American Academy of Dermatology Association

Scope of Practice Toolkit

November 2021

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EXECUTIVE SUMMARY

Scope of Practice Toolkit

Each year, the AADA tracks hundreds of scope of practice bills across the US. Scope of practice threats to the practice of dermatology come from several fronts including:

- Non-physician health care providers (eg, nurse practitioners, physician assistants, optometrists, dentists, dental hygienists, pharmacists, naturopaths).
- Estheticians, cosmetologists, and electrologists.

As state policymakers search for ways to reduce health care costs and increase patient access, non-physician clinicians have seized the opportunity to expand their scope of practice. The COVID-19 pandemic accelerated this effort.

The AADA opposes efforts to allow independent practice by non-physicians and advocates for a physician-led, team-based approach to care that ensures the safety and best outcomes for each patient. It is the AADA's position that the optimal dermatologic care is delivered when a board-certified dermatologist provides direct, on-site supervision to all non-dermatologist personnel. We advocate at the federal and state levels to ensure each member of the care team is practicing at a level consistent with their training and education.

Our success in this effort depends on the active engagement by dermatologists working through their state societies with support and guidance from the AADA. The Scope of Practice Toolkit provides state dermatology societies with critical resources including:

- Template comment letters.
- Sample testimony.
- Messaging guidance and leave behind materials.
- Relevant research citations.

Scope of Practice Toolkit

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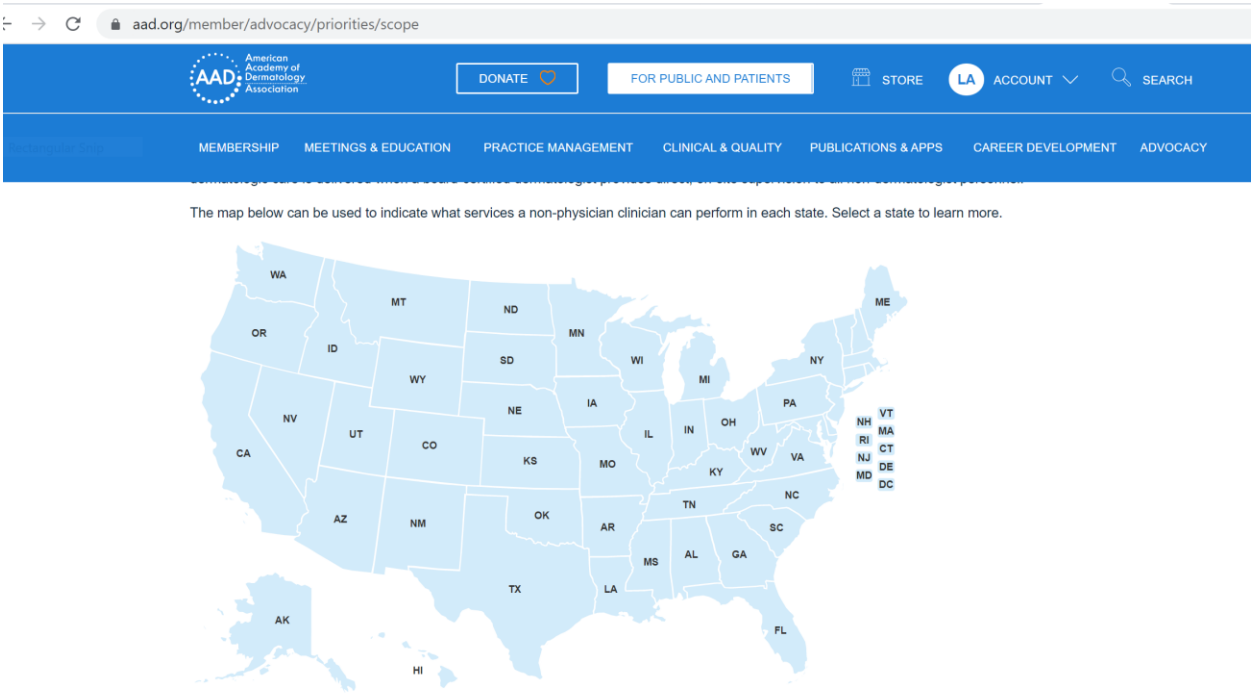
Visit the below link to view an interactive map of each state's scope of practice laws

aad.org/member/advocacy/priorities/scope



ASDSA American Society for Dermatologic Surgery ASSOCIATION

Wisconsin Dermatological Society ~est. 1951~

July 26, 2021

The Honorable Patrick Testin
Chair, Senate Health Committee
Room 8 South
State Capitol
PO Box 7882
Madison, WI 53707

