OAAPN

Ohio Association of Advanced Practice Nurses

Sub House Bill 177
House Health Committee
Proponent Testimony
November 19, 2019
Joscelyn Greaves, OAAPN President

Chairman Lipps, Vice Chairman Manning, Ranking Member West, and members of the House Health committee, I am Joscelyn Greaves, president of the Ohio Association of Advanced Practice Nurses. Thank you for allowing me to testify before you as a proponent to Sub HB 177, which will improve access to care for Ohioans.

Before reviewing the sub-bill changes, I want to clarify that Sub HB 177 is not related to HB 224, which is the CRNA's bill. While OAAPN as an organization is supportive of their efforts, these bills have frequently been confused. There are four types of APRNs: Certified Registered Nurse Anesthetists (CRNA), Certified Nurse Practitioners (CNP), Certified Nurse Midwives (CNM), and Clinical Nurse Specialists (CNS). Currently in Ohio law CRNAs are the only APRN who are directly supervised by a physician. Sub HB 177 does not change that law. Sub HB 177 deals only with CNSs, CNPs, and CNMs, who are not supervised. Though all APRNS professionally collaborate with their physician colleagues, it is the CNS, CNP and CNM who must, under current law, have a mandated written contract with a physician in order to practice which is known as the Standard Care Arrangement (SCA). In most cases, the physician, who signs the contract, is not on site with that APRN. The "As Introduced" version of HB 177 completely removed the Standard Care Arrangement (SCA) between a physician and an APRN. This contract is an impediment to APRN practice, provides little oversight and is another barrier to citizen care access

Based on feedback from Health Committee members, we heard you loud and clear when you requested that there be some type of transition to practice period placed in Sub HB 177 before newly graduated APRNs could practice without an SCA. After much thought and discussion, it made sense to keep the SCA that is in place under current law until the new APRN has completed a minimum of 2000 clinical hours. This would take at least one year to do. Sub HB 177 will also allow new APRNs to contract with another experienced APRN who has more than the 2,000 hours of clinical experience. Additionally, this bill allows any APRN to keep their SCA in place, if they so choose. Lastly, any APRN who has completed the required 2,000 hours under an SCA, prior to the effective date of this bill, will be grandfathered in once proof is provided to the Board of Nursing that clinical requirements have been met as determined by this bill.

Ohio will be the 28th state to remove mandated collaboration contracts. Several of the 27 states did so as much as 20 years ago. I've attached a map with my testimony that illustrates those states in which the contract was removed. This diagram should not to be confused with the map provided by our national organization (American Association of Nurse Practitioners) which shows the number of states that have full practice authority, which currently stands at 22 states and Washington D.C. To be considered a full practice state, nurse practitioners must be free from any legal restriction on their clinical scope of practice.

The Health Committee currently has more than four scope of practice bills before them. Fortunately, Sub HB 177 is not one of them. Sub HB 177 does not expand any of the three types of APRNs practice abilities. What an Ohio APRN can do today under the Nurse Practice Act will remain the same tomorrow when this bill is enacted. This bill does not change any regulatory measures as it relates to the Board of Nursing. The Board's duty is simple: public safety. Sub HB 177 makes no changes to how the Board regulates and investigates complaints filed by members of the public. If an APRN practices outside of his/her scope, the Board may take their licenses away. This duty is the same as the Board of Medicine's as it relates to physician licenses. Additionally, for physicians and APRNs who own their own practices, other checks and balances are already in place. Insurance companies have the ability and do chart reviews to ensure evaluation and procedure codes are accurate and prescriptions are for appropriate use and formulary.

The impetus behind this bill is simple. It is extremely difficult to find physicians who are willing to collaborate with an APRN. Large hospital systems continue to buy out physician practices making fewer collaborators available. Additionally, there has been numerous discussions with committee members that many physician collaborators charge exorbitant monthly fees. There is no opposition to reasonable fees for service but the higher fees clearly show a supply and demand issue. Furthermore, there has been discussion of prohibiting these types of payments; however, that path would only exacerbate the problem: no physician would be willing to collaborate because there would be no incentive.

