**Testimony to the Michigan House Health Policy Committee**
**relevant to Senate Bill 2 (S.B. 2), licensure of advanced practice registered nurses**

**September 9, 2014**

My name is Ani Turner and I am the Deputy Director of the Center for Sustainable Health Spending at Altarum Institute, a nonprofit health research organization headquartered in Ann Arbor. My background includes degrees in Mathematics and Applied Economics from the University of Michigan and over 25 years of experience analyzing issues related to health and health care. One of my areas of professional focus has been data and projections related to the health workforce. As this committee considers S.B. 2, I would like to briefly present relevant findings from projections of the future supply and demand for clinicians, compare Michigan's advanced practice registered nurse (APRN) practice environment to other states, and highlight the evidence on outcomes we might expect under S.B. 2.

Like much of the nation, Michigan faces an increase in demand for health care at the same time that a large proportion of our physicians will be reaching retirement age. Michigan's population, like the nation's, is aging. About one in seven people in Michigan today is 65 or older. In just a decade, one in five will be 65 or older.[1] Older populations are more likely to have one or more chronic conditions and to have a higher demand for health care services.

In addition, more Michiganders are gaining health insurance under the provisions of the Affordable Care Act. As of September 8, 2014, over 375,000 people were newly enrolled in the Healthy Michigan program.[2] This figure exceeds the first year enrollment goal of 322,000, but is still less than the total estimated eligible Healthy Michigan population of 477,000. Another 275,000 people selected a health plan through Michigan's health insurance exchange for 2014;[3] again, a large number of people, but representing less than half of those potentially eligible for insurance through the exchange. With thousands more potentially eligible for expanded coverage and probable lags in the newly insured receiving care, it is likely that the full effect of expanded coverage has not yet been felt.

Even as the demand for services increases, much of our physician and APRN workforce will reach retirement age in the next decade. Over half (53%) of Michigan physicians are age 55 or older, as are about half of APRNs in Michigan (50% of nurse practitioners, 45% of certified registered nurse anesthetists, and 52% of certified nurse midwives).[4]

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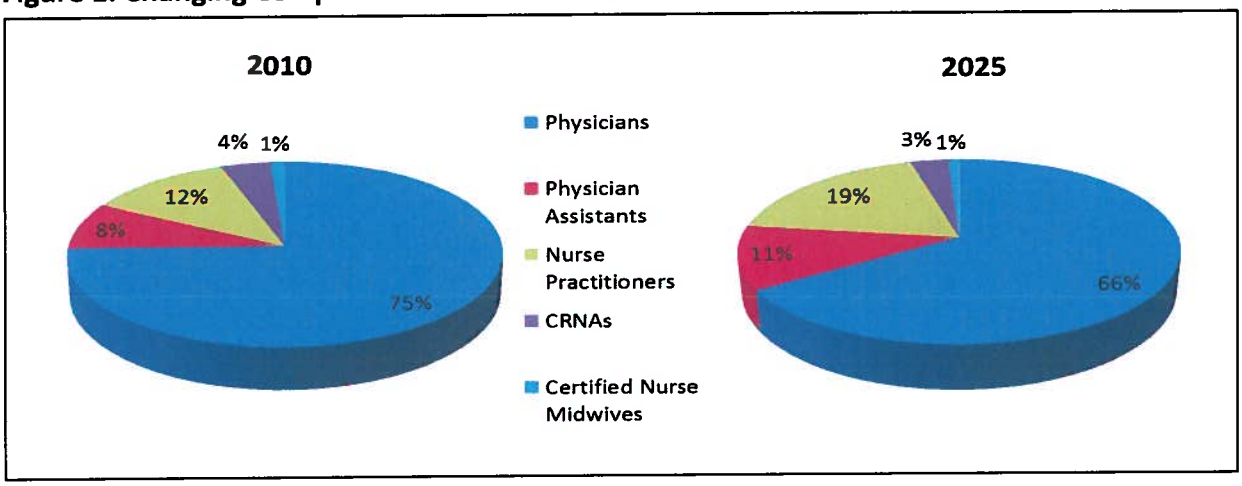
[1] Population projections developed for the Michigan Department of Transportation by the Institute for Research on Labor, Employment, and the Economy, University of Michigan, March 2012.
[2] Michigan Department of Community Health.
[3] Kaiser Family Foundation State Marketplace Statistics.
[4] Michigan Department of Community Health Survey of Physicians: Survey Findings 2012 and Survey of Nurses 2013: Analysis of Advanced Practice Registered Nurses.

