Keep the *Team*

Maintain physician-led, team-based care across Pennsylvania.

This legislative session you will be asked to vote on legislation that will allow nurse practitioners (NPs) to diagnosis and treat your constituents without the benefit and expertise of direct physician involvement. Last year, the General Assembly unanimously approved legislation (Act 198) that recognized that healthcare delivery is a team effort and that physicians, the most highly trained provider, should lead the team. Existing law appropriately ensures that patients cared for by NPs have direct access to a physician when their care requires a more highly trained professional.

7 reasons to oppose the independent licensure of nurse practitioners

1. **The best and most effective care occurs when a team of health care professionals with complementary—not interchangeable—skills work together.** Recently, the Pennsylvania General Assembly embraced this model of care through enactment of the Patient Centered Medical Home Act (Act 198 of 2014)— a law which promotes integration and teamwork among providers to improve health care outcomes and reduce health care costs within Medicaid. Studies have consistently shown that when health care professionals work together in a coordinated, efficient manner, care improves.

2. **The collaborative requirement between NPs and physicians enhances and does not impede the ability of NPs to deliver quality patient care.** NPs can see patients independently, order lab or diagnostic tests, make referrals, and prescribe medication as outlined in their collaborative agreement. The collaborative requirement makes this possible, while ensuring that patients have direct access to a physician when their care requires a more highly trained professional. Collaboration also ensures that NPs have access to a physician for regular consultation—a precaution which increases safety and reduces the risk of poor patient outcomes.

3. **The education and training of a NP falls significantly short of the education and training of a physician.** With only 500 to 720 hours of direct patient care acquired through training, the average NP has less clinical experience than a physician obtains in just the first year of a three-year medical residency. Furthermore, unlike NP postgraduate educational requirements—which vary widely and can be completed in as little as 18 months—a physician's educational path is uniform nationwide, with standardized medical curriculum, clinical training, and licensure. A physician undertakes a minimum of 7 years of exhaustive medical education and training, during which they complete 12,000 to 16,000 hours of direct patient care, before they can practice independently.

4. **Collaboration requirements do not prevent NPs from currently practicing in rural and underserved areas.** The process of collaboration requires immediate availability of the physician by direct communication, radio, telephone or telecommunications; a predetermined plan for emergency services; and availability of the physician to the NP on a regularly scheduled basis for the purpose of referrals and review of other medical protocols. There is no evidence that doing away with this flexible safeguard and granting NPs independent licensure will do anything to improve access to care.

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5 **Current licensure standards are not arbitrary; they serve an especially important function in supporting critical safety and quality objectives.** By definition, collaboration is a process in which a NP works with one or more physicians to deliver health care services within the scope of the NP's expertise and with minimal administrative burden. The implementation of collaborative agreements is seamless when providers coordinate care efficiently and maximize the complementary skill sets of both professionals—the true essence of patient-centered, team-based care.

6 **A majority of states require NPs to have a physician's collaboration or supervision in order to practice, with many states requiring even more stringent oversight than what currently exists in Pennsylvania.** Additionally, in those states that have granted NPs full practice autonomy, neither access to care nor cost savings have substantially increased. These states continue to suffer the same dilemma of attracting providers to rural and underserved areas.

7 **Increasing the responsibility of NPs is not the solution to a shortage of physicians.** Allowing NPs to independently practice would afford nurses the same authority and clinical autonomy that physicians have, without the education and training that our state currently requires of physicians. Claims of a physician shortage do not justify granting NPs full clinical autonomy; and an increased demand for services should not marginalize appropriate medical education and training.

	Primary Care physician (M.D. or D.O.)	**Nurse Practitioner**
Length of graduate level education	*4 years*	*2-4 years*
Years of residency and/or fellowship (clinical training)	*3-7 years*	*n/a*
Total hours of direct patient care required through training	*12,000 – 16,000 clinical hours*	*500-720 clinical hours*