Some committee members requested examples of invoices showing proof of these charges which were provided to the previous Chair's office. For the committee's benefit, a few of those examples have been included with your packet for review today. One particular contract documents a revenue stream of a collaborating physician of $40,000 to $100,000 per year (between $3,000 - $8,333 per month) based on the productivity of the Nurse Practitioner where minimal physician involvement is provided. Another example is noted by the check that is attached, where the CNP pays the collaborating physician $1000 a month. Several Ohio APRNs have closed practices or moved theirs to neighboring states due to unsustainable overhead.

I also want to draw attention to some of the maps I have provided to the committee. Please look at the comparison of two neighboring states which have already removed the SCA. Notice that the number of APRNs in both West Virginia and Kentucky increased substantially in almost all of their counties. With this contract removed, it helped these states and many others address the nationwide crisis of access to quality care. Also, please notice the letter to the committee validating where this data has been obtained. Our opponents will tell you that APRNs and physicians are largely concentrated in the same areas. This statement is not totally inaccurate if simple arithmetic is used. Based on the high number of jobs and the population base there will be large concentrations of both provider types in the major cities, but these maps already show APRNs are more likely to be in counties outside of main population bases. With over 159 federally designated health care shortage areas (HPSA) and over 1.5 million Ohioans living in these underserved areas, Ohio can take a huge leap forward in addressing the access to care issue with the passage of Sub. HB 177.

Lastly, I would like to read the list of proponents for Sub HB 177 so the committee is aware of the vast support for this bill:

AARP
AARP Ohio
Americans for Prosperity
American College of Nurse Midwives
Northeast Ohio Nurse Practitioners
Ohio Council for Home Care and Hospice
Ohio Association of Advanced Practice Nurses

Ohio Nurses Association
Ohio State Association of Nurse Anesthetists
National Association of Pediatric Nurse Practitioners
Northeast Ohio Clinical Nurse Specialists
Gerontological Advanced Practice Nurses Association
Ohio State Council
Ohio Association of Area Agencies on Aging (o4a)
Ohio Health Care Association
Charitable Healthcare Network
Society of Otorhinolaryngology and Head-Neck Nurses
Bon Secours Mercy Health System

Thank you for allowing me to testify before you today on this important piece of legislation and I urge your support of the bill.

Sincerely,

Joscelyn Greaves
President of Ohio Association of Advance Practice Nurses (OAAPN)

OAAPN
Ohio Association of Advanced Practice Nurses

To: **Ohio House Health Committee**
From: **Ohio Association of Advanced Practice Nurses**
Date: **May 16, 2019**
Subject: **HB177 – Clarifications on Healthcare Workforce Provider Data Sources**

Considering independently sourced workforce licensure data vs. incomplete organizational data

During Opponents Testimony offered by the Ohio State Medical Association on Tuesday, May 14, several points were raised that call into question the data OAAPN provided in regard to Ohio's nurse practitioner and physician workforce during our April 30 testimony before the committee. It is important to clarify the sources and validity of data, especially if it is being called into question.

OSMA bases its workforce statistics on data compiled by the Association of American Medical Colleges (AAMC). The AAMC uses the AMA Masterfile as the basis of its data reporting. It should be noted that many researchers are moving away from using this source because of the decreasing percentage their membership represents (less than 25% of practicing physicians[1]). The majority of all provider membership data is voluntarily collected, whereas licensure data – which we used – is a regulated data source for actively practicing providers. In fact, the federal government has also moved away from using the AMA Masterfile and other national provider Masterfile data sources and now utilizes the National Provider Identifier (NPI) for the basis of its physician shortage designation program. This is a substantial indicator of the AMA Masterfile's diminished quality to accurately represent all physicians (MD, DO). Therefore, it is our position that any report or comment based solely on the AAMC data should be carefully considered, if at all[2-3]. We have attached the data collection/quality assurance methodology used to create the data that is represented in our statistics and maps.

