



TO: Senate Committee on Health  
Senator Patrick Testin, Chair

FROM: Wisconsin Medical Society  
Wisconsin Academy of Family Physicians  
Wisconsin Academy of Ophthalmology  
Wisconsin Chapter – American Academy of Pediatrics  
Wisconsin Chapter – American College of Emergency Physicians  
Wisconsin Dermatological Society  
Wisconsin Psychiatric Association  
Wisconsin Radiological Society  
Wisconsin Society of Anesthesiologists  
Medical College of Wisconsin

DATE: July 28, 2021

RE: **Opposition** to 2021 Senate Bill 394

On behalf of Wisconsin's major physician-led entities – representing more than 12,000 physicians statewide – thank you for this opportunity to testify on 2021 Senate Bill 394, related to Advanced Practice Registered Nurses (APRNs). Nurses are an important part of the physician-led health care team, and physicians value the care they give patients. Our **opposition** to Senate Bill 394 should not be interpreted as criticism of the nursing profession; rather, the legislation's significant expansion of APRN scope coupled with removing physicians from the patient care equation is not in the best interests of the public and could threaten Wisconsin's status as one of the nation's health care quality leaders.

### **SB 394 Removes Collaboration Requirements; Dramatically Expands APRN Scope of Practice**

The current collaboration requirements for advanced practice nurses are currently under attack at the state's Board of Nursing, which for the past several months has discussed its desire to alter the nursing administrative code provisions requiring collaboration: N 8.02(5) provides the definition of the collaboration requirements, which attach to advanced practice nurses through N 8.10. Nursing board member statements coupled with public comments from the state's major nursing groups have revealed a desire to remove these provisions altogether or to redefine "collaboration" to essentially mean unofficial consultation with any health care professional.

Running alongside this collaboration-canceling effort are proposed scope of practice definitions for advanced practice nurses that would for the first time grant broad powers along the entire spectrum of an episode of care. For example, the proposed definition for the “practice of nurse practitioner” appears to mimic much of the breadth that the layperson would assume is what is within physician scope. Section 95 of SB 394 (p. 43) creates a new statute:

441.001 (3r) PRACTICE OF A NURSE PRACTITIONER. “Practice of a nurse practitioner” means practice in ambulatory, acute, and long-term care settings as a primary and specialty care provider who assesses, diagnoses, treats, and manages acute, episodic, and chronic illnesses.

The coordination is likely not coincidental. As the Board of Nursing – at the nursing organizations’ urging – attempts to remove collaboration requirements for advanced nurses from the administrative code, the same organizations are pushing legislation that establishes broad, physician-like scope of practice definitions.

The bill also defers any future scope expansions to the nursing board, removing the state legislature from its usual policy-deliberating role – see the newly-created §441.09(6) (p. 53), which grants the nursing board the ability to “further define” the scope of practice for all APRNs, as well as the scope of issuing prescription orders.

The legislation also explicitly removes §441.15 WI STATS, which requires certified nurse midwives to practice in collaboration with a physician who has experience in obstetrics (such as an obstetrician or a family practice physician). While the bill now includes an “in case of emergency” provision (p. 52, lines 3-8) for births that devolve into emergency situations beyond the midwife’s scope, we believe it is wiser to continue requiring midwife-physician collaboration to better help prevent those emergency situations from occurring in the first place.

But while the advanced nursing scope of practice language the bill proposes appears similar to that level of care entrusted to physicians, a major difference between the two professions remains: the level of education, training and experience necessary before becoming a fully-licensed and practicing professional.

### **Patients Deserve Care from Professionals with the Most Education and Training: Physicians**

Of all health care professions, none require as much rigorous education and post-graduate training as it takes to become a practicing physician. While nurses require additional education to become advanced practice nurses, the curriculum and experience is nowhere near that required of physicians.

The American Academy of Family Physicians (AAFP) has an excellent two-page background memo (see Exhibit A attached to this memo) summarizing the different paths to becoming a family practice physician vs. becoming a nurse practitioner. A primary care physician completes between **12,000 to 16,000 hours** of competency-based, clinical training following four years of medical school and three years of residency. A nurse practitioner, in comparison, will complete perhaps 500 to 1,500 hours of post-graduate experience. While admirable, these additional hours are far from equivalent, and therefore should not allow for the opportunity to provide independent primary care.

Independent diagnosing, treatment and prescribing is the practice of medicine, and physicians spend nearly 11 years to properly hone those skills. Wisconsin’s patients deserve to receive care from the most highly educated, fully-trained health care professionals: physicians.

## **Studies Show Disparities in Physician vs. Non-Physician Prescribing, Imaging, Referrals**

Various studies comparing physician-led care with non-physician led care show differences in the quality and efficiency of care provided – which is perhaps not surprising considering the education and training differences inherent between physicians and advanced nursing.

