Good morning Mr. Chair and members of APRN Technical Review Committee. My name is Dr. Susan Bailey, a practicing allergist and immunologist from Fort Worth Texas and President of the American Medical Association. It’s an honor to be here today on behalf of the AMA. I’m pleased to provide our insight from a national perspective as you consider the Board of Nursing’s proposal and its impact on patients in Nebraska. These issues are very important to the AMA and physicians across this country.

As you know from the recent letter submitted to the Committee by the AMA, the AMA has serious concerns with the proposed scope expansions before you. As you consider this proposal, we encourage the Committee to rely on fact-based resources including a thorough review of the impact of scope expansions on health care costs and patient safety, the education and training of physicians compared to APRNs and whether such expansions will impact access to care.

I would like to begin my remarks talking about health care costs and patient safety. Multiple studies have shown that increasing the scope of practice of APRNs has led to increased health care costs. This is due to increased prescribing of antibiotics and opioids by non-physicians compared to physicians, as well as increased utilization of diagnostic imaging. I’d like to provide an overview of a handful of these studies. While many of these studies focus on nurse practitioners, which as you know are the largest group of APRNs, I understand the prescriptive authority of nurse practitioners is not part of the proposal. However, these studies are informative for your discussion on extending prescriptive authority to clinical nurse specialists.

Let me start with a recent study published in the Journal of Internal Medicine, in which the authors compared the opioid prescribing patterns of physicians and other non-physicians. Using a retrospective cross-sectional analysis of Medicare claims data they found 6.3 percent of nurse practitioners prescribed opioids to more than 50 percent of their patients compared to just 1.3% of physicians.¹

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Perhaps even more relevant to your discussion today is the study’s findings when comparing states that allowed nurse practitioners to independently prescribe compared to those that required physician involvement. The study found nurse practitioners in independent prescribing states were 20 times more likely to overprescribe opioids than those states that had restrictions on prescribing.²

These findings are supported by conclusions from other longitudinal studies on opioid prescribing which found nurse practitioners significantly increased opioid prescribing while at the same time almost every medical specialty decreased prescribing of opioids. This national trend is 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.³ There was also an increase in opioid prescribing by nurse practitioners in the 22 states that AANP declares “independent.”

These findings should give you great pause. In fact, they highlight the fact that effective pain control requires a team-based approach. Opioid analgesics may be appropriate for some patients—such as those with a severe acute injury, those who have cancer or in hospice, and for many patients with chronic pain. These all are conditions that require close physician oversight to ensure the right treatment at the right time. Physicians have reduced opioid prescribing nationwide because of their increased judiciousness as well as their education and training. The data is not clear as to why nurse practitioners are prescribing more opioids, but breaking apart physician-led, team-based care is certainly not the answer to more effective care for patients with pain.

We see similar finding on studies analyzing antibiotic prescribing by non-physicians compared to physicians. Again, many of these studies focus on nurse practitioners, because they are the largest group of APRNs. Studies have shown patients seen by non-physicians, including nurse practitioners were 15 times more likely to receive an antibiotic than those seen by a physician.⁴ Similarly, patients in ambulatory visits involving nurse practitioners and physician assistants

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² Id.
³ Source: IQVIA Xponent market research services. (c) IQVIA 2020. All rights reserved.
more frequently resulted in an antibiotic prescription compared with physician visits.\textsuperscript{5} While seemingly innocuous, overprescribing of antibiotics can lead to antibiotic resistance which can result in difficult to treat infections such as resistant Staph, need for hospitalization, and even death. Antimicrobial stewardship programs around the world have existed for more than a decade with the goal of reducing the number of antibiotic prescriptions, not increasing them.

Finally, multiple studies have found nurse practitioners order more diagnostic testing compared to physicians.

