical Nurse Specialists.

With the trend of large hospital systems buying physician practices, it is becoming increasingly difficult for APRNs to find a physician to collaborate with them. This means, physicians who were once able to be collaborators in the community with any APRN can now only be collaborators for that system and with APRNs also employed by the system. This drastically limits providers in certain areas.

Today, more than 1.4 million Ohioans lack necessary access to vital primary care services as well as other services like mental/behavioral health. In fact, the federal government has designated 159 - and growing - healthcare provider shortage areas across the state. This means that just 55% of patient need is met.

According to the U.S. News and World Report Best States rankings, Ohio is 36th in healthcare. Anecdotally, eight of the top ten states for healthcare also do not require this contract. APRNs offer a high-quality, accessible, and affordable solution to the state's healthcare access problem.

Ohio's current laws governing APRNs are outdated and interfere with an APRN's ability to provide needed healthcare, especially to vulnerable populations in medically underserved areas. H.B. 177 is NOT an expansion of APRN scope-of-practice. Instead, it eliminates barriers to access that cause delay in treatment and contribute to health care inefficiency. According to numerous studies from the Journal of the American Medical Association (JAMA), research points to APRNs having higher concentrations in rural areas. Additionally, even in urban centers, APRNs are more likely to work with indigent populations. One such JAMA study looks at data from 2010 – 2016 and shows a narrowing gap between primary care APRNs and physician workforce supply overtime, particularly in low income and rural areas. These areas have higher demand for primary care clinicians and larger disparities in access to care. The growling NP supply in these areas is offsetting low physician supply and thus may increase primary care

capacity in underserved communities. It also indicates in rural health service areas there were 41.3 APRNs per 100,000 population, whereas the highest physician supply was in metropolitan health service areas with 68 physicians per 100,000 population.

Under current collaborative contracts, which 28 states have safely removed including our neighbors in Kentucky and West Virginia, direct supervision is not required of the physician. And, in most cases, the physician is typically in another location only available by electronic means. In many instances, APRN's have very little interaction with their collaborating physician. Instead, they are professionally collaborating with a multitude of other physicians and APRNs depending on the needs of the patient. In some cases, a patient may need to see a physician, in others, they may need to see an APRN with a specific specialty. APRNs would continue to professionally collaborate with other providers on a regular basis just as physicians currently do when something is outside of their education and training.

It has been said by our friends on the opposing side of this issue that APRNs just want to practice medicine. Again, I want to reiterate that this bill does not grant additional scope to APRNs. If this bill passed today, APRNs would enjoy no further scope beyond what is already spelled out for them in the revised code. In that same vein, APRNs are strictly regulated by the Board of Nursing just as the Board of Medicine has oversight with physicians. The Ohio Board of Nursing is one of the most vigilant regulators in the country and nothing in this bill will make that any different. Just as the Board of Medicine would strip the license of a physician practicing outside of their scope so too would the Board of Nursing for an APRN. All it takes is one complaint to either of these Boards and an investigation is opened. Bottom line is APRNs and physicians are professionals and the people who choose to be bad actors will lose their license.

Over the next ten years, the United States will face a shortage of more than 90,000 physicians. As Ohioans are aging and increasingly accessing primary care and other health services, this shortfall will become more and more acute. APRNs are licensed professionals who have post-graduate education (Masters or Doctorate degree). They are trained to diagnose illness, treat patients, order tests, prescribe medicines (including schedule II's), deliver babies, and/or administer anesthesia and do this in both primary and specialty care settings. They are required to pass rigorous national certification board exams to demonstrate their expertise, knowledge, and competency. APRNs are trained and equipped to fill the void of the millions of citizens nationwide that are being added to the healthcare marketplace.

Currently 28 states, plus Washington D.C. have enacted legislation that gives patients direct access to APRN care and eliminates the requirement that APRNs enter into a contract with a physician to deliver care. It is my belief that this proposed legislation will help address, in a safe way, a significant access issue that utilizes highly trained APRNs.

This legislation is one solution that will address the shortage of providers in Ohio in a drastic way. Thank you and I welcome any questions.