As seen in Exhibit B attached to this memo, primary care provided by non-physicians can result in more drugs being prescribed, more tests being ordered and more referrals to expensive specialists than if a physician would have given the care.

Some excerpts:

- A report from the Infectious Diseases Society of America studying nurse practitioner and physician assistant antibiotic prescribing found that ambulatory visits involving those professions resulted in **significantly more antibiotic prescribing** than visits with physicians.
- A study utilizing 2015 Medicare claims data compared opioid prescribing patterns of physicians, NPs and PAs working in primary care settings. Analysis showed that while just 1.3 percent of physicians **prescribed opioids** to more than 50 percent of their patients, 6.3 percent of nurse practitioners did so.
- A Mayo Clinic study in 2013 concluded that nurse practitioners and physician assistants made **inappropriate referrals to tertiary referral centers** for patients with more complex medical problems to a level that could offset any alleged “savings” when substituting non-physician care for that of physicians.
- A 2014 *JAMA Internal Medicine* study found that nurse practitioners and physician assistants were associated with **more ordered diagnostic imaging** than were primary care physicians following an outpatient visit. Overuse of diagnostic imaging exposes patients to unnecessary radiation and is another example of offsetting any potential “savings.”
- A University of Wisconsin study from 2015 compared the malignancy rate of biopsies performed by dermatologists versus non-physicians. The findings suggest that **non-physicians perform more biopsies** than do physicians – increasing patient morbidity and the cost of care.<sup>1</sup>

Physician-led care has consistently contributed to Wisconsin’s status as a high-quality health care leader among the states. The examples of inefficient and more expensive care provided above suggest that moving away from physician-led care could endanger Wisconsin’s high-quality status.

## **The Bill Increases non-Physician Prescribing Opportunities While Deferring Future Scope to BON**

The bill would enable all nurse practitioners who obtain the new APRN designation to diagnose, treat and prescribe medications independently. The bill also authorizes nurse anesthetists to provide full anesthesia care with no supervision or even collaboration with an anesthesiologist or other physician. And as it does with future APRN general scope of practice decisions, the bill offloads to the Board of Nursing future decisions about what drugs APRNs will be allowed to prescribe – once again removing the legislature as the gatekeeper on important policy.

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<sup>1</sup> Bennett, D., Xu, Y (2015, August). Biopsy Use in Skin Cancer Diagnosis: Comparing Dermatology Physicians and Advanced Practice Professionals, *JAMA Dermatol.* August 2015 Volume 151, Number 8.

Furthermore, the bill as drafted contains a provision which would codify a choice allowed by the U.S. Centers for Medicare & Medicaid Services (CMS) to opt-out of a federal requirement that nurse anesthetists be supervised by a physician to receive Medicare and Medicaid reimbursement for anesthesia services. Wisconsin would be the first state in the nation to codify what is usually an administration's decision. And in doing so, the bill locks the legislature into supporting this questionable policy statement [see the bill's creation of §441.09 (5m), p. 53]:

The legislature finds that allowing certified registered nurse anesthetists to administer anesthesia without supervision or direction from an operating practitioner, physician, or anesthesiologist increases access to quality anesthesia services throughout the state and is in the best interests of the citizens of the state.

Currently, Wisconsin opts out of the supervision requirement related to Medicare reimbursement but continues to require physician supervision for Medicaid reimbursement – a requirement strongly supported by the Wisconsin Society of Anesthesiologists. There is no sound public policy justification for this provision – and in establishing this “opt-out” in statute rather than following the CMS procedure, it may not be allowable under federal rule.

**Experiences in Other States Show that Nursing Independence Does Not Increase Rural, etc. Access**  
A common justification for allowing nursing independence despite the concerns noted above is that doing so will bring primary care to areas where it is not readily available, such as rural locations. Evidence from other states appears to show otherwise, as you can see from Exhibit C attached to this memo: physicians and advanced practice nurses tend to practice in the same areas – even in the states where some level of non-physician independence is allowed.

In fact, as also cited in Exhibit C, an Affordable Care Act-mandated study tracking employment choices of APRN students upon graduation found that only 25% of APRNs in the study chose to work in medically underserved communities, with the vast majority of those working in urban settings. Only 9% of those APRN graduates went to work in rural areas, and only 2% worked in Federally Qualified Health Centers.

Instead of proposals such as SB 394, policymakers should instead continue to support initiatives and programs that will help spur physicians and other health care professionals to work in our state, and especially in rural Wisconsin. For example, the Medical College of Wisconsin has successfully created two new medical schools, both in central Wisconsin and in Green Bay. The legislature has also provided additional funding for Graduate Medical Education, expanding opportunities for medical residents to stay and practice in Wisconsin. But the real gains in improving access to and coordination of patient care will come largely from solidifying and expanding the use of physician-led teams.

For the above reasons, physicians across the state oppose Senate Bill 394. Thank you for your consideration.



