October 5, 2020

Nebraska Department of Health and Human Services Licensing Unit
Attn: Credentialing Review
PO Box 94986
Lincoln, NE 68509-4986

Dear Members of the APRN Technical Review Committee:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I write to provide comments on the Nebraska Board of Nursing’s proposal for consideration by the APRN Technical Review Committee (Committee). The AMA has serious concerns with the application including the broad focus and proposed scope expansions of certified nurse midwives (CNMs), nurse practitioners (NPs) and clinical nurse specialists (CNS). The AMA also questions the presumptive need for these changes to allow Nebraska to adopt an APRN Compact which is no longer in effect (a new APRN Compact was adopted after submission of this proposal). Finally, the AMA is deeply concerned the APRN proposal before the Committee threatens the health and safety of patients in Nebraska and will increase overall health care costs while failing to expand access to care.

As stated above, the AMA is alarmed that this proposal, which would remove the transition to practice requirements for NPs, allow CNS to prescribe and remove the requirement that CNMs maintain a practice agreement with a physician, threatens the health and safety of patients. It is our long-held belief that health care professionals’ scope of practice should be based on standardized, adequate training and demonstrated competence in patient care. This is imperative in protecting the health and safety of our patients. While all health care professionals share an important role in providing care to patients, their skillset is not interchangeable with that of a fully trained physician. This is why the AMA has long supported physician-led health care teams, with each member drawing on their specific strengths, working together and sharing decisions and information for the benefit of the patient. Just as teams do in business, government, sports and schools, health care teams require leadership. With seven or more years of postgraduate education and more than 10,000 hours of clinical experience, physicians are uniquely qualified to lead the health care team. **Team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients.**

Moreover, there is strong evidence that increasing the scope of practice of APRNs has resulted in increased health care costs due to overprescribing and overutilization of diagnostic imaging and other services. For example, a 2020 study published in the *Journal of Internal Medicine* found 3.8% of physicians (MDs/DOs) compared to 8.0% of NPs met at least one definition of overprescribing opioids
and 1.3% of physicians compared to 6.3% of NPs prescribed an opioid to at least 50% of patients.\(^1\) The study further found, in states that allow independent prescribing, NPs were \textbf{20 times more likely to overprescribe opioids than those in prescription-restricted states.}\(^2\)

Multiple studies have also shown that NPs order more diagnostic imaging than physicians, which increases health care costs and threatens patient safety by exposing patients to unnecessary radiation. For example, a study in the \textit{Journal of the American College of Radiology}, which analyzed the total utilization rate per 1,000 of skeletal x-ray utilization for Medicare beneficiaries from 2003 to 2015, found ordering increased substantially – \textbf{more than 400\%} – by nonphysicians, primarily NPs and physician assistants during this time frame.\(^3\) A separate study published in \textit{JAMA Internal Medicine} found NPs ordered more diagnostic imaging than primary care physicians following an outpatient visit. The study controlled for imaging claims that occurred after a referral to a specialist.\(^4\) The authors opined this increased utilization may have important ramifications on costs, safety and quality of care. They further found greater coordination in health care teams may produce better outcomes than merely expanding nurse practitioner scope of practice alone.

Many of these studies have been limited to NPs because few states allow prescriptive authority of CNS. However, the findings are clear, NPs tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians and overprescribe antibiotics\(^5\) – all which increase health care costs and threaten patient safety. Before expanding the scope of practice of NPs, CNMs and, CNS we encourage the Committee to carefully review these studies. We believe you will agree that the results are startling and have significant impact on the assessment of risk to the health and welfare of Nebraska patients, as well as the impact on the cost of health care in Nebraska.

APRNs have long claimed that expansion of their scope of practice will result in increased access to care in rural and underserved areas and help fill the gaps in primary care. This is a false promise and simply not true. Despite these promises, the evidence demonstrates that APRNs tend to practice in the same areas of the state as physicians. This occurs irrespective of state scope of practice laws. For example, in Nebraska while the number of NPs have increased, NPs have \textbf{not} moved into rural areas of the state – despite being granted independent practice in 2015. Furthermore, nationwide there has been a greater growth in the number of NPs in states that support physician-led team-based care compared to states that allow independent practice. This reflects the reality on the ground: physicians and NPs prefer working


\(^2\)Id.


together in team-based care models, not separated in siloed models of care. Moreover, it ought to be noted that recent workforce studies suggest newly graduated NPs are choosing to pursue specialty or subspecialty degrees rather than primary care.\(^6\) All of this points to one conclusion. **The facts are clear:** expanding the scope of practice of APRNs will **not** solve access to care problems in rural and underserved areas.

Finally, the Nebraska Board of Nursing indicates the scope of practice expansions proposed in their application are required so that they can enter the APRN Compact, which was drafted and adopted by the National Council of State Boards of Nursing (NCSBN). Unlike compacts created for other health care professionals, which focus on license portability, the APRN Compact includes provisions that preempt state scope of practice laws. The APRN Compact was initially adopted in 2015. After only three states adopted the original APRN Compact, however, the effort came to a halt when it failed to garner adoption by the minimum 10 states required to become effective. **This is the Compact referred to in the application before the Committee submitted on June 11, 2020 and is no longer in effect.** The NCSBN adopted a new version of the APRN Compact on August 12, 2020. This version of the APRN Compact includes many of the same provisions that caused concerns among state legislatures in 2015-2019. To date, it is noteworthy that no state has adopted the most recent version of the APRN Compact. Like the earlier version of the APRN Compact, the AMA is vehemently opposed to the new version especially because it is being used as a vehicle to expand scope of practice as opposed to focusing on license portability, as other health profession compacts do.

Thank you for the opportunity to provide these comments. If you have any questions, please contact Kimberly Horvath, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at kimberly.horvath@ama-assn.org.

Sincerely,

James L. Madara, MD

cc: Nebraska Medical Association

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