Dear Chair Testin,

On behalf of the undersigned organizations representing approximately 141 board-certified dermatologists in Wisconsin, we urge you to oppose SB 394, which would authorize nurse practitioners (NPs) to practice independently. Efforts to permanently loosen state scope of practice laws during the COVID-19 pandemic are dangerous and short-sighted. The diagnosis and treatment of COVID-19 patients can be complicated and necessitates treatment by a physician-led team.

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Studies demonstrate differences in patient outcomes and/or utilization rates. A 2015 study from the University of Wisconsin comparing malignancy rate of biopsies performed by dermatologists versus non-physicians suggests that non-physicians, having less acute diagnostic skills, perform more biopsies, thus increasing patient morbidity and the cost of care.[1] A 2013 study by the Mayo Clinic comparing the quality of patient referrals from physicians, nurse practitioners, and physician assistants found that the inappropriate referrals to tertiary referral centers by nurse practitioners and physician assistants could offset any potential savings from the increased use of nurse practitioners and physician assistants.[2] Additionally, there has been a recent rapid increase in malpractice claims filed against nurse practitioners, particularly for poorly performed cosmetic procedures.[3]

The education and training of a nurse practitioner fall significantly short of the education and training of a physician. Board-certified dermatologists evaluate and treat over 3,000 different diseases and conditions. Dermatologists see patients of all ages - from newborns to the elderly. With only 500 to 720 hours of direct patient care acquired through training, the average nurse practitioner has less clinical experience than what a physician obtains in just the first year of a three-year dermatology residency. Furthermore, unlike nurse practitioner postgraduate educational requirements—which vary widely, can be done online, and can be completed in as little as 19 - 24 months—a physician's educational path is uniform nationwide, with standardized medical curriculum, clinical training, and licensure.

Board-certified dermatologists undertake a minimum of 8 years of medical education and training (4 years of medical school, 1 year of internship, 3 years (minimum) of dermatology residency), during which they complete 12,000 to 16,000 hours of direct patient care, before they can practice independently. Dermatologists must pass 3 standardized USMLE training exams to become licensed physicians and then pass a comprehensive examination at the conclusion of their residency training to become board-certified in dermatology.

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[1] Bennett, D., Xu, Y (2015, August). Biopsy Use in Skin Cancer Diagnosis: Comparing Dermatology Physicians and Advanced Practice Professionals, JAMA Dermatol. August 2015 Volume 151, Number 8.

[2] 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.

[3] Jalian H. R., Avram, M.(2013,October 16). Increased Risk of Litigation Associated With Laser Surgery by Nonphysician Operators. *JAMA Dermatol*.doi:10.1001/jamadermatol.2013.7117.

Existing law does not prevent nurse practitioners from currently practicing in rural and underserved areas. There is no evidence that eliminating safeguards found in collaborative practice agreements improve access to care. The geographic mapping initiative of the American Medical Association demonstrates that non-physician providers are not located in rural or underserved areas, but rather are concentrated in the same geographic areas as physicians.

Public supports physician-led team-based care. The public supports the physician-led team care model. According to four nationwide surveys, 84% of respondents prefer a physician to have primary responsibility for their diagnosis and management of their health care, and 91% of respondents said that a physician's years of medical education and training are vital to optimal patient care, especially in the event of a complication or medical emergency.[4]

As physicians, our number one priority is the health and welfare of our patients. We appreciate the opportunity to provide written comments on this important public health issue and urge you to oppose SB 394. We remain committed to providing high quality care and serving the best interests of our patients through physician-led team-based care. For further information, please contact the Wisconsin Dermatological Society at widermsociety@wildapricot.org.