## **Education and Training: Family Physicians versus Nurse Practitioners**

Most Nurse Practitioners (NP)—also known as Advanced Practice Nurses (APN) and Advanced Registered Nurse Practitioners (ARNP)—receive their education typically through a one-and-a-half to three-year degree program that confers a Master of Science in Nursing (MSN), depending on the prior education of the student. While many nurses have a MSN degree, there are alternate pathways available in a state to achieve NP licensure without advanced collegiate education. There is no single national accreditation agency for NP programs. Rather, NP education programs are housed within graduate programs accredited by one of several accreditation entities, including the American Association of Colleges of Nursing's (AACN) Commission on Collegiate Nursing Education (CCNE), the Accreditation Commission for Education in Nursing (ACEN), and the National Association of Nurse Practitioners in Women's Health Council on Accreditation. As of August 2015, there were 264 Practice Doctorate in Nursing programs enrolling students at schools of nursing, and an additional 60 DNP programs in planning stages. Typically, master's level nursing programs require students for entry at least to have passed the National Council Licensure Exam for Registered Nurses (NCLEX-RN) and satisfactorily completed the Graduate Record Examination (GRE).

Vanderbilt University's MSN program, for example, offers a Family Nurse Practitioner (FNP) specialization program. For registered nurses with a Bachelor of Science in Nursing (BSN), the MSN program is three semesters of 40 total credit hours, inclusive of didactic and clinical education. According to the program's handbook, MSN FNP candidates receive a total of 800 combined hours of didactic and lab education. Clinical education is estimated to amount to approximately 1,400 hours. For students with a bachelor's degree and no nursing experience, Vanderbilt offers a program of six semesters, or three full-time years, of education and training that leads to an MSN degree.

Family Physicians receive their education typically through a four-year degree program at one of the 175 accredited allopathic or osteopathic medical schools in the United States. Students must pass the Medical College Admissions Test for entrance into medical school. Medical students spend nearly 9,000 hours in lectures, clinical study, lab and direct patient care. The overall training process begins with medical school and continues through residency. During their time in medical school, students take two "step" exams, called the United States Medical Licensing Examination (USMLE) or the National Board of Osteopathic Medical Examiners COMLEX-USA exams, and must take core clerkships, or periods of clinical instruction. Passing both exams and the clerkships grants students the Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) degree, which entitles them to start full clinical training in a residency program.

Most family medicine residency programs, which are accredited by the Accreditation Council for Graduate Medical Education (ACGME), require three years of training. As with other specialties, family medicine residency programs have specific requirements with certain numbers of hours and patient care experiences that must be completed for board certification. They are designed to provide integrated experiences in ambulatory, community and inpatient environments during three years of concentrated study and hands-on training.

The first year of residency called the internship year, is when the final "step" of the USMLE or COMLEX (Step 3 exam) is taken. During their three years of training, residents must meet the program requirements for both residency education in family medicine

and certification by the American Board of Family Medicine (ABFM) or the American Osteopathic Board of Family Practice (AOBFP). Specific requirements for family medicine training vary by residency program. After three “program years” of training are completed and all requirements are met, residents are eligible to take the certification exam by the ABFM or AOBFP. Toward the end of residency, physicians also apply for licensure from their state medical boards, which determines where they can practice as a board-certified family physician. Although each state is different in their requirements for initial medical licensure, it is a necessity that physicians pass Step 3 of the USMLE.

The below tables offer a side-by-side comparison of the education and training involved in becoming a family physician versus the requirements to become a nurse practitioner.

*Degrees Required and Time to Completion*

	Undergraduate Degree	Entrance Exam	Post-Graduate Schooling	Residency and Duration	TOTAL TIME FOR COMPLETION
Family Physician (MD or DO)	Standard 4-year BA/BS	Medical College Admissions Test (MCAT)	4 years, doctoral program (MD or DO)	REQUIRED, 3 years minimum	<b>11 years</b>
Nurse Practitioner (NP, ARNP, etc.)	Standard 4-year BA/BS*	Graduate Record Examination (GRE) and National Council Licensure Exam for Registered Nurses (NCLEX-RN)	1.5 – 3 years, master’s program (MSN)	NONE	<b>5.5 – 7 years</b>

*Clinical Hours for Completion*

	Combined Hours (Clinical Years)	Residency Hours
Family Physician	6,000	9,000 – 10,000
Nurse Practitioner	500 – 1,500	0
DIFFERENCE	5,500 – 5,000	9,000 – 10,000

\*While a standard 4-year degree, preferably a BSN, is recommended, alternate pathways exist for an RN without a bachelor’s degree to enter some master’s programs.

Vanderbilt University Family Nurse Practitioner Program information retrieved from <https://nursing.vanderbilt.edu/msn/fnp/index.php> and the *Vanderbilt University School of Nursing Student Handbook 2016-2017* at <https://nursing.vanderbilt.edu/students/current/pdf/handbook.pdf> [Accessed March 2017].

