Statement of Winifred V. Quinn on Behalf of AARP

re: North Carolina and Full Practice Authority of Advanced Practice Registered Nurses

(or Consumers' Direct Access to APRNs)

March 29, 2022

Thank you for the opportunity to speak on this very important topic of full practice authority for Advance Practice Registered Nurses, or APRNs, and to give the consumer perspective on behalf of our 1.1 million AARP members in NC and nearly 38 million members across the nation.

AARP has been working hard for more than a decade on this issue at the state and national levels because our members need and want improved access to and choice of health care professionals. Access to affordable, quality health care is a top priority for AARP and its members.

On behalf of patients and consumers I'd like to start with a few points about what proposals like the Save Act are about and are <u>not</u> about.

- They <u>are</u> about access to care, patient choice and making the most of our scarce health care resources. They are <u>not</u> about a turf war between nurses and physicians. They are about patients and families.

- By removing the bureaucratic mandate for APRNs to be supervised by another clinical sector, and, be able to provide the clinical care which they are experts in, full practice authority bills are about consumers having direct access to <u>all</u> health professionals. The

current mandates and their unnecessary paperwork are red tape that occupies too much time of all APRNs, as well as their contracted physicians.

- I want to underscore this point. This unnecessary paperwork prevents patients from having better access to physicians as well as APRNs. We strongly support physicians and appreciate all of the hard work and great care they provide. We would like less of their time spent on paperwork and more time with healthcare consumers.

- By removing this bureaucratic red tape, patients would also have direct access to all APRNs in the state.

- AARP deeply values the care that all four sets of APRNs provide.

  - Nurse practitioners are the most prevalent. While some are in specialty areas, most are in primary care. And a good proportion of nurse practitioners are gerontological experts. They are also more likely to provide care to people in under-served communities, including rural areas.

  - Certified registered nurse anesthetists provide very important services for older adults, especially in rural areas. Rather than traveling far distances, or delaying necessary care, older adults with access to certified registered nurse anesthetists would have better health outcomes. Their families would also be able to take less time off of work to transport their older loved ones greater distances for care.

- Many people may not see a connection between the needs of people 50 plus and certified nurse midwives. But we do. Certified nurse midwives are often the main primary care provider for all people in rural communities. Also, women 50 and older continue to have women's healthcare needs. And, certified nurse midwives are excellent women's healthcare clinicians as well as primary care providers.

- Finally, there are clinical nurse specialists. Perhaps the most unsung heroes among all of the APRNs. They also provide VERY IMPORTANT services for older adults. Especially when it comes to chronic care management. They are the most highly skilled clinicians for people with multiple chronic conditions. When people with chronic conditions lack the care, where and when they need it, they are most likely to be hospitalized and re-hospitalized within 30 days of discharge.

    - Clinical nurse specialists are the top clinicians who can improve the quality of life for people with chronic conditions and they play a very important role in containing healthcare costs.

    - To refer to my own experiences as a family caregiver, which I bet it is something most of you can relate to, when my parents were in the throes of needing a lot of help, the physicians provided great clinical care. But the efforts it took to make sure that my parents were getting care and services at home when they needed them was nearly impossible to manage as a family caregiver. And in fact, my parents were unnecessarily re-hospitalized on numerous occasions because of the lack of coordination

between care and the services they needed. Clinical nurse specialists can really help solve so many problems.

- As can all of the APRN groups I just described.

- Above all, bills like the Save Act are about health care quality and access. **Patients and families know this. And, the evidence is there, over many years and many studies: the quality of care provided by APRNs is no less than that of physicians. And, are often excellent complements in the clinical care provided by physicians and other health care providers.**

- **We often hear unfounded concerns about the quality of care provided by APRNs. I want to be clear: AARP would not be supportive of full practice authority legislation if it in any way compromised health care quality.**

Now, I'd like to review – again from the consumer perspective – the evidence in favor of APRN full practice authority and patients' direct access to care. AARP relies upon a mountain of evidence that shows how much consumers benefit from direct access to APRNs.