Sincerely,

American Academy of Dermatology Association
American Society for Dermatologic Surgery Association
Wisconsin Dermatological Society

[4] Surveys of nearly 1,000 adults on behalf of the AMA Scope of Practice Partnership were conducted between 2008 and 2018.

May 3, 2021

Members of Louisiana House of Representatives
State of Louisiana
State Capitol
P.O. Box 44486
Baton Rouge, LA 70804-4486

Re: **Opposition to HB 442**

Dear Members of the Louisiana House of Representatives,

On behalf of the nearly 16,500 U.S.-based members of the American Academy of Dermatology Association ("Academy"), we oppose HB 442, which would eliminate physician supervision of physician assistants. Efforts to permanently loosen state scope of practice laws, especially during the current COVID-19 pandemic, are dangerous and short-sighted. Moreover, the diagnosis and treatment of COVID-19 patients can be complicated and necessitate treatment by a physician-led team. We urge you to oppose HB 442 for the reasons set forth below.

The best and most effective care occurs when a team of health care professionals with complementary—not interchangeable—skills work together. Dermatologists and physician assistants have long worked together to meet their patients' needs. This is because the physician-led team approach to care works. HB 442 seeks to jeopardize this success by eliminating the physician's role as the leader of team-based care, which will lead to fragmented care.

Efforts to disassemble the physician-physician assistant relationship will further compartmentalize the delivery of health care. The optimal way to provide dermatologic care is under the direction of a board-certified dermatologist, who retains ultimate responsibility for

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patient care and tasks delegated to care team members.[1] The dermatologist also remains responsible for ensuring that all delegated activities are within the scope of each care team member's training and level of experience.

The education and training of a physician assistant falls significantly short of the education and training of a physician. Board-certified dermatologists diagnose and treat over 3,000 different diseases and conditions. Dermatologists see patients of all ages, from newborns to the elderly. A board-certified dermatologist undertakes a minimum of 8 years of exhaustive medical education and training (4 years of medical school, 1 year of internship, 3 years (minimum) of dermatology residency), during which they complete 12,000 to 16,000 hours of direct patient care, before they can practice independently.

Medical students who attend schools accredited by the Liaison Committee on Medical Education are required to care for patients in both inpatient and outpatient settings in the following clinical rotations: family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery.[2] Similarly, students at colleges of osteopathic medicine that are accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation must receive education in the following clinical disciplines: internal medicine, obstetrics/gynecology, pediatrics, family practice, surgery, psychiatry, radiology, preventive medicine, and public health.[3] All medical students must also select a number of specialty elective rotations to round out their exposure to the branches of medicine, ensuring a broad and comprehensive medical knowledge base upon which they build by choosing an area of practice specialization for graduate medical education, commonly known as residency.

In stark contrast, physician assistants complete a 26-month physician assistant program followed by 2,000 hours of clinical rotations, which emphasize primary care in ambulatory clinics, physician offices and acute or long-term care facilities.[4] Rotations could also include family medicine**,** internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry.[5] Unlike physicians, physician assistants are not required to

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[1] AAD Position Statement on the Practice of Dermatology: Protecting and Preserving Patient Safety and Quality Care, https://server.aad.org/Forms/Policies/Uploads/PS/PS-Practice%20of%20Dermatology-Protecting%20Preserving%20Patient%20Safety%20Quality%20Care.pdf
[2] Web, Liaison Committee on Medical Education (LCME). LCME Accreditation Standards with annotations.*www.lcme.org*
[3] Web, https://www.aacom.org/docs/default-source/cib/aacom-cib-2019-all-web.pdf?sfvrsn=95e22597_8
[4] https://www.aapa.org/what-is-a-pa/#tabs-2-how-are-pas-educated-and-trained
[5] https://www.aapa.org/wp-content/uploads/2016/12/Issue_Brief_PA_Education.pdf.

complete a residency program. Physician assistants who elect to practice in dermatology are trained in the clinic by dermatologists.[6] There are no uniform training requirements in such a setting. Training requirements, including length of time, vary from practice to practice.[7]

By any measure, the differences in training are significant. Given the wide array of challenges and complexity that confront health care practitioners, particularly as the population ages, physicians' additional training and expertise allows them to substantively reduce the incidence of complications and to recognize and treat complications appropriately should they occur.