Further, OSMA calls into question that 48% of NPs in the state specialize in primary care. It asserts that just 15% of the total population of "APRNs" in Ohio specialize in primary care. OAAPNs testimony in this regard was specific to nurse practitioners; however, the report OSMA references relates to all RNs.

To be clear, the total number of actively licensed APRN's in Ohio is 16,444, and our data indicates the number of NPs is 12,484. Leveraging data that includes all APRNs in the state or RNs is simply not accurate.

Below, we have included links to references cited above. Please do not hesitate to reach out to us if you have further questions on this matter.

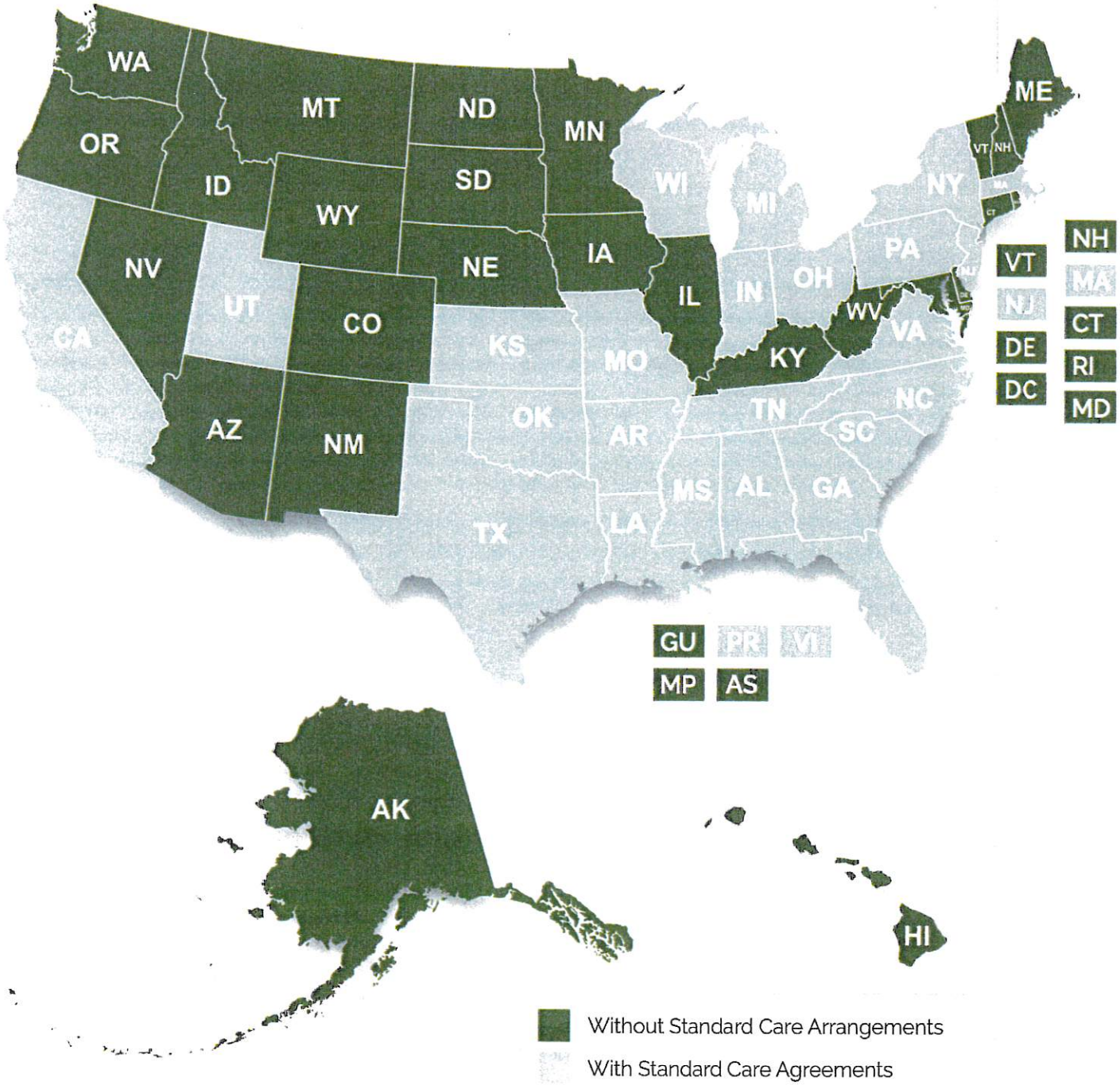
[1] Graham, J., (12/22/2016). Like a slap in the face: Dissent roils the AMA, the nation's largest doctor's group. Retrieved on 5/15/2019 from: https://www.statnews.com/2016/12/22/american-medical-association-divisions/