First, I Would Like to Discuss Evidence of Quality

- There is overwhelming evidence based on rigorous research over many years demonstrating that quality of services provided by APRNs is equal to or higher than that of other health professionals.
    - Arguments to the contrary do not hold up to decades of real world and research evidence.
    - Last year, a team of researchers, led by Dr. Yang at Towson University in Maryland, produced a summary of quality-related studies over the past 20 years.[i] Among the findings, these stand out as they pertain to consumers:
        - Most studies found no difference between the quality of care provided by nurse practitioners and physicians.
        - One study found no differences in quality of care for Medicare beneficiaries being cared for by nurse practitioners in full practice authority states and those where nurse practitioners are required to contract with physicians. In other words, physician supervision had no impact on quality of care.
            - And, as a consumer, I would like to point out that with 2 clinicians involved in the provision of care, both clinicians are getting paid. This ends up being a cost to the healthcare system and is absorbed by consumers.

- Other studies did find some significant differences that need to be underscored:

- Spetz et al. (2013) reported a lower number of hospitalizations, less emergency department use, and a lower number of chronic condition indicators in states with full practice authority compared with those without it.
- Traczynski and Udalova (2018) also found higher patient satisfaction for office visits in full practice authority states compared to states with restricted practice authority.

- Three other studies focused on health status of a specific care domain (Alexander & Schnell, 2019; Grecu & Spector, 2019; Smith-Gagen et al., 2019). The researchers reported significant improvement in self-reported mental health status and a decrease in mental health needs (Alexander & Schnell, 2019) and opioid-related mortality rates (Grecu & Spector, 2019) in states with nurse practitioner prescriptive authority. Smith-Gagen and their team (2019) found twofold higher odds of being diagnosed with late-stage cervical cancer in states where consumers lack direct access to APRNs compared with those with full practice authority.
    - Just to underscore this. Women were more likely to be diagnosed with an advanced stage cervical cancer in states with the red tape of mandatory contracts between APRNs and physicians.

- The prestigious National Academy of Medicine, after its lengthy and rigorous review of the evidence, recommended that states remove outdated barriers preventing APRNs from practicing to the full extent of their education and training.[ii] The 2021 report was a follow up to its precursor from the Institute of Medicine, which recommended the same.[iii]
- In its 2012 review of evidence of the quality of care provided by nurse practitioners, the National Governors Association found that nurse practitioners provided "at least equal

quality of care to patients as compared to physicians" in studies measuring patient satisfaction, [iv] [v] [vi] [vii] [vii] time spent with patients, prescribing accuracy, [vi] [iv] [ix] the provision of preventive education, and key health outcomes. [x] [xi]

- A meta-analysis of 11 research trials comparing pregnancy and birthing care led by certified nurse midwives in traditional care models concluded that certified nurse midwife care is associated with reduced adverse outcomes and shorter newborn hospital stays without any reduction in maternal or child health. [x, xi]
- As far back as 2003, a 22-state case control study of Medicare patients found no difference in outcomes between certified registered nurse anesthetists and anesthesiologists working alone or as part of a care team.[iv]
- Benjamin McMichael, Professor at the University of Alabama School of Law, published a 2021 analysis regarding opioid prescribing[v]. He found that of the approximately 1.5 billion individual opioid prescriptions between 2011 and 2018, across all nurse practitioners and physicians, full practice authority for nurse practitioners was associated with a statistically significant decline of between 2% and 7% in total annual opioids prescribed to all patients.

<u>Now I Would Like to Review the Evidence of Improved Access</u>

- Four published research papers that focused on access to care reported that, in states where nurse practitioners have full practice authority: nurse practitioner supply is higher[vi]; nurse practitioner supply is linked to greater care access[vii]; and there were fewer

avoidable hospitalizations and re-hospitalizations and lower rates of nursing home resident hospitalizations.[viii]

- A 2015 study found that in states with full practice authority for nurse practitioners, Medicaid patients were more likely to get new patient appointments and experience fewer office visit costs.[ix]

- The same study, that included a survey of approximately 1,000 primary care physicians and nurse practitioners, found that nurse practitioners are more likely than physicians to practice in urban and rural areas and more likely to treat Medicaid recipients.