## AMA Issue Brief: Expanding nurse practitioner scope of practice leads to increased utilization of health care resources

Studies have shown, nurse practitioners may end up increasing costs to the health care system due to inappropriate prescribing, unnecessary referrals to specialists, and unnecessary orders for diagnostic imaging studies such as x-rays.

### Increased or inappropriate prescribing: antibiotics

A brief report by the Infectious Diseases Society of America examined NP and physician assistant (PA) antibiotic prescribing, compared with physician-only visits for both overall visits and visits for acute respiratory tract infections (ARTIs) between 1998-2011.<sup>1</sup> **The study found that ambulatory visits involving NPs and PAs more frequently resulted in an antibiotic prescription compared with physician visits.** Similarly, with ARTI visits, NPs and PAs prescribed antibiotics 61 percent of the time while physicians prescribed antibiotics 54 percent of the time. The authors noted that their findings were consistent with several previous studies.<sup>2</sup>

The authors suggested several reasons for this discrepancy.<sup>3</sup> First, antibiotic stewardship programs tend to focus on physicians rather than NPs or PAs. However, the authors noted that elements of antibiotic stewardship are often included in NP and PA educational curriculum, and concluded that differences in antibiotic prescribing are more likely due to practice environment, learned clinical behaviors, or differences in patient communication rather than medical education. **While the authors hypothesized that there may be significant differences in the patient mix between physicians and NPs or PAs, the authors found that higher rates of antibiotic prescribing persisted among NP and PA visits, even when the analysis was restricted to patients with the same diagnosis.** The authors concluded that, as the proportion of outpatient visits involving NPs and PAs continues to increase, interventions to reduce inappropriate antibiotic use should target these providers in addition to physicians.

A study from Infection Control and Hospital Epidemiology similarly found inappropriate antimicrobial prescribing among advanced practice providers (APPs) in ambulatory practices.<sup>4</sup> The study collected data regarding over 488,000 outpatient visits between 2014 and 2016 regarding common upper respiratory conditions that should not require antibiotics. The visits reflected urgent care, family medicine, internal medicine and pediatric providers. **The study found that adult patients seen by APPs were 15 percent**

<sup>1</sup> Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. Open Forum Infectious Diseases. 2016:1-4.

<sup>2</sup> Grijalva CG, Nuorti JP, Griffin MR. Antibiotic prescription rates for acute respiratory tract infections in US ambulatory settings. JAMA 2009; 302:758–66.

<sup>3</sup> *Supra* note 1.

<sup>4</sup> Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. Infection Control & Hospital Epidemiology. 2018:1-9.



**more likely to receive an antibiotic than those seen by a physician.** The rate of prescribing for pediatric patients was similar. Like the authors of the IDSA study, the authors of the ICHE study recommended that future education and antimicrobial stewardship efforts should target APPs.

## Increased or inappropriate prescribing: opioids

Using 2015 Medicare claims data, the authors conducted a retrospective cross-sectional analysis to determine the opioid prescribing patterns of physicians, nurse practitioners and physician assistants who worked in primary care and prescribed at least 50 prescriptions.<sup>5</sup> Based on their analysis, **they found 6.3 percent of nurse practitioners and 8.4 percent of physician assistants prescribed opioids to more than 50 percent of their patients compared to just 1.3 percent of physicians.** They also **found NPs and PAs in states with independent prescription authority for schedule II opioids were 20 times more likely to overprescribe opioids than NPs and PAs in states with restricted prescription authority.** Of note, the study also found from 2013 to 2017, when almost every medical specialty decreased opioid prescribing, NPs and PAs significantly increased opioid prescribing. The authors opined on potential solutions for reducing NP and PA prescribing, such as implementing mandatory continuing education in safe opioid prescribing and restricting NPs and PAs prescribing authority.

These findings are also supported by an analysis of prescribing data from IQVIA, a worldwide data science and market research firm, which shows that between 2018 and 2019 opioid prescribing by nurse practitioners increased year-over-year in the vast majority of states, while opioid prescribing declined overall.<sup>6</sup> There was also an increase in opioid prescribing by nurse practitioners in the 22 states that AANP declares as “independent” or “full practice authority.”

## Unnecessary referrals

**According to a 2013 study by the Mayo Clinic, inappropriate referrals to tertiary referral centers by NPs and PAs could offset any potential savings from the increased use of NPs and PAs.**<sup>7</sup> The study compared the quality of physician referrals for patients with complex medical problems against referrals from nurse practitioners and physician assistants for patients with the same problems. Blinded to the source of the referrals, a panel of five experienced physicians used a seven-instrument assessment to determine the quality of each referral. Physician referrals received “significantly higher” scores in six of the seven assessment areas: (1) referral question clearly articulated, (2) clinical information provided, (3) documented understanding of the patient’s pathophysiology, (4) appropriate evaluation performed locally, (5) appropriate management performed locally, and (6) confidence returning patient to referring health care professional. Physician referrals were also more likely to be evaluated as necessary than NP or PA referrals, which were more likely to be evaluated as having little clinical value.