[2] Bindman, A.B., (2013). Using the National Provider Identifier for Health Care Workforce Evaluation, *MMRR, vol., 3(3).* Retrieved from: http://cms.hhs.gov/mmrr/Downloads/MMRR2013_003_03_b03.pdf

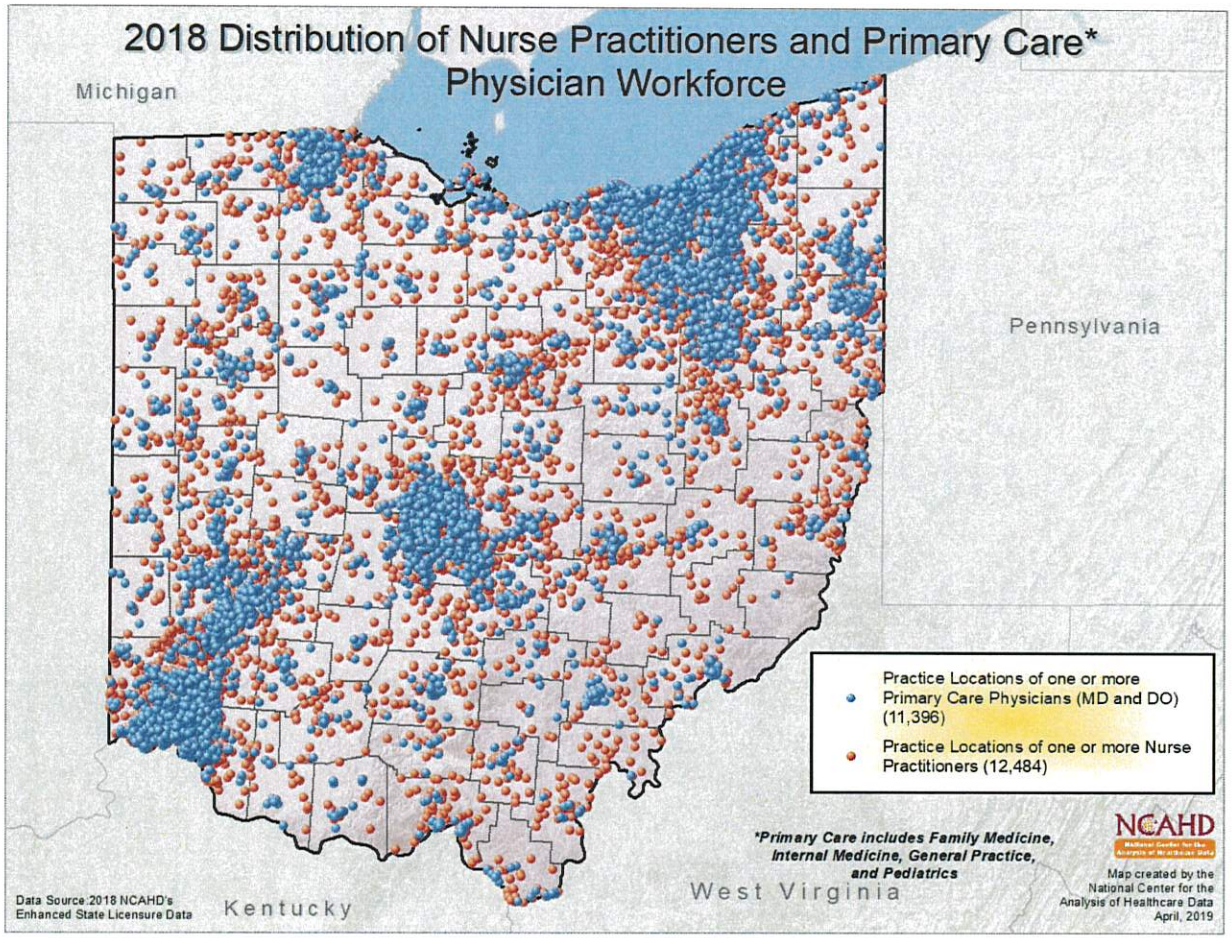
[3] Clark, J. & DiGaetano, R., (2014). Using the National Provider Identifier File as the Sampling Frame for a Physician Survey. Joint Statistical Meeting – Survey Research Methods Section. Retrieved from: http://www.amstat.org/sections/srms/Proceedings/y2014/Files/311621_87847.pdf