- A 2016 study found that states with laws allowing APRNs to practice to the full extent of their education and training had 40 percent more nurse practitioners per capita and people living in those states had significantly greater access to primary care than in restricted care states.[x]

- Bearing this out, one example of the impact of passage of full practice authority on the number of APRNs practicing in a state came from Nevada. Nevadans saw a 68 percent increase in the number of APRNs practicing in their state between June of 2013 when their legislation was signed by the Governor, and January 2017.[xi]

- In 2017, the Veterans Administration authorized its health system to enable APRNs caring for our veterans to practice to the full extent of the education and training. All VA

facilities are now operating under these rules.[xii] A study published in 2021 found that removal of practice barriers has reduced wait times for veterans to get medical appointments. Veterans enjoyed more timely appointments for primary care, specialty care, and mental health care in those VA facilities with APRN full practice authority, compared to those facilities which had not yet implement the reforms.

- A 2018 study published by the American Enterprise Institute found that geographic access to primary care was significantly higher in states that did not restrict nurse practitioner scope-of-practice compared to those that did: 63 percent of people living in nonrestrictive states had geographic access to counties with a high capacity of primary care clinicians compared to 34 percent of people living in states that restricted nurse practitioner scope-of-practice. Results also showed that states with restricted nurse practitioner scope-of-practice had 40 percent fewer nurse practitioners compared to those without. These findings suggest that lifting state-level scope-of-practice restrictions on nurse practitioners would, over time, increase access to primary care, particularly in rural areas.

Yang's 2020 meta analysis of a large number of research studies on the impact of full practice authority for nurse practitioners concludes with "Advocates for full practice authority argue that removing nurse practitioner practice restrictions could improve access to primary care. Our review found strong and uniform evidence to support this

argument, indicating that full practice authority was positively associated with access to care and health service utilization, especially in primary care settings, without increasing potential patient safety issues" (for example, over-prescribing medications with high abuse potential such as opioids).

AS FAR AS COST IS CONCERNED

Yang's over-arching report included studies regarding cost.

- Spetz, a health economist, found patients who visited retail clinics in full practice authority states had significantly lower total, non-inpatient, and prescription payments compared with those in restricted states (Spetz et al., 2013). Further, nurse practitioners in states with full or partial prescriptive authority were associated with significantly more prescriptions filled and higher total and prescription payments relative to more restricted states (Spetz et al., 2013).
- Knepper et al. (2015) found that restricted practice authority was associated with higher direct and indirect costs of diabetes management (Knepper et al., 2015). Kleiner et al. (2016) specifically focused on the price of well-child visits and reported a significant decrease in the price of these visits in states recognizing nurse practitioner prescriptive authority.
- In contrast, Stange's 2014 study on a national sample of office visits, reported no significant difference in total charges according to the level of state nurse practitioner practice regulations. In other words, nurse practitioners' full practice authority didn't drive up costs.

- Two other studies (Timmons, 2017; Poghosyan et al., 2019) examined the change in total costs of Medicaid claims per beneficiary, using the same years of data. Timmons (2017) found no significant change, whereas Poghosyan et al. (2019) reported a significant decrease in total costs of Medicaid claims per beneficiaries.

Cost citations other than Yang's meta-analysis:

- A 2018 American Enterprise Institute study found that across all five measures, the cost of primary care provided by nurse practitioners ranged between 11 percent and 29 percent less than the cost of primary care by physicians.[xiii] The gap was most pronounced for evaluation and management services—composing 80 percent of claims that primary care physicians and primary care nurse practitioners bill to Medicare. Beneficiaries treated by primary care nurse practitioners who received such services cost Medicare 29 percent less than beneficiaries who received their primary care from primary care physicians. The large differences in costs between primary care nurse practitioners and primary care physicians persisted even after taking into account that Medicare pays nurse practitioners at 85 percent of the rate of physicians for the same services. In other words, full deployment of primary care nurse practitioners doesn't only make sense – it saves dollars.

