AARP® Real Possibilities
Kansas

6220 SW 29th Street, #300 | Topeka, KS 66614
1-866-448-3619 | Fax: 785-232-1465 | TTY: 1-877-434-7598
aarp.org/ks | ksaarp@aarp.org | twitter: @aarpks
facebook.com/AARPKS

DATE: February 11, 2019

TO: The Honorable Brenda Landwehr, Chair
House Health and Human Services Committee

Re: HB 2066, relating to certain requirements for Advance Practice Registered Nurses

Madam Chair and members of the committee,

My name is Judy Davis-Cole. I am submitting testimony in favor of HB 2066. I represent the interests of approximately 318,000 AARP Kansas members, as well as my own interests. I am a volunteer for AARP, a retired master's-prepared nurse, and a concerned Kansan.

According to the updated January, 2019 Encyclopedia Britannica, the World Health Organization (WHO) recognizes nursing as the backbone of most health care systems around the world (8).

In Kansas, this 'backbone' is hampered by requiring physician supervision of our Advanced Practice Registered Nurses (APRNs). This results in reduced scope of practice: it limits the ability of the APRN to function at the full extent of their education, skill, and experience.

As stated by Victoria Sweet, M.D., the author of a New York Times article "Far More than a Lady with a Lamp'; "Nightingale (i.e., Florence Nightingale) understood the different goals of doctor, nurse, lawyer and economist. From her study of hospitals she'd concluded that patients get the best care when no single power is ascendant, rather when there is the 'perpetual rub' between doctor, nurse, and administrator." (9) In other words, the patient benefits from a doctor/nurse relationship that is collaborative rather than hierarchical.

Nursing has always been distinct from medicine. It was never intended to be under the jurisdiction of the medical profession. Even though providing health care is the goal of both nursing and medicine, nursing has its own schools, its own philosophies and philosophers, its own scientific studies and its own framework of care delivery (4). Nursing has always been more wholistic in approach, whereas medicine is more germ theory/cause and effect. People would be better served by having access to both philosophies of health care in order to benefit from quality care delivery.

Although a nurse should carry out a physician's order if he/she agrees that it is in the best interest of the patient; that same nurse is obligated to not carry out that order if he/she believes that it is not in the best interest of the patient (10). The belief that a nurse must always function under physician supervision is certainly outdated and unnecessary.

Some will argue that this supervision is necessary to protect the public from unqualified, inadequate, or dangerous care delivery. However, over 35 years of scientific reports indicate that APRNs are at least comparable, and in some cases superior to, physicians in the provision of primary care. Furthermore, surveys show that patients of APRNs are more satisfied with their clinical exchanges than with physician interactions (1). Indeed, according to AARP's Public Policy Institute survey in 2018, 87% of Kansas voters aged 45 and over support allowing APRNs to serve as the primary and acute care provider of record (2).

The care delivered by APRNs is safe care. This is documented in part by the reported incidences of malpractice litigation. According to CPH and Associates statistics reported in 2017, of 222,000 APRNs, only 1.9% were named as primary defendants in malpractice litigation. This is comparable to a study from 1991 -2007 in which 1.5% of APRNs were named in malpractice litigation, whereas 37% of physicians were named in these types of the cases (5). In an interesting article "Understanding Nurse Practitioner Liability", it was shown that Nurse Practitioners with malpractice claims were more likely to have been mentored by a physician in their first two years of practice. Nurse Practitioners without malpractice claims were more likely to have been mentored by another nurse practitioner (7).

According to the Online Journal of Issues in Nursing in 2009, there also is a low incidence of disciplinary action taken against APRNs by professional boards (6).

We know that there is a shortage of primary care providers in our country. This is certainly true in Kansas. According to AARP's public policy institute survey, Kansas ranks 40th in the nation for the number of physicians per 100,000 people. In fact, 6 counties have no physicians, and 18 counties have only one physician (2).

This shortage of primary care physicians will only become worse. Currently, only 1/3 of physicians choose to practice primary care; only one in six medical school graduates go into primary care. It is projected that at this rate, by 2030, there will be 49,000 fewer primary care physicians (3).

On the other hand, currently there are 262,000 APRNs nationally. 78% of these APRNs specialize in primary care. Furthermore, it is projected that 16,000 APRNs will graduate per year, so that by 2025, there will be 299,000 primary care APRNs (3).

These nurses are more likely than physicians to practice in geographically underserved areas.

This is all accomplished while being more cost-effective.

- The costs involved in seeing an APRN is between 11% and 29% of that of a physician's care. Medicare reimburses APRNs at 85% of physician reimbursements (3).
- Florida's Office of Program Policy Analysis and Government Accountability acknowledges that full scope of practice for APRNs may save more than $7 million dollars in Medicaid costs (3).
- Economist Ray Perryman of Texas says that allowing APRNs to practice at the top of their training could increase the state's economic output by eight billion dollars (3).

As stated by Gordon Moore in JAMA, 1991, "Primary care is the most affordable safety net we can offer our citizens."

Let's offer all Kansans more easily accessible quality primary care, by joining the other 22 states that have removed the barrier of physician supervision to independent (full practice) APRNs. Full practice APRNs:

- Are more likely to practice in geographically underserved areas (increased care access);
- Deliver primary care that is comparable to physician-delivered primary care;
- Deliver safe care with high patient satisfaction rates;
- Deliver cost-effective care; and
- Offer patients the choice of a second framework of health care delivery.

Please support and pass HB 2066. The health care of Kansans is at stake.

Respectfully submitted,

Judy Davis-Cole, RN, MN (retired); AARP volunteer

References

1. Science of Caring.UCSF.edu/policy/gazing-future-advanced-practice-nursing
2. AARP, "Give Nurses Full Authority to Heal", 2018
3. American Enterprise Institute; Nurse Practitioners, Sept., 2018
4. Journal of Nursing Philosophy; Current Nursing.com "Nursing Theories-a Companion to Nursing Theories and Models
5. CPHins.com/nurse-practitioners-and-professional-negligence-lawsuits
6. OJIN.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/ojin/Table of Content 2009
7. International.aanporg/content/docs/understandingnursepractitionerliability.pdf
8. Encyclopedia Britannica, updated January, 2019
9. Sweet, Victoria, M.D., "Far More than a Lady with a Lamp", New York Times, March 3, 2014
10. RegisteredNursing.org/does-a-nurse-always-have-to-follow-doctor's-orders