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AMERICAN COLLEGE OF
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Testimony for the Joint Legislative Budget Higher Education Hearing

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9:30AM

Honorable Chairs and Members of the Senate and Assembly Higher Education Committees, Senate Finance Committee and Assembly Ways & Means Committee, thank you for the opportunity to submit testimony related to our priorities for the SFY 2024-25 Executive Budget Proposal.

The New York American College of Emergency Physicians (NYACEP) represents over 3,000 dedicated emergency medicine physicians committed to speaking out for broad access to quality health care, especially emergency health services for all citizens. Currently in New York State we are facing an opioid epidemic, violence in our emergency departments, a shortage of physicians and an erosion of the patient safety standards that have been a hallmark of New York State's healthcare system for years.

Outlined below are our SFY 2024-25 State budget priorities. We appreciate your consideration and ask for your support.

SUPPORT Proposals To:

1. **SUPPORT: 3-Day Supply of Narcotics (Buprenorphine) Proposal (H/MH Article VII Part U)**
   NYACEP strongly supports the proposal to align State law with recently revised DEA regulations that permit providers in hospital emergency departments to dispense up to a three-day supply of the schedule III-V narcotics (Buprenorphine) for the purpose of initiating maintenance or detoxification treatment while arrangements are being made for a patient referral.

   Patients suffering from an acute overdose, intoxication or withdrawal often present to the Emergency Department (ED) for treatment. The nature of addiction often causes these patients to repeatedly present to the ED. These visits represent a critical opportunity to intervene. Many emergency medicine (EM) clinicians recognize these opportunities as a "call for help" but do not feel empowered to make a difference, typically given a lack of connection to resources outside the ED. While EM physicians might be very comfortable treating the acute phase of illness, the transition to outpatient care is something we typically have no control over. The standard is often to provide information for local addiction treatment services upon discharge. This proposal enables EM clinicians to provide a bridge to help these patients in the short-term between when they are discharged and are able to be referred to the proper outpatient care, enabling their patients to have more success in treating their addiction.

   Aligning state law with the recently revised DEA regulations would enable ED physicians to do more for their patients and help provide more complete care to those individuals battling addiction. NYACEP asks that you support this proposal for inclusion in the final budget.

OPPOSE Proposals To:

1. **OPPOSE: Nurse Practitioner (NP) Modernization Act Extender (H/MH Article VII Part P)**
   NYACEP is strongly opposed to extending the exemption for NPs with over 3,600 hours to practice independently without a collaborative agreement with a physician. The shift in New York State that allowed for NP independent practice represents a safety risk to patients and leads to increased health care costs. Nurse practitioners have no residency

requirement and only 500-720 hours of clinical training, their education is far less rigorous than the training of physicians. By sharp contrast, physicians complete 4 years of medical school plus 3-7 years of residency, including 10,000-16,000 hours of clinical training.

It is more than just the vast difference in hours of education and training, it is also the difference in rigor and standardization between medical school/residency and nurse practitioner programs. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological and behavioral aspects of human conditions. This period of intense study is supplemented by two years of patient care rotations through different specialties, during which medical students assist licensed physicians in the care of patients. During clinical rotations, medical students continue to develop their clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine. Following graduation, students must then pass a series of examinations to assess a physician's readiness for licensure. At this point, medical students "match" into a 3-7 residency program during which they provide care in a select surgical or medical specialty under the supervision of experienced physician faculty. As resident physicians gain experience and demonstrate growth in their ability to care for patients, they are given greater responsibility and independence. NP programs do not have similar time-tested standardizations. In summary, NP education and training to deliver patient care is not interchangeable with physician education and training.

In the January 2022 edition of the Journal of the Mississippi State Medical Organization, Batson et al. published an article entitled "Mississippi Frontline – Targeting Value-based Care with Physician-led Care Teams". This was a retrospective study looking at almost

10 years of data from that Hattiesburg Clinic looking at over 300 physicians and 150 advanced practice nurse and physician assistant providers. *The study found that allowing advance practice providers to function with independent panels failed to meet goals in the primary care setting of providing patients with an equivalent value-based experience for quality of care, keeping costs stable and meeting patients' expectations and satisfaction with healthcare delivery*.

Another recent study showed that, in states that allow independent prescribing, NPs were 20 times more likely to overprescribe opioids than those in prescription-restricted states. Given the current opioid epidemic now more than ever it is critical that patients receive the highest standard of care and that is a team based effort. Health care is a team effort that is optimized when the team members, including the patients, work together-communicating, merging observations, expertise, and decision-making responsibilities-with the common goal of providing the safest and most appropriate care. Effective teams, whether in health care, sports, or other arenas, have leaders. In health care, those leaders are the physicians who have 7 years or more of postgraduate education and at least 10,000-16,000 hours of clinical experience and bear the burden of responsibility for appropriate diagnosis and care. NYACEP believes there is a place for nurse practitioners in the healthcare workforce. However, in high stakes scenarios, with undifferentiated, acutely ill patients, as present in the ED, nurse practitioners are best suited as a member of a physician led team.