The study’s authors suggested that these differences be considered with respect to interacting patient, health care professional, and system-related factors. The authors observed that patients who require

<sup>5</sup> MJ Lozada, MA Raji, JS Goodwin, YF Kuo, Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns. Journal General Internal Medicine. 2020; 35(9):2584-2592.

<sup>6</sup> Source: IQVIA Xponent market research services. (c) IQVIA 2020. All rights reserved.

<sup>7</sup> Lohr RH, West CP, Beliveau M, et al. Comparison of the Quality of Patient Referrals from Physicians, Physician Assistants, and Nurse Practitioners. Mayo Clinic Proceedings. 2013;88:1266-1271.



referral to a tertiary medical center are typically more complex and undifferentiated in terms of a diagnosis. Although there is evidence that NPs and PAs can deliver effective primary care, the authors found little research on the ability of NPs and PAs to independently manage patients with undifferentiated and complex problems. However, the authors found many examples of excellent care of patients with complex medical problems within multidisciplinary teams in which NPs and PAs had immediate access to physician support—a level of support not necessarily available in all outpatient practice settings. The authors also noted that their survey of referring NPs and PAs indicated that they usually did not consult with a physician colleague before referring a patient.

Based on these results, researchers concluded that there is an opportunity to improve the quality of patient referrals from NPs and PAs in primary care practices by involving integrated health care teams that combine the skills of physicians, NPs, and PAs.

## Inappropriate Diagnostic Imaging

A recent JAMA Internal Medicine study investigated diagnostic imaging, such as medical imaging, by NPs and PAs compared to primary care physicians, after office-based encounters.<sup>8</sup> The study controlled for imaging claims that occurred after follow-up care such as specialty referrals.

The study's authors noted that previous research<sup>9</sup> found that in 34 percent of emergency department cases, NPs and PAs recommended imaging studies when physicians had not, and offered a reminder that overuse of diagnostic imaging may expose patients to unnecessary radiation and offset some savings otherwise achieved by the expanded use of NPs and PAs.

The JAMA Internal Medicine study found that NPs and PAs were associated with more ordered diagnostic imaging than primary care physicians following an outpatient visit.<sup>10</sup> The difference was more pronounced for radiographs – a test for which larger numbers of NPs and PAs are authorized to order – than non-radiographs. Further, NPs and PAs were associated with more imaging than primary care physicians on both new and established patients, though results were more pronounced with new patients, where NPs and PAs were not found to order differently for advanced imaging examinations, but were associated with higher rates for radiography orders.

The findings suggest that expanding the authority and use of NPs may alleviate physician shortages, but the increased imaging may have ramifications on care and overall costs. While the authors could not discern whether the difference in ordering represented overuse by NPs, rather than underuse by primary care physicians, efforts to expand access to care by simply substituting NPs for physicians without careful imagining appropriate mechanisms may further elevate health care costs and potentially increase unnecessary radiation exposure.

In the end, the study's authors noted that their results do not mean that NPs and PAs cannot serve an important, growing role in primary care access. **Rather, the authors warned that any such expansion**

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<sup>8</sup> D.R. Hughes, et al., A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA Internal Med.* 2014;175(1):101-07.

<sup>9</sup> Seaberg DC, MacLeod BA. Correlation between triage nurse and physician ordering of ED tests. *Am J Emerg Med.* 1998;16(1):8-11.

<sup>10</sup> *Supra* note 6.

**must be mindful of the additional cost, safety, and quality implications it may incur. Greater coordination in health care teams may produce better outcomes than merely expanding NP scope of practice alone.**

Similarly, a new study published in the Journal of the American College of Radiology found that skeletal x-ray utilization among Medicare beneficiaries increased among non-physicians, particularly NPs and PAs. The study, which analyzed Medicare Part B fee-for-service claims from 2003 to 2015, calculated utilization rates per 1,000 Medicare beneficiaries. While skeletal radiology is a basic and “low tech” form of imaging, it is the largest single category of imaging examinations, comprising 22.8 percent of all noninvasive diagnostic imaging performed in the Medicare population in 2015.

**The study found that skeletal x-ray ordering increased substantially – by 441 percent – among non-physician providers, primarily nurse practitioners and physician assistants.** Orders among primary care physicians decreased by 33.5 percent, which the authors hypothesized may reflect a tendency for PCPs to delegate NPs and PAs who work with them to take on the responsibility of interpreting x-rays. Still, the authors suggested that interpretations by NPs and PAs may warrant further scrutiny.