OAAPN
Ohio Association of Advanced Practice Nurses

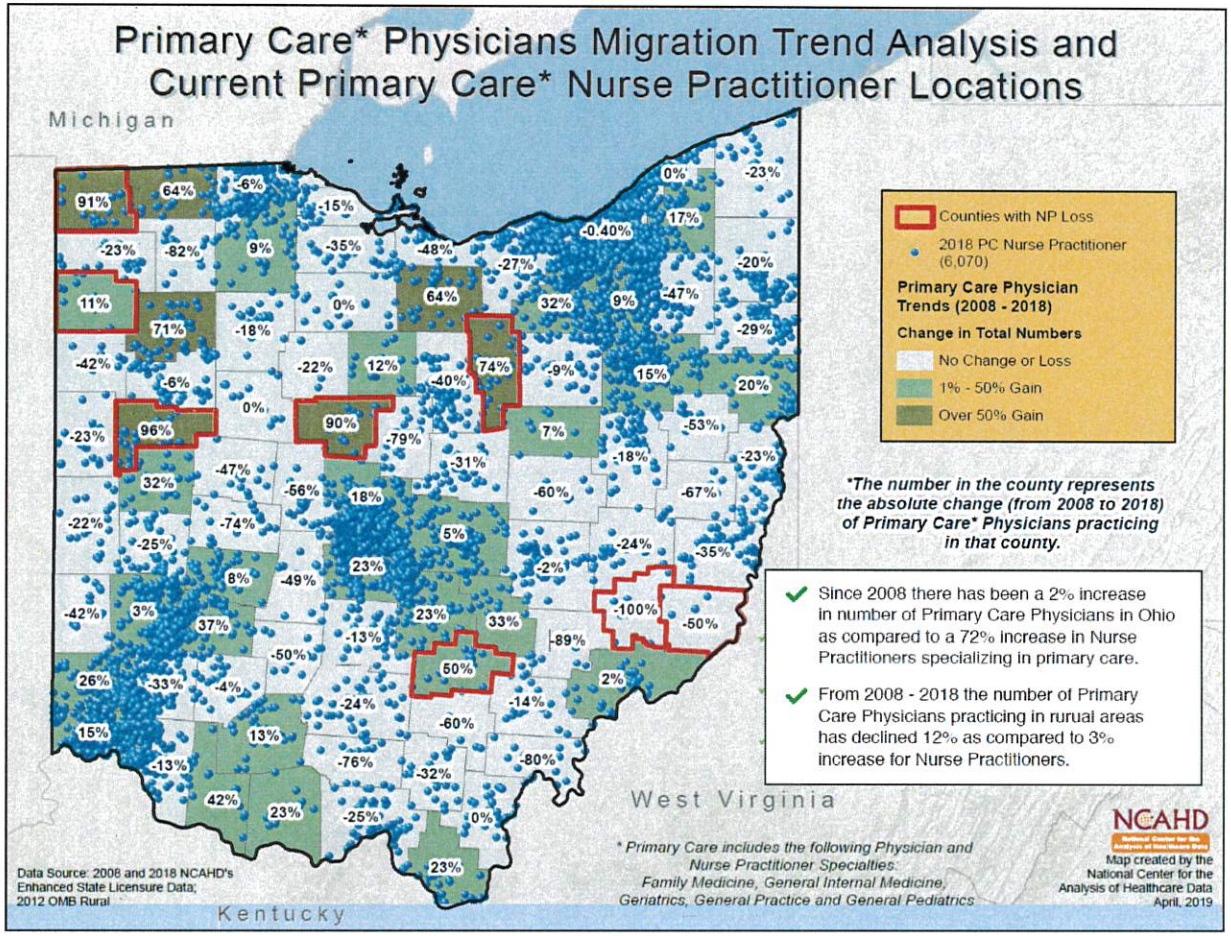
States Without Standard Care Arrangements