Studies demonstrate differences in patient outcomes and utilization rates. New research shows that dermatologists are more effective than physician assistants in diagnosing skin cancer. Researchers examined data from 33,647 skin cancer screenings in 20,270 patients at University of Pittsburgh Medical Center-affiliated offices from January 2011 through December 2015. Compared to dermatologists, physician assistants needed to perform more biopsies to detect melanoma and nonmelanoma skin cancer. To diagnose one case of melanoma, the number needed to biopsy was 39.4 for physician assistants and 25.4 for dermatologists. To diagnose one case of skin cancer, the number needed to biopsy was 3.9 for physician assistants and 3.3 for dermatologists.[8]

Dermatologists were more likely than physician assistants to diagnose noninvasive melanoma, which the authors note is more difficult to identify than invasive melanoma. Early detection and treatment of noninvasive melanoma can result in improved patient outcomes and lower treatment costs.

A 2015 study from the University of Wisconsin comparing malignancy rate of biopsies performed by dermatologists versus non-physicians suggests that non-physicians, having less acute diagnostic skills, perform more biopsies, thus increasing patient morbidity and the cost of care.[9] Removing physician supervision of physician assistants would lead to misdiagnoses, adverse events, and increased health care costs This is a public health hazard that will be aggravated by this legislation.

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[6] Web, The Society of Dermatology Physician Assistants, http://hireadermpa.com/dermpa-training/
[7] I*d.*
[8] Matsumoto, M. et al (2018, May). Estimating the cost of Skin Cancer Detection by Dermatology Providers in a Large Health Care System. JAMA Dermatol. May 2018 Volume 154, Number 5.
[9] Bennett, D., Xu, Y (2015, August). Biopsy Use in Skin Cancer Diagnosis: Comparing Dermatology Physicians and Advanced Practice Professionals, JAMA Dermatol. August 2015 Volume 151, Number 8.

The public supports physician-led team-based care. As members of the health care delivery system, it is a common goal of both physicians and physician assistants to ensure that patients receive the highest quality care. We believe this is achieved when health care is delivered by a physician-led team; a model that is also supported by the public. According to four nationwide surveys, 84% of respondents prefer a physician to have primary responsibility for diagnosing and managing their health care and 91% of respondents said that a physician's years of medical education and training are vital to optimal patient care, especially in the event of a complication or medical emergency.[10]

There is a wide spectrum of training and expertise among health care professionals. In a clinical setting, it is often impossible for patients to know whether the person providing their care is a physician, nurse, physician assistant, pharmacist, dentist, or dental hygienist. This creates a great deal of confusion for individuals receiving health care. Our patients have the right to know the credentials and the level of training of the person making important medical diagnoses, delivering medications through an intravenous line, using a scalpel, or pointing a laser at their face, torso, arms or legs.

Additionally, nationwide surveys confirm increasing patient confusion regarding the many types of health care providers - including physicians, nurses, physician assistants, technicians and other varied providers. Nearly 80% of those surveyed support state legislation requiring all health care advertising materials to clearly designate the level of education, skills and training of all health care professionals promoting their services. The survey revealed:

- 47 percent of patients incorrectly believe an optometrist is a medical doctor;
- 39 percent of patients believe a nurse with a "doctor of nursing practice" degree is a medical doctor;
- 44 percent of patients believe it is difficult to identify who is a licensed medical doctor and who is not by reading what services they offer, their title and other licensing credentials in advertising or other marketing materials.

Existing law does not prevent physician assistants from currently practicing in rural and underserved areas. Existing state law does not set geographic boundaries nor is there evidence that eliminating the supervisory relationship will improve access to care. This is further illustrated by the geographic mapping initiative of the American Medical Association, which

[10] Surveys of nearly 1,000 adults on behalf of the AMA Scope of Practice Partnership were conducted in 2008, 2010, 2012, and 2018.

demonstrates that non-physician health care providers are not located in rural or underserved areas, but rather, are concentrated in the same geographic areas as physicians.

