Ohio ACEP
American College of Emergency Physicians
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Chair Gross, Vice Chair Barhorst, Ranking Member Baker, and members of the House Medicaid Committee, thank you for the opportunity to speak with you today. My name is Dr. Christina Campana, and I am here today on behalf the Ohio Chapter of the American College of Emergency Physicians (ACEP) in opposition to HB 508. Ohio ACEP represents over 1600 emergency physicians, residents, and medical students.

I am an emergency physician and the President of Ohio ACEP. My entire 16 years of practice have been in both academic and community settings, and I actively work in all practice environments, including a rural critical access hospital. I am a published physician researcher and former medical journal reviewer, Associate Professor, serve on national ACEP Council, and am a national Board Examiner for the American Board of Emergency Medicine.

This testimony does not diminish the extraordinary contributions of Advanced Practice Providers (APPs) in caring for patients. They are valued and essential members of a healthcare team. Medicine, particularly Emergency Medicine (EM), works best as a team sport, and physician-led care is central to that success. Today, I will outline why Standard Care Agreements (SCAs) are far more than "just a piece of paper"—they are a vital safeguard for patient safety and quality. I will review the growing body of data showing that unsupervised practice has not improved outcomes or access and share some examples from our Ohio ACEP members who have seen firsthand the challenges that arise when collaboration is not followed from care models.

Proponents of HB 508 have described SCAs as "just paperwork", but that characterization misses their real purpose. These agreements are the framework that defines how the healthcare team works together—how patients are triaged, complex cases are escalated, and quality and safety are maintained. Emergency Medicine is like working in a mine field wearing clown shoes: high-risk, high acuity, high litigation. "The eyes cannot see what the mind doesn't know". A routine complaint may seem simple and is often attributed to common causes; however, the depth of training and education of an attending physician will recognize that simple symptoms can also be a sign of a life-threatening condition. The physician-led model ensures that there's immediate access to a broader clinical differential when that "routine" complaint turns out to be serious. In EM, a SCA isn't a form to be filled; it's a living document that sets expectations for consultation, collaboration, and patient protection. It's how we make sure every patient gets the benefit of the entire team's training and experience, which is vital in high-acuity or uncertain situations such as the emergency department (ED) where patients are the sickest and often present with life-threatening problems. Removing SCAs would dismantle the safety net in the ED and put patients at risk.

While proponents of this bill often cite no difference in care as a reason for removing SCAs, the data does not support that statement. Outdated and underpowered data has been used to support the unsupervised practice of medicine. What evidence does exist? The short answer is that we don't have much, if any, at all. What *is* supported in the data is that APPs can provide high quality care, but when in physician-led teams. Since the Cochrane Study has been quoted by proponents and is likely the most cited reference by APP organizations, I'd like to briefly summarize the studies that were used to

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generate the statement that “Nurse practitioners (NPs) can probably provide equal or better care and health outcomes for patients”.[1] In 2018, Cochrane looked at almost 9000 studies regarding unsupervised practice of NPs. Of those studies, only 18 were found to be of sufficient quality to use in their analysis. In summary, all of the studies cited only involved stable, low-acuity patients with minor problems, diagnoses had already been made, no critically ill patients were seen, and economic and marketing endpoints were measured, such as patient satisfaction and whether or not a patient would even be willing to see an NP. *None* of the studies examined the ability to diagnose and 17 out of 18 studies were done under some form of physician supervision.

Multiple large studies, specifically from Standford University and Hattiesburg Clinic show that when NPs practice independently, patients do not experience better access, outcomes, or lower costs. In fact, that data shows high rates of unnecessary testing, imaging, and increase in ED referrals, leading to increased costs without measurable improvement in quality of care.[2] You’ve heard proponents of this bill comment that the Veterans Health Administration (VHA) granted unsupervised practice over 10 years ago. What you haven’t heard is their data and outcomes from doing so. The Standford Study specifically looked at unsupervised practices of NPs in the VHA EDs and found the aforementioned results and that assigning just 25% of emergency cases to NPs resulted in net costs of $74 million annually for the VHA.[3] In 2022, the *Journal of Nursing Regulation*, one of the top 5 nursing journals in the world, found that due to wide variability in NP education, training, licensure, and certification that NPs should not practice independently in the ED regardless of state law or hospital policy, to protect patient safety.[4] So, while the goal of expanding care is admirable, the data makes it clear that removing SCAs does not achieve it and in fact fragments care while driving up costs. These recent studies have also played a role in neighboring states that have passed legislation mandating a physician in the ED 24/7.

Our ACEP members have shared numerous stories that show why physician oversight matters. The stories are abundant and involve misdiagnoses, unnecessary ED visits, inappropriate prescribing and management, and increased specialist referrals. One physician told me that their hospital is putting a doctor back in triage because APPs were over-ordering tests, leading to longer wait times, extra radiology workload, and unnecessary costs for the patients. These aren’t isolated events; they represent the gaps that appear when clinical decision making becomes siloed. In the ED, SCAs help prevent these types of outcomes—not by limiting scope or value, but by ensuring that patients benefit from the full spectrum of medical expertise available. It’s not about hierarchy, it’s about safety, teamwork, and accountability for the patients we serve.

In closing, we should maintain standards and collaboration that keep patients safe and ensure consistent, high-quality care across Ohio. Removing physician involvement does not expand access, improve outcomes, or lower costs—the data, workforce trends, and the stories from our front lines make that clear. As emergency physicians, we work side by side every day with APPs and deeply respect their contributions. Just as no pilot flies without co-pilots and a checklist, medicine works best when we work together—with clear roles, shared responsibility, and accountability to our patients. For these reasons, I urge you to oppose HB 508. Thank you, Chair Gross, Vice Chair Barhorst, Ranking Member Baker, and members of the committee for the opportunity to present testimony. I am happy to answer any questions.

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[1] Laurent et al. *Cochrane Database Sys. Rev*. 2018 Jul 16; 2018 (7).

[2] Batson et al. Targeting Value-Based Care with Physician-led Care Teams*. Journal of the Mississippi State Medical Association*. Jan 2022. Vol LXIII;No.1,pp19-21.

[3] Chan D.C. et al. Productivity of Professions: Evidence from the Emergency Department. *National Bureau of Economic Research* Working Paper No 30607. Oct 2022 (Revised Jul 2024). DOI: 10.3386/w30608.

[4] Lavin et al. Analysis of Nurse Practioners' Education Preparation, Credentialling, and Scope of Practice in U.S. Emergency Departments*. J of Nursing Regulation*. Vol 12, Issue 4; pp50-62. Jan 2022.

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