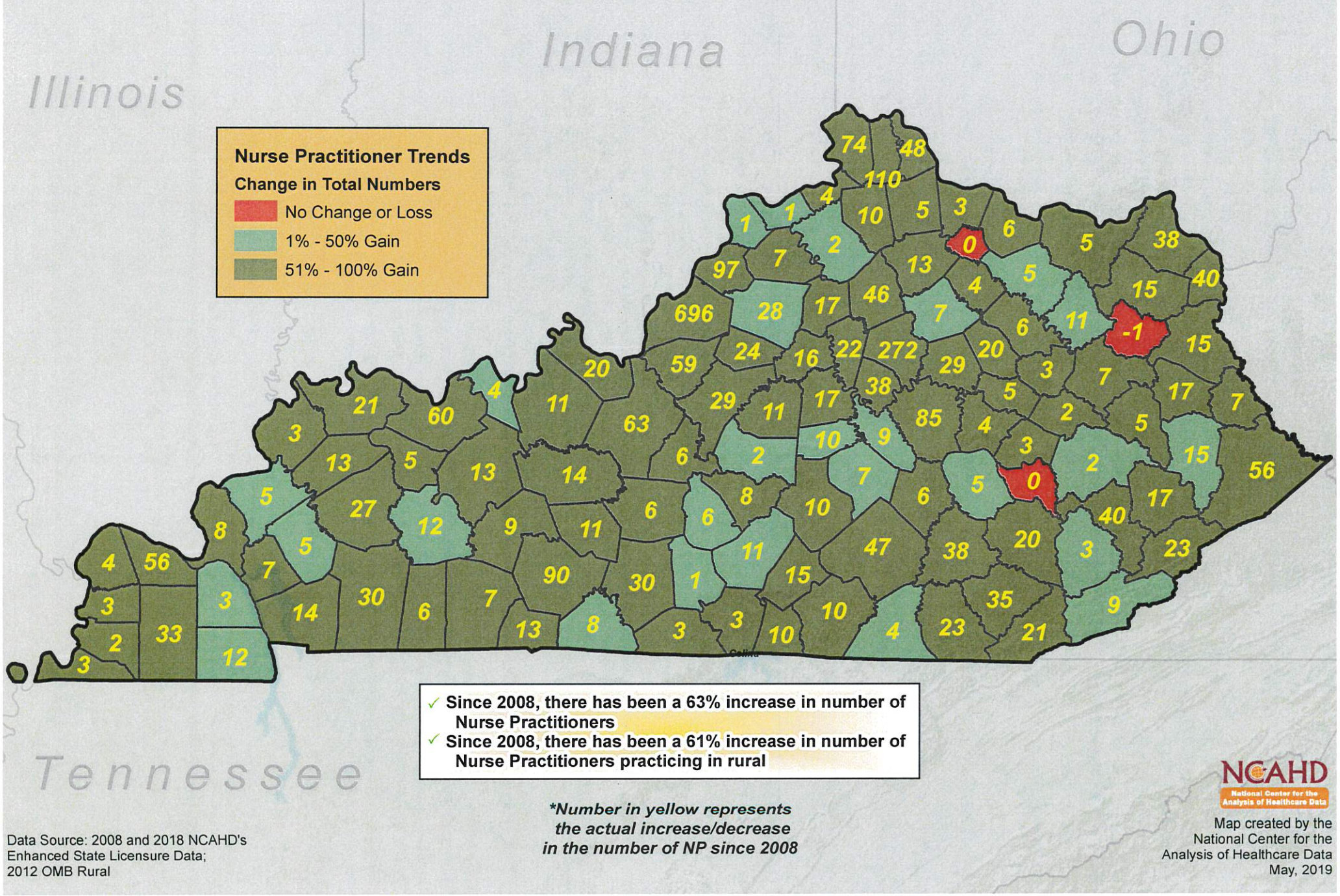
2018 Distribution of Ohio's Nurse Practitioners and Primary Care Physician Workforce