As physicians, our number one priority is the health and welfare of our patients. We appreciate the opportunity to provide written comments on this important public health issue. We respectfully urge you to carefully consider the ramifications of HB 442, which suggests physician and physician assistants are equivalent in training and education. We remain committed to providing high quality care and serving the best interests of our patients through physician-led team-based care. For further information, please contact Lisa Albany, director of state policy for the American Academy of Dermatology Association, at **LAlbany@aad.org** or (202) 842-3555.

Sincerely,

Kenneth J. Tomecki, MD, FAAD
President
American Academy of Dermatology Association

September 30, 2019

Karen G. Wilson
Healthcare Quality Safety Branch
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Wilson:

On behalf of the undersigned organizations representing approximately 14,000 dermatologists nationwide, we urge you to oppose the application submitted by the Connecticut State Dental Association (CSDA) to expand the scope of practice of dentistry to allow dentists to administer botulinum neurotoxins and dermal fillers for the functional or cosmetic enhancement of the gums, cheeks, jaws, lips, oral cavity and associated structures of the maxillofacial areas. This expansion would be limited to the practice of dentistry and related to the delivery of a patient's comprehensive dental treatment. We believe these procedures are outside the scope of practice of dentists and are a risk to patient safety. The addition of these procedures also necessitates different training and education requirements, which will likely result in inconsistent standards for the same procedures performed by other practitioners. For these reasons, we urge you to oppose CSDA's application request.

Procedures by any means, methods, devices or instruments that can alter or cause biologic change or damage the skin and subcutaneous tissue constitute the practice of medicine and surgery. This includes the use of foreign or natural substances by injection or insertion.[1] [2] Our organizations believe that procedures using a Food and Drug Administration (FDA)-regulated device, such as those that can alter or cause biologic change or damage, should only be performed by a physician or appropriately trained non-physician personnel under the direct, onsite supervision of an appropriately

[1] ASDSA *Position Statement on the Practice of Medicine.* http://asdsa.asds.net/uploadedFiles/ASDSA/Policymakers/ASDSA-Definition%20of%20the%20Practice%20of%20Medicine.pdf

[2] AADA *Position Statement on Medical Spa Standards of Practice*. https://www.aad.org/Forms/Policies/Uploads/PS/PS-Medical%20Spa%20Standards%20of%20Practice.pdf

trained physician.[3] This rule jeopardizes patient safety and disregards what is considered adequate and appropriate medical education and training. Quality patient care includes evaluating a patient's needs and condition(s), selecting an appropriate course of treatment and providing adequate follow-up care.

According to the American Dental Association, three or more years of undergraduate education plus four years of dental school is required to graduate and become a general dentist.[4] The focus of their education is oral health rather than skin and facial tissue. Dentists are not required to demonstrate competency in procedures involving skin and soft tissue augmentation with products that can alter or damage living tissue. It is of upmost importance that the health care provider performing procedures with neurotoxins (such as botulinum toxin) or dermal fillers have specific, long-term training (such as a medical residency in plastic, facial or dermatologic surgery). The education for dentists does not include this type of intense training; additionally, any short-term training program offered by manufacturers of these products does not adequately protect patient safety.

An analysis by the FDA's General and Plastic Surgery Devices Panel of six years of adverse event reports associated with the use of injectable dermal fillers concluded the following: there are a number of adverse events that are serious and unexpected, such as facial, lip and eye palsy, disfigurement, retinal vascular occlusion, blindness, as well as rare but life-threatening events such as severe allergic reactions and anaphylactic shock.

- Some of the common adverse events that are expected to occur shortly after injection and resolve quickly can have a delayed onset and/or remain for a long period of time and turn into more serious problems.
- A number of the adverse events reported to the FDA and the device manufacturers imply that, in these cases, the administration of injectables were performed by untrained personnel or in settings other than health clinics or doctors' offices.[5]

A survey conducted by the Physicians Coalition for Injectable Safety found that 84 percent of physician respondents had seen at least one patient with complications from cosmetic injectables and 38 percent had seen complications arising from cosmetic injections administered by an unqualified or untrained provider.[6] Injectable fillers that are approved for injection in the dermis or mid-to-deep dermis require extensive

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[3] ASDSA *Position Statement on Delegation*. http://asdsa.asds.net/uploadedFiles/ASDSA/Policymakers/ASDSA-%20Delegation%20Position%20Statement(4).pdf

[4] General Dentistry. Retrieved from http://www.ada.org/en/education-careers/careers-in-dentistry/general-dentistry.