We can quantify the impact of trends such as the aging of the population and expected physician retirements using health workforce projection models. Such models typically project supply by starting with the current supply, adding in the number of new clinicians graduating from training programs, and subtracting expected deaths and retirements over time. For a particular state, net migration into or out of the state is also considered. Models of clinician demand typically look at how the population uses clinician services by age, sex, level of insurance coverage, and other factors, and projects those needs into the future based on the expected size and characteristics of the population.

Workforce projection models that automate these types of calculations and allow testing of various assumptions and scenarios have been developed by federal and state governments and by organizations such as the Association of American Medical Colleges and the Robert Graham Center of the American Academy of Family Practitioners. Michigan commissioned such a study for physicians in 2006. ***Every such modeling effort at the state or national level in recent years has projected a significant shortage of physicians.*** National models show shortages of over 90,000 physicians by 2020,[5] while a shortage of about 4,500 physicians was projected for Michigan.[6]

Less widely known than the projections of physician shortages is that ***models that also include APRNs and physician assistants (PAs), find that the shortage of physicians could be largely alleviated if APRNs and PAs are fully integrated into health care delivery.***[7] The supply of APRNs and PAs has been growing more rapidly than the supply of physicians, so that the nation's clinician workforce is projected to go from three-quarters physicians in 2010 to two-thirds physicians in 2025 (Figure 1). The severity of the clinician shortage in the U.S. and in Michigan will depend on how well the skills of this new clinician workforce can be leveraged.

**Figure 1: Changing Composition of the U.S. Clinician Workforce**




*Source: Unpublished Altarum Institute U.S. clinician supply projections developed under contract to the National Center for Health Workforce Analysis, Health Resources and Services Administration.*

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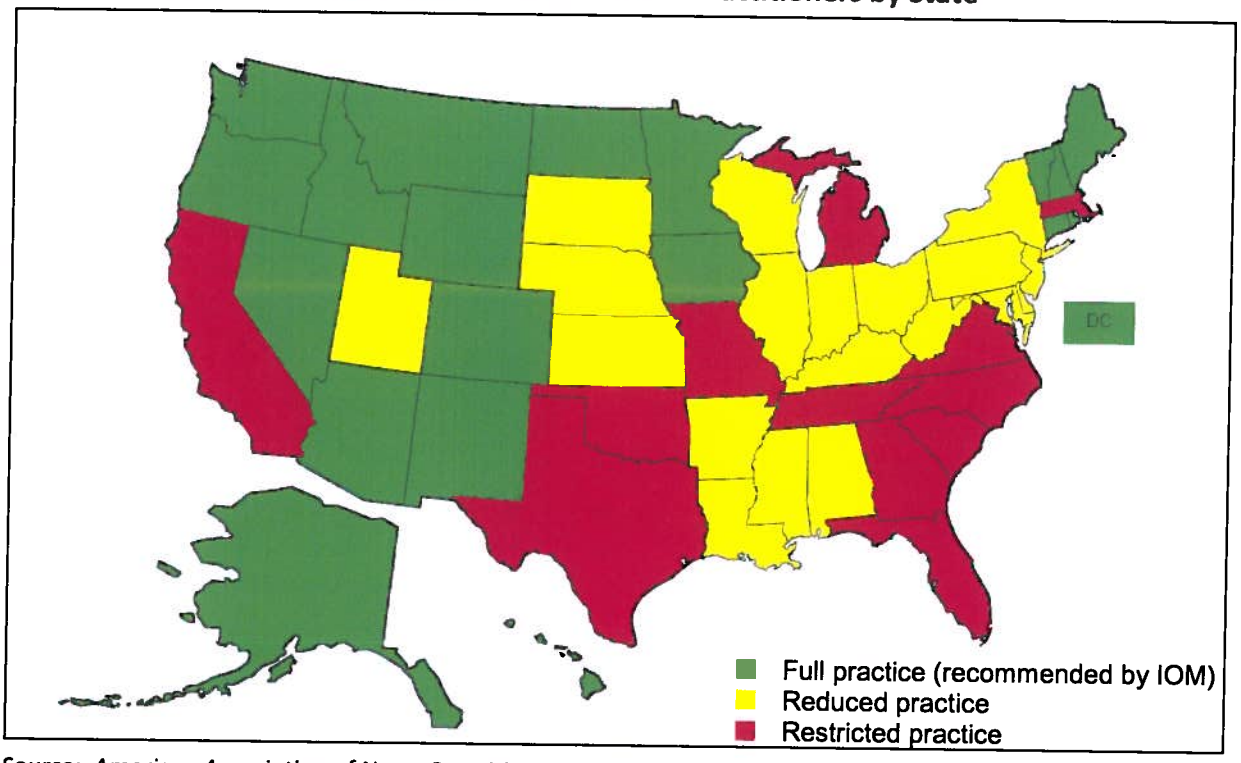
[5] Association of American Medical Colleges, Center for Workforce Studies, June 2010 analysis.
[6] Center for Health Workforce Studies, SUNY at Albany, *Michigan Physician Supply and Demand through 2020,* prepared for the Michigan Blue Ribbon Committee on Physician Workforce, December 2006.
[7] National Center for Health Workforce Analysis, *Projecting the Supply and Demand for Primary Care Practitioners through 2020,* November 2013.