For example, a study in the Journal of the American College of Radiology found over a 12-year period (from 2003-2015) that ordering of x-rays increased by more than 400 percent among non-physicians, including nurse practitioners.\textsuperscript{6} A separate study published in JAMA Internal Medicine found nurse practitioners ordered more diagnostic imaging than primary care physicians following an outpatient visit.\textsuperscript{7} 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.\textsuperscript{8}

The facts are clear. Expanding the scope of practice of APRNs to allow independent practice and prescriptive privileges will increase utilization of diagnostic services, antibiotic prescribing and opioid prescribing - all of which can take a real toll on health care costs as well as threaten the health and safety of patients. We implore you to put patients first and reject this proposal. These added costs and patient safety concerns will place a strain on the health care system, on our patients and on their families.

But there is an alternative to the approach in the Board of Nursing proposal. Team-based care.

All health care professionals play an important role in providing care to patients, including nurse practitioners, nurse midwives, clinical nurse specialists, physician

\textsuperscript{7} 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
\textsuperscript{8} Id.
assistants, pharmacists, the list goes on. It really does take a whole team to care for patients. And patients are better served when all members of the health care team share information, and decision making based on their unique skills – all with the common goal of improving the health of the patient. This is why the AMA is a fervent supporter of physician-led teams. This support is evident across the AMA and across the continuum of physician education and training. This begins with medical school education. For example, when the AMA launched their Accelerating Change in Medical Education Initiative in 2013, there was a model that included the integration of patient-centered, team-based care into the medical school curriculum. This innovative approach demonstrated the importance of making sure tomorrow’s physicians are trained to work in inter-professional teams and are prepared to lead those teams.

I’m happy to report this curriculum has now been integrated in a number of medical schools across the country. In fact, in many instances the school of medicine and school of nursing have come together to teach the curriculum. We believe this underscores the importance of teaching all healthcare professionals how to work in a team environment early on in their education.

As you well know from your work in government, teams require leaders. In fact, we have leaders in virtually all areas of our life, in business, in sports, even in our families. We need leaders in health care too. It only makes sense that teams leaders should be the ones with the most education and experience.

With more than 10,000 to 16,000 hours of clinical training during their four years of medical school and three to seven years of residency, physicians have far more education and training than APRNs. For example, NPs complete just 2-3 years of graduate level education and 500-720 hours of clinical training, and APRNs are not required to complete a residency program.

Now I’d like to turn to access to care. APRNs have long claimed that expansion of their scope of practice will result in increased access to care in rural and underserved areas. While often promised, this simply does not happen. The AMA has data on practice locations of physicians and APRNs across the country, which we’ve collected over time. State by state and year after year the data demonstrates very clearly that APRNs tend to practice in the same areas of the state as physicians. This is true even in states that have allowed scope expansion. We’ve seen a nationwide trend, in fact, that there has been a greater growth in the number of nurse practitioners in states that support physician-led team-based care compared to states that allow independent practice. This likely reflects the
reality on the ground: that physicians and APRNs prefer working together in team-based care models, not separated in siloed models of care. There are likely other factors at play, but we do know this; expanding the scope of practice of APRNs will not solve access to care problems in rural or underserved areas.

Finally, I would like to address the presumptive need for these changes so Nebraska can enter the APRN Compact. As the Committee likely knows, since this proposal was submitted, the APRN Compact has been revised and re-adopted by the National Council of State Boards of Nursing. The original Compact adopted by the NCSBN in 2015 failed to become effective because it could not garner enough support in other states. Similar to the 2015 version, the new version would supersede state scope of practice laws for all four types of APRNs by removing any physician supervision or collaboration requirements and allowing APRNs to prescribe non-controlled medications and devices. The Compact would create uniform licensure requirements, which may or may not comport with Nebraska’s current requirements, yet it would default all licenses issued in the state to a multistate license. Of note, the Compact would also include nurse anesthetists, which are not the included in this proposal. It’s important to point out every other health care professional Compact, including the Interstate Medical Licensure Compact, Psychology Interjurisdictional Compact and others are merely license portability laws, the APRN Compact is the only health professional Compact that would supersede state scope of practice laws.

Thank you for the opportunity to present today on behalf of the AMA. I’m happy to answer any questions.

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