Source Notes: These materials include information derived from market research information provided by IQVIA, Inc. (“IQVIA”). IQVIA market research information is proprietary to IQVIA and available by subscription from IQVIA. The IQVIA Xponent® market research data includes estimates of dispensed drug prescription information from retail pharmacies (chain, mass merchandisers, independent and food stores) in the United States. IQVIA sources transaction information for +90% of the retail channel and uses a customized and patented estimation methodology to generate accurate market estimates. IQVIA employs various proprietary methodologies in data sourcing, data receipt, data editing and cleansing, creation and maintenance of reference files, data quality assurances processes, reference data bridging, database management and report creation to produce these estimates. More information about IQVIA can be found at [www.IQVIA.com](http://www.IQVIA.com).

## Issue brief: Access to care

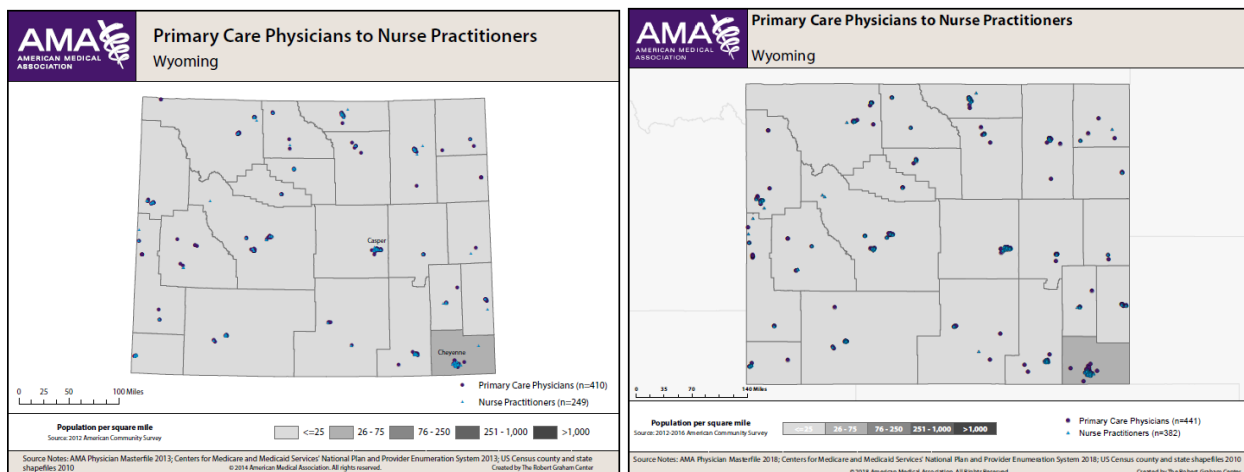
Proponents of scope expansions often claim such measures are necessary to expand access to care in rural areas. However, in reviewing the actual practice locations of primary care physicians compared to nurse practitioners, it is clear, that physicians and nurse practitioners tend to practice in the same areas of the state - even in those states where nurse practitioners can practice without physician supervision or collaboration. For the most part, state laws that have expanded the scope of practice of nurse practitioners have not necessarily led to more nurse practitioners in rural areas.

The AMA has mapped the actual practice locations of primary care physicians and nurse practitioners in all-50 states, DC and nationwide using data from the AMA Masterfile to determine the practice location of primary care physicians and data from the Centers for Medicare and Medicaid Services (CMS) for the location of nurse practitioners. Following are maps from 2013 and 2018 illustrating the practice location of nurse practitioners and primary care physicians from states with varying levels of nurse practitioner independent practice.

## Independent Practice States

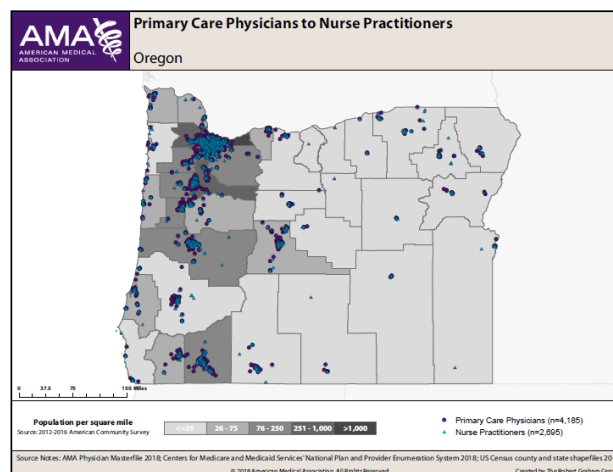
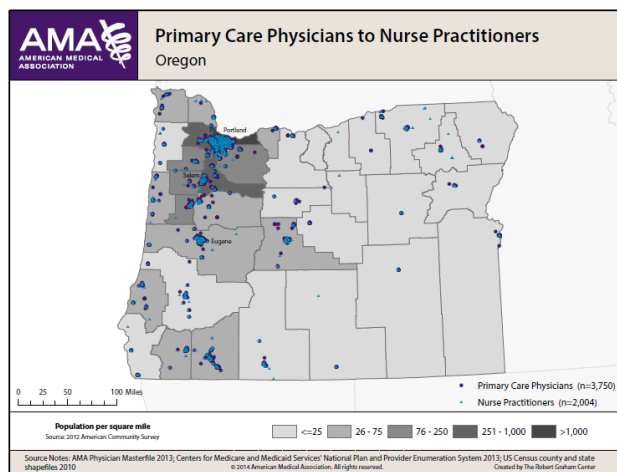
### Wyoming

In 2018 there were only 382 nurse practitioners in Wyoming compared to 441 Primary Care Physicians. The number of nurse practitioners in the state has not increased since they allowed independent practice, nor have nurse practitioner moved into rural areas of the state.