Primary Care Physicians Trend Migration Analysis and Nurse Practitioner locations (2008-2018)



Kentucky Nurse Practitioner Migration Trend Analysis (2008-2018)



- ✓ Since 2008, there has been a 63% increase in number of Nurse Practitioners
- ✓ Since 2008, there has been a 61% increase in number of Nurse Practitioners practicing in rural

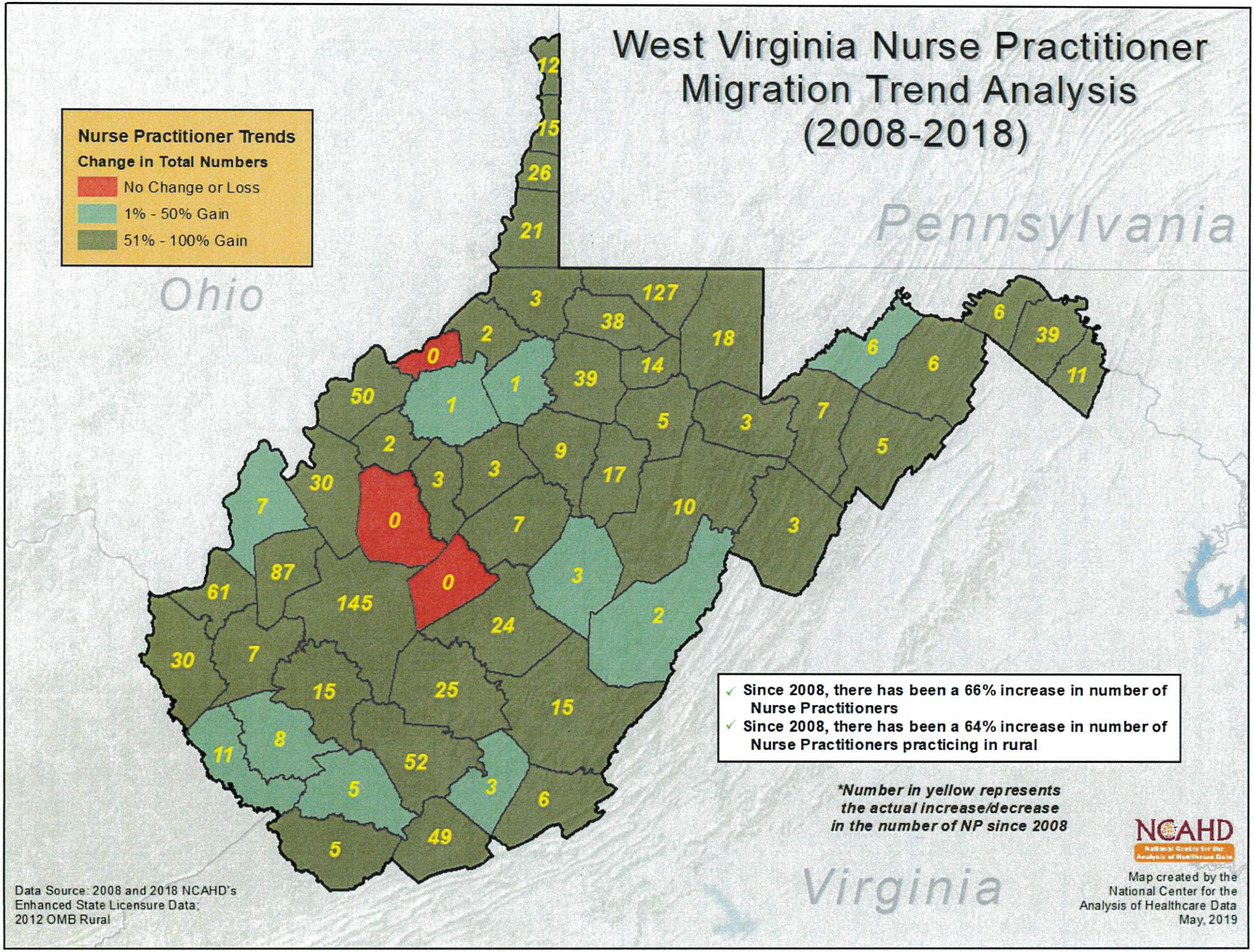
**Number in yellow represents the actual increase/decrease in the number of NP since 2008*

