AMERICAN SOCIETY OF PLASTIC SURGEONS ®
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VASPS
Virginia Society of Plastic Surgeons

February 9, 2021

The Honorable Louise Lucas, *Chair*
Pocahontas Building, Room E604
900 East Main Street
Richmond, VA 23219

RE: Oppose H.B. 1737

Dear Chairwoman Lucas:

On behalf of the Virginia Society of Plastic Surgeons (VASPS) and the American Society of Plastic Surgeons (ASPS), we are writing in opposition to H.B. 1737. ASPS is the largest association of plastic surgeons in the world, and in conjunction with the VASPS, represents more than 7,000 members and 94 percent of all board-certified plastic surgeons in the United States – including 251 board-certified plastic surgeons in Virginia. Our mission is to advance quality care for plastic surgery patients and promote public policy that protects patient safety.

Virginia's 2018 law allowing nurse practitioners (NPs) to practice independently following five years of collaborative practice represented a dangerous expansion of the NP's role in patient care. To now decrease the amount of time spent practicing collaboratively to *only* two years is reckless. There has not been adequate time to demonstrate that NPs can safely practice independently after five years of training to even begin considering a decrease in their training time. As a result, this effort to more significantly expand their scope of practice is, quite frankly, irresponsible.

Moreover, we are writing today to specifically address three areas which lobbyists for NPs have pointed to as justification for NP independent practice. In each of these areas, proponents have made claims about the benefits and safety of the change that do not square with data and analyses.

First, proponents claim that NPs have training equivalent to that necessary to practice primary care medicine. They do not. NPs do not receive sufficient medical training to provide them with the clinical expertise to practice outside of a collaborative agreement. Five years of collaborative practice with a physician – let alone two years – is an arbitrary benchmark to establish to allow NPs to then practice independently. The safe practice of medicine requires a foundational training that they simply do not have.

Most NPs receive their bachelor's degree in nursing, followed by a master's degree. While the master's degree and advanced clinical experience make these providers more skilled than other nurses, those factors in no way equate to the education gained through medical school.

In contrast, all primary care and specialty physicians receive a bachelor's degree, followed by a four-year degree from an accredited medical school. Medical students spend nearly 9,000 hours in lectures, clinical study, lab and direct patient care. The comprehensive physician training continues through post-graduate medical education, where all physicians are trained in accredited residency programs and receive at least

three additional years of training before becoming licensed and board certified. Ultimately, physicians will train for eight to sixteen years, as much as eight times as long as an NP. Only this depth and duration of training prepares a provider to safely execute all the responsibilities the bill seeks to grant to NPs.

Their training is in no way equivalent to that of physicians, who offer essential diagnostic and medical expertise to patients. So, while we do not agree with the current laws in place surrounding NPs and collaborative agreements in Virginia, five years of training is much safer than two.

The second claim NPs make that we'd like to address involves purported increases in access to primary care services in areas where there are current shortages. Granting NPs independent practice allows them to provide a broad scope of medical care, as noted above. It does not restrict practice to only primary care services. Even if it did, and even if NPs limited their independent practice to primary care, data from states that have granted nurses independent practice clearly shows that nurse practice locations correlate highly to primary care physician locations. In other words, they are not going to rural or physician-shortage areas to establish a practice and are therefore not addressing access problems. The American Medical Association has an easy-to-use workforce data mapping tool that can demonstrate this.[1]

Finally, we also strongly question NPs' claim that their independent practice reduces costs. While they may be reimbursed at a lower rate than physicians, ample evidence suggests increases in utilization across multiple measures when NPs are charged with decision-making. Here is a sample:

- OVERPRESCRIBING OF ANTIBIOTICS: A 2018 Infection Control & Hospital Epidemiology study showed that NPs and other advanced practice non-physicians prescribed antibiotics 15 percent more frequently than physicians.[2] A study limited to prescribing for acute respiratory infections found NPs prescribing 7 percent more frequently.[3] Increased antibiotic usage not only increases costs of care directly, but potentially indirectly because of the increased health risks associated with increased antibiotic resistant organisms.

- INAPPROPRIATE REFERRAL TO HIGHER-COST SPECIALISTS: A 2013 Mayo Clinic study estimated that inappropriate referrals to specialists by NPs and PAs could offset any potential savings from the increased use of NPs and PAs.[4]

- UNNECESSARY DIAGNOSTIC IMAGING: A 1998 study in the American Journal of Emergency Medicine found that NPs and PAs recommended imaging studies when physicians had not in 34 percent of emergency department cases.[5] A 2014 JAMA study found that NPs and PAs ordered more diagnostic imaging than primary care physicians, on both new and established patients.[6]

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[1] https://www.ama-assn.org/about/research/health-workforce-mapper

[2] 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.

[3] 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.

[4] 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

[5] Seaberg DC, MacLeod BA. Correlation between triage nurse and physician ordering of ED tests. Am J Emerg Med. 1998;16(1):8-11.

[6] 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.

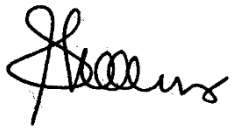
The last of the three areas of utilization is not only concerning because of implications for cost. It's important to remember that NPs are also unnecessarily exposing patients to dangerous radiation when they overprescribe diagnostic imaging.

Ultimately, H.B. 1737 may actually *increase* the cost of care while also undermining the physician-centered, team-based healthcare delivery model. Continuing to decrease the amount of time spent working in a collaborative agreement with a physician will likely have an escalating effect on those increased costs. The lead physician plays a critical role in determining whether the patient is a candidate for medical services, identifying potential complications before they arise, and triaging complications that may occur. The erosion of physician-centered, team-based healthcare will, in turn, negatively impact patient quality outcomes.

Generally speaking, NPs should continue to practice in collaboration with a physician who specializes in the medical care offered. This allows for seamless consultation in case the NP needs advice regarding care, more effective identification when referring to a specialist, and faster admission to a hospital, if needed. While we realize Virginia has already expanded APRN scope of practice to remove this vital collaboration after five years, we strongly urge you to not further erode NPs' training and team-based healthcare by decreasing five years to two.

Thank you for consideration of our comments. Please do not hesitate to contact Patrick Hermes, ASPS Director of Advocacy and Government Relations, at phermes@plasticsurgery.org or (847) 228-3331 with any questions or concerns.

Sincerely,



Joseph Losee, MD, FACS, FAAP
President, American Society of Plastic Surgeons

Helena M. Guarda, MD
President, Virginia Society of Plastic Surgeons

cc: Members, Senate Committee on Education and Health