## Oregon

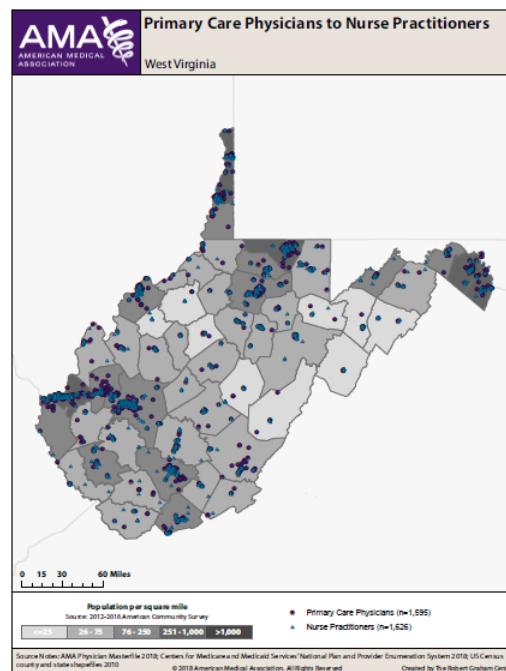
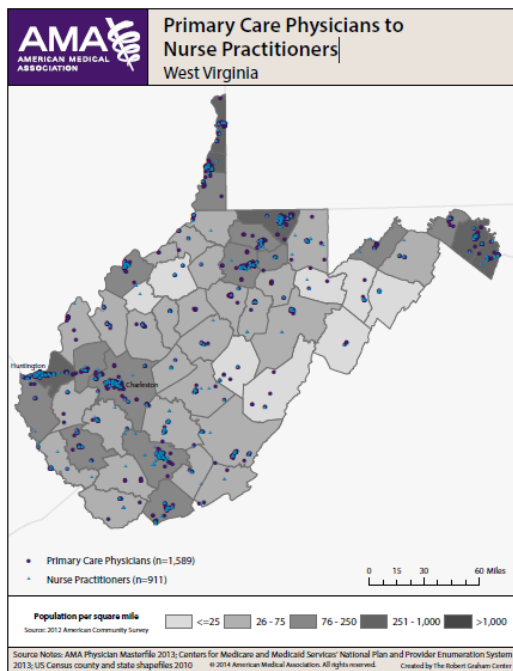
Similar to Wyoming, while allowing independent practice for decades, nurse practitioners have not moved to rural areas of the state and continue to practice in the same areas of the state as physicians. The number of nurse practitioners in the state increased from 2,004 in 2013 to 2,695 in 2018 a slower rate of growth than other areas of the country.



## Physician involvement required for 3 years to prescribe

### West Virginia

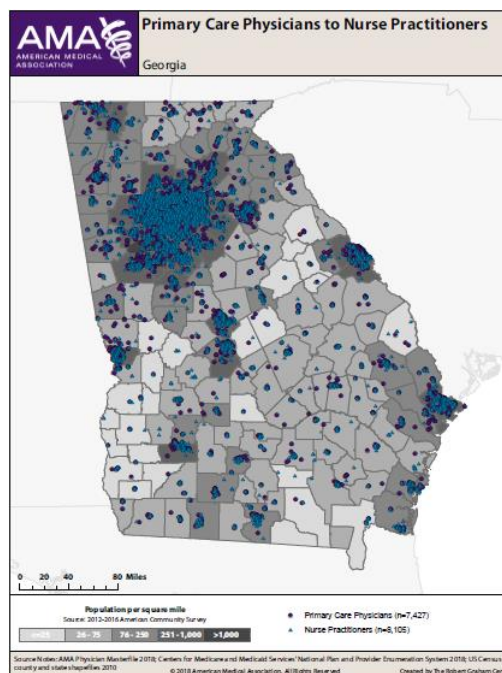
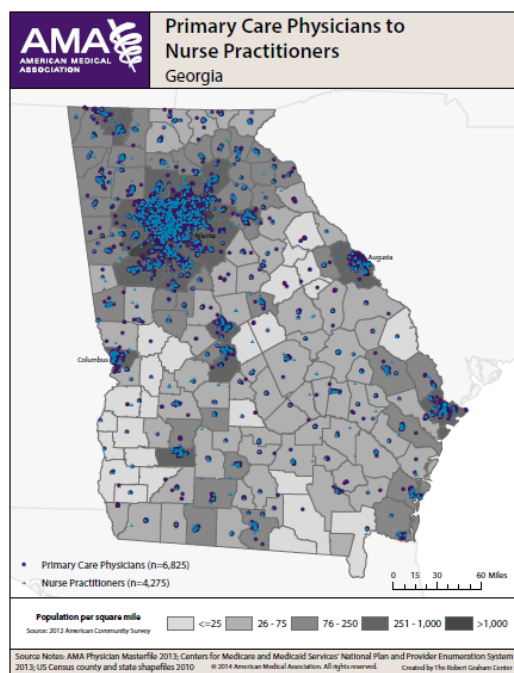
West Virginia enacted legislation in 2017 that allows nurse practitioners to diagnose and treat patients without physician involvement; they are still required to have a collaborative relationship for prescriptive practice with a physician for three years. While there was an increase in the overall number of nurse practitioner in the state, they continued to practice in the same areas of the state as physicians.