Data Source: 2008 and 2018 NCAHD's Enhanced State Licensure Data; 2012 OMB Rural

NCAHD
National Center for the Analysis of Healthcare Data

Map created by the National Center for the Analysis of Healthcare Data
May, 2019

West Virginia Nurse Practitioner Migration Trend Analysis (2008-2018)



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NCAHD
National Center for the Analysis of Healthcare Data

Map created by the National Center for the Analysis of Healthcare Data
May, 2019

442

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69-3/434

6/10/2019

PAY TO THE ORDER OF _____ $**1,000.00

One Thousand and 00/100********** DOLLARS

090371/12-04

MEMO Medical Collaborator Monthly Fee June 2019

6/10/2019 442
Medical Collaborator Monthly Fee June 2019 1,000.00

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6/10/2019 442
Medical Collaborator Monthly Fee June 2019 1,000.00

WesBanco CK (Opera Medical Collaborator Monthly Fee June 2019 1,000.00

Here is exhibit C of our medical direction contract. Please note that this creates a revenue of between $40,000 and $100,000 per year (between $3000 and $8000 + per month) for my collaborating physician and at any point in time, my business would be in jeopardy of closing should he decide to dissolve. This would leave me with a practice space rental agreement of $2900 per month for the next 5 years, and business loans totaling $280,000.00 for required equipment for the proper treatment of patients. It would be extremely difficult to replace my medical director as our practice is very specialized.

EXHIBIT C

MEDICAL DIRECTION [redacted]

APRN, RN, LE and Collaborating Physician agree to collaborate in providing services to patients in the manner within their scope of practice as dictated by the state. APRN may provide to the patients nursing care that requires knowledge and skill obtained from advanced formal education and clinical experience. RN may provide patients nursing care that requires knowledge and skill obtained from advanced formal education and clinical experience. An esthetician shall provide cosmetology services within a salon where the license is current, active and appropriate to the scope of practice of esthetics for an esthetician as set forth in section 4713.01 of the Revised Code and the rules of the board. The APRN will see all patients and conduct a good faith exam and prescribe treatments as needed or desired.

APRN, RN and / or LE shall ensure that patients receives timely and direct evaluation by Collaborating Physician when indicated, and shall refer for emergency consultation if necessary. This includes, but is not limited to:

Abnormal progression of healing

Patient request

Any needs that are outside the scope of the APRN's practice

_____DNP, APRN, FNP-C shall see patients at _____ Plastic Surgeons 1 day per week.

Should either party choose to dissolve the agreement, the APRN will have 120 days to obtain a new medical director.

CONTRACT

DATE	EXPIRATION DATE
4/2018	12/2019

[redacted]

[redacted]

MONTHLY	Job: Collaborative services	PAYMENT	DUE DATE
$500.00	10% chart review and sign home care orders	TERMS	

		30th of each month

Quotation prepared by:

Signing Collaborative agreement fulfills this contract