In 2015, Duke University economists conducted an analysis of the economic benefits that the State of North Carolina would experience if you were to remove the red tape that prevents patients from having direct access to APRNs.[xiv]

They found that it:

- Would ease the shortage of primary care providers in North Carolina;
- Could provide at least $433 million in savings to the health care system in your state, and
- Would also create at least 3,800 new jobs, generating tax revenues of more than $20 million.

Other benefits of ensuring that consumers have direct access to APRNs are:

- Caregiver Productivity. In other words, family members wouldn't need to take as much time off of work to drive their loved ones to appointments or provide direct care.
- It addresses needs of aging population, one of key factors in where people choose for retirement is access to health care.
- Aligns with care that North Carolina active-duty military and their families and veterans have.

So, that is a review of studies pertaining to consumers and APRN full practice authority. Specifically about quality, access to care, and cost.

Just to quickly wrap up, I want to point out that when opponents of legislation like the SAVE Act raise fears of what it would mean for patients, consider this:

- 24 states, some as long ago as 30+ years, have been operating under similar legislation.
- No state that has passed legislation like this has ever gone back and repealed it. In fact, it has been the opposite, states have moved to further remove barriers to care.
- Most recently, two states, Massachusetts and Delaware, that eased barriers during the COVID pandemic, have removed those barriers permanently.

Thank you and I would be happy to take any questions you might have.

---

[i] Yang, B.K., Johantgen, M.E., et al. (2021). State Nurse Practitioner Practice Regulations and U.S. Health Care Delivery Outcomes: A Systematic Review. Medical Care Research and Review, 78(3), 183-196.

[ii] National Academy of Medicine. (2021). The Future of Nursing 2020-2030: Charting a Path to Health Equity.

[iii] Institute of Medicine Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. (2011). The Future of Nursing: Leading Change, Advancing Health.

[iv] Pine, M., Holt, KD., Lou YB. (2003). Surgical mortality and type of anesthesia provider. AANA Journal. April, 71(2): 109-16.

[v] McMichael, BJ. (2021). Nurse Practitioner Scope of Practice Laws and Opioid Prescribing. Milbank Quarterly, 99(3): 721-745.

[vi] Reagan PB, & Salsberry PJ. (2013). The effects of state-level scope-of-practice regulations on the number and growth of nurse practitioners. *Nursing Outlook*, 6(1), 392-399.

[vii] Stange K. 2014. How does provider supply and regulation influence health care markets? Evidence from nurse practitioners and physician assistants. *Journal of Health Economics*, 33, 1-27.

[viii] Oliver G, Pennington L, Revelle S, & Rantz M. (2014). Impact of nurse practitioners on health outcomes of Medicare and Medicaid patients. *Nursing Outlook*, 62(6), 440-447.

[ix] Perloff J, DesRoches CM & Buerhaus P (2015). Comparing the cost of care provided to Medicare beneficiaries assigned to primary care nurse practitioners and physicians. *Health Services Research.* doi: 10.1111/1475-6773.12425.

[x] Graves, J. A., P. Mishra, R. S. Dittus, R. Parikh, J. Perloff, and P. Buerhaus. 2016. Role of geography and nurse practitioner scope-of-practice in efforts to expand primary care system capacity. *Medical Care* 54(1):81–89.

[xi] VanBeuge, S. (2018). APRN Growth in Nevada 2008-2018. A Power Point presentation provided to AARP by the author in 2018.

[xii] Rugs, D. et al. (2021). A preliminary evaluation of full practice authority of advance practice registered nurses in the Veterans Health Administration. Nursing Outlook, 69(2): 147-158.

[xiii] Buerhaus. P. (2018). Nurse Practitioners: A Solution to America's Primary Care Crisis. American Enterprise Institute.

[xiv] Conover, C., Richards, R. (2015). Economic benefits of less restrictive regulation of advanced practice nurses in North Carolina