## Physician supervision or collaboration required to diagnose, treat, and prescribe

### Georgia

In Georgia, nurse practitioners practice pursuant to a protocol agreement with physician supervision and delegation. Supporting a physician-led team-based care approach, Georgia has seen tremendous growth in the number of nurse practitioners in the state, increasing from 4,275 in 2013 to 8,105 in 2018. This demonstrates that changes in nurse practitioner scope of practice laws are not the sole reason for growth of nurse practitioners in a state.



### Other studies confirm our findings

The Graduate Nurse Demonstration Project which was mandated as part of the Affordable Care Act of 2010, involved the Centers for Medicare & Medicaid Services (CMS) providing payments to five eligible hospitals, each of which partnered with schools of nursing (SONs), community-based care settings (CCSs), and other hospitals to expand clinical education for additional APRN students.<sup>1</sup> One of the goals of the project was to determine if funding clinical APRN education would increase the number of APRNs and to determine the employment choices of APRNs following graduation. A study of alumni from this program found only 25% of alumni served medically underserved communities, however, the vast majority were in urban settings, as only 9% went on to work in rural areas and only 2% worked in FQHCs.<sup>2</sup>

<sup>1</sup> The Graduate Nurse Education Demonstration Project: Final Evaluation Report, Centers for Medicare and Medicaid Services. August 2019. <https://innovation.cms.gov/files/reports/gne-final-eval-rpt.pdf>. Accessed Oct. 9, 2020

<sup>2</sup> *Id.*



## Fewer nurse practitioners are providing primary care

These maps likely overrepresent the number of nurse practitioners practicing in primary care. While the maps compare primary care physicians to all nurse practitioners in a state, data have shown a growing number of nurse practitioners are not practicing in primary care. For example, after examining state licensing renewal forms, the Oregon Center for Nursing found only 25% of nurse practitioners practice in primary care. This trend is also supported in recent workforce studies, which have found newly graduated nurse practitioners are more likely to enter specialty or subspecialty care rather than primary care.<sup>3</sup>

## Physician-led team care is equitable care

The AMA is deeply concerned with the notion that patients in rural and underserved areas, often a vulnerable and medically complex population, should settle for care from a health care provider with a fraction of the education and clinical training of physicians. All patients, regardless of zip code, deserve care led by a physician. Rather than allow an unproven path forward, policymakers should consider proven solutions to increasing access to care, including supporting physician-led team-based care. **In fact, evidence shows that states that require physician-led team-based care have seen a greater overall increase in the number of nurse practitioners compared to states that allow independent practice.** Other proven reforms include telehealth expansion, expanding GME slots, loan forgiveness programs for physicians practicing in rural and underserved areas and programs that encourage students from underserved areas to pursue medical school.

## NP scope expansion has led to RN workforce shortage

Nurse practitioners have used the notion of a physician shortage to advance their scope of practice, however, one often unmentioned result of the growth of the NP workforce, is its impact on the registered nurse (RN) workforce in the country. According to an analysis of the Bureau of Labor Statistics, between 2014 and 2024 an estimated one million new RNs will be needed across the country.<sup>4</sup> At this same time, however, the growth of the NPs workforce has reduced the size of the RN workforce by up to 80,000 nationwide.<sup>5</sup>

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<sup>3</sup> Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners, 2017. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; October 2017

<sup>4</sup> Health Care Employment Projections, 2014-2024: An Analysis of Bureau of Labor Statistics Projections by Setting and by Occupation, Center for Health Workforce Studies, School of Public Health, SUNY Albany; (2016).

<sup>5</sup> David I. Auerbach, Peter I. Buerhaus, and Douglas O. Staiger, "Implications of the Rapid Growth of the Nurse Practitioner Workforce in the US," Health Affairs; 39, 2 (Feb. 2020).