NYACEP strongly opposes extending the Nurse Practitioner Modernization Act. NYACEP respectfully asks the Legislature to reject this proposal and sunset Nurse Practitioner independent practice in order to enable patients to receive care in a team based effort which has been proven to provide the highest standard of care.

2. **OPPOSE: Expanded Physician Assistant (PA) Scope of Practice (H/MH Article VII Part Q)**

NYACEP is strongly opposed to expanding PA scope of practice which would allow PAs to practice without the supervision of a physician independently in primary care or in hospitals if they have practiced more than 8,000 hours. While physician assistants are an integral part of the healthcare team, the current care and training model for PAs is with physician supervision. We believe this proposal would fragment patient care and compromise patient quality, safety and outcomes. The current care model expands the primary care reach at a time when there is not only a shortage of primary care physicians but most health care practitioners.

The ability for PAs to practice without physician supervision would sacrifice quality for our patients as the training and experience of PAs is not equal to that of physicians. In a recent Medical Society survey, 75% of the physician respondents indicated that advanced care practitioners working independently during the pandemic under the Governor's Executive Orders (waiving physician supervision requirements) had committed an error while treating a patient; 90% indicated that the error could have been prevented had there been physician oversight. PAs have less training in the form of didactic and clinical

education in obtaining degrees, and the training is built around a model of supervision with physicians.

NYACEP has long held the best emergency medical care is provided and led by American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) certified emergency physicians. Patients expect care to be given or directly supervised by an emergency physician. This includes all levels and locations of emergency departments (EDs), including rural environments, where there is often a lower concentration of board-certified emergency physicians. NYACEP believes PAs serve an integral role within the physician-led emergency department care team. Recognizing variations in resources and access, patients should be able to expect the same quality of emergency physician-led care from PAs, regardless of the location and setting of the ED to which they present.

NYACEP believes patients are entitled to receive care and services from health care practitioners who are adequately trained and educated in accordance with provisions of the New York State Education Law to maintain patient safety and quality of care. For emergency physicians, after earning an undergraduate degree, one attends medical school for four years. During these four years, the typical medical student will complete approximately 2,500-3,000 lecture hours and 5,722 clinical hours. Following medical school, to become board certified, one must complete an Emergency Medicine (EM) residency of either three or four years, which typically includes 6,000-10,000 clinical hours of which 4,225 hours will be spent completing supervised specialty training in the ED. After residency, some physicians may complete fellowship training to further enhance their clinical practice in areas such as ultrasound, critical care, pediatric emergency medicine, EMS disaster medicine, toxicology, and other related disciplines. Board certification in emergency medicine is granted by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Medicine (AOBEM). To become certified, an emergency physician must pass both the written (qualifying) and oral (certifying) exams. Once initially board certified, the physician must then complete ABEM's Continuing Certification requirements to retain certification.

There have been various studies that have shown that non-physician practitioners order more diagnostic imaging than physicians for the same clinical presentation, which not only increases health care costs but also threatens patient safety by exposing them to unnecessary radiation. In a study by the Journal of the American College of Radiology that analyzed skeletal x-ray utilization for Medicare beneficiaries from 2003 to 2015, *ordering of diagnostic imaging increased substantially-more than 400% by non-physicians, primarily NPs and PAs during this time frame.*

Finally, in the January 2022 edition of the Journal of the Mississippi State Medical Organization, Batson et al. published an article entitled "Mississippi Frontline – Targeting Value-based Care with Physician-led Care Teams". This was a retrospective study looking at almost 10 years of data from that Hattiesburg Clinic looking at over 300 physicians and 150 advanced practice nurse and physician assistant providers. *The study found that allowing advance practice providers to function with independent panels*

failed to meet goals in the primary care setting of providing patients with an equivalent value-based experience for quality of care, keeping costs stable and meeting patients' expectations and satisfaction with healthcare delivery.

In sum, while PAs play a critical role in providing care to patients, their skillsets are not interchangeable with that of fully trained physicians. Patient care would be adversely affected by removing requirements for physician supervision of PAs and this would further deepen the healthcare disparities in our state with unequal levels of care provided in communities.

This would be a very significant divergence from the care model that has been in place in New York since inception. This change should not be hastily enacted as part of the state budget. Rather, much further discussion and objective studies are needed to demonstrate the value and ensure that it does not result in health care costs increasing and most importantly, that patient quality of care is not sacrificed. **For these reasons, NYACEP strongly urges your opposition to this proposal and requests that it be rejected in the budget.**

NYACEP greatly appreciates your continued interest and support for physicians and emergency medicine, we work everyday to respond to the health emergencies of your constituents. Thank you for your recognition and support of our members and their mission to support quality emergency medical care. New York State trains the greatest number of residents in the country but they leave due to the difficult malpractice environment and legislation like this further promotes physician shortages in New York State.