The Institute of Medicine, in collaboration with the Robert Wood Johnson Foundation, brought together a diverse team of national experts who conducted working sessions, gathered and assimilated relevant research, conducted public meetings and site visits, and spent over a year studying the capacity of the nursing workforce to meet the nation's future health care and public health needs. The study concluded that all APRNs should be practicing to the full extent of their education and national certification, and that "what nurse practitioners are able to do once they graduate varies widely for reasons that are related not to their ability, education or training, or safety concerns, but to the political decisions of the state in which they work."[8]

How does Michigan compare to other states in the APRN practice environment? The map in Figure 2 shows that Michigan is among the 12 most restrictive states for the practice of nurse practitioners (NPs). It is the only state in the Midwest so restricted. The map shows 20 states (including DC) with practice laws consistent with the IOM recommendations (green), and another 19 states somewhere in between (yellow). Thus, in 39 states, NPs are less restricted in their practice than in Michigan.

**Figure 2: Degree of Practice Restrictions for Nurse Practitioners by State**




*Source: American Association of Nurse Practitioners*

The presence of many other areas of the country with less restrictive practice environments means we don't have to speculate on what might happen under S.B. 2 – we can look at what is happening now in most of the rest of the nation. A March 2013 study compared various measures of quality of care, frequency of routine checkups, and emergency room use between states, taking into account the timing of changes to nurse practice acts. The study found that in states that allow NPs to practice and

[8] Institute of Medicine, *The Future of Nursing: Leading Change, Advancing Health*, National Academies Press, 2011.

prescribe without physician supervision, the frequency of routine checkups increases and various measures of care quality improve. Patients with conditions that respond to primary care also showed reduced emergency room use, suggesting both an improvement in health and cost savings in the provision of care.[9] The study found that improvements came about because populations had greater access to a health care provider, and there was a reduction in the administrative burden to both physicians and APRNs, allowing more time for patient care.

Many other studies and syntheses of research conducted over the past few decades have found no evidence of lower quality of care or outcomes under independent APRN practice. As stated by the Institute of Medicine:

> *...the contention that APRNs are less able than physicians to deliver care that is safe, effective, and efficient is not supported by the decades of research that has examined this question... No studies suggest that care is better in states that have more restrictive scope-of-practice regulations for APRNs than in those that do not. Yet most states continue to restrict the practice of APRNs beyond what is warranted by either their education or their training."*

S.B. 2 offers an opportunity to improve access to care and reduce health care spending in Michigan, as other states have done, by allowing APRNs to fully apply their training to serve our growing health care needs and alleviate our growing clinician shortages.

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[9] Traczynski, Jeffrey and Victoria Udalova, *Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes*, Working paper, March 15th, 2013 and presentation at the 5th Biennial Conference of the American Society of Health Economists, June 25, 2014.