[5] FDA General and Plastic Surgery Devices Panel. Dermal Filler Devices. November 11, 2008. Retrieved from https://www.fda.gov/ohrms/dockets/ac/08/briefing/2008-4391b1-01%20-%20FDA%20Executive%20Summary%20Dermal%20Fillers.pdf

[6] New Data Finds Greater Measures Needed For Consumer Safety And Education On Injectable Therapies. August 15 2007. Retrieved from https://www.aafprs.org/media/press_release/150807.htm

knowledge of facial anatomy to ensure proper placement of the injections. Understanding which injectable product is appropriate for each anatomic site and its particular limitations are fundamental to avoiding adverse effects. Furthermore, in discussing these devices, the FDA's Consumer Health Information materials suggest that patients should discuss fillers with a doctor who can refer the patient to a specialist in the field of dermatology or aesthetic plastic surgery.[7]

In order to protect the citizens of Connecticut from adverse events and ensure quality patient care, we urge you to oppose CSDA's request to expand the scope of practice of dentistry to include the administration of botulinum neurotoxins and dermal fillers for the functional or cosmetic enhancement of the gums, cheeks, jaws, lips, oral cavity and associated structures of the maxillofacial areas**.** Dentists do not have the comprehensive education and training that is required to identify and respond to potential complications resulting from the administration of these devices. We appreciate the opportunity to provide comments on this issue. For further information, please contact Emily Ninnemann, ASDSA Manager of Advocacy and Practice Affairs, at 847-956-9121 or *eninnemann@asds.net.*

Sincerely,

George J. Hruza, MD, MBA, FAAD
President
American Academy of Dermatology Association

Murad Alam, MD
President
American Society for Dermatologic Surgery Association

[7] Filling in Wrinkles Safely. Retrieved from https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm049349.htm

January 25, 2021

The Honorable Mark Sickles
Chair, Health, Welfare and Institutions Committee
Virginia House of Delegates
PO Box 406
Richmond, VA 23219

Dear Chairman Sickles:

On behalf of the over 13,800 U.S. members of the American Academy of Dermatology Association (AADA) and the members of the Virginia Dermatology Society (VDS), we oppose HB 2044, which would license the alternative health care practice of naturopathy and misinform patients by equating the training of a naturopath with the extensive training of a licensed physician.

As dermatologists, our utmost concerns are patient care and patient safety. Quality patient care includes evaluating a patient's needs and current condition, selecting an appropriate course of treatment, and providing adequate information and follow-up care. In order to provide this level of care, dermatologists complete at least twelve years of training, which includes a three-year dermatology residency program. Their education and training prepare them to diagnose and treat more than 3,000 different diseases and to recognize and address unexpected medical events and complications. Naturopaths complete four years of graduate-level education, but are not required to complete a residency, even though every physician in Virginia must complete a residency in order to attain licensure.

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It is misleading to allow individuals who have not completed a medical residency to identify themselves as doctors or physicians. Pursuant to HB 2044, naturopaths could use a number of misleading terms to identify themselves, including "naturopathic medical doctor," "doctor of natural medicine," "doctor of naturopathy," and "doctor of naturopathic medicine."

Furthermore, the Virginia Department of Health Professions ("DPH") has rejected previous efforts to license naturopaths, most recently in August 2020. The Board of Professions of the DPH concluded that naturopaths do not meet the criteria required for licensure. [1]

In order to protect Virginia's patients from adverse events and ensure quality care, the AADA and VDS oppose the licensure of naturopaths proposed by HB 2044. We appreciate the opportunity to share our concerns on this issue. Please contact Lisa Albany, JD, director of state policy, at lalbany@aad.org or (202) 842-3555 should you have any questions.

Sincerely,

Bruce H. Thiers MD, FAAD
President
American Academy of Dermatology Association

Valerie M. Harvey, MD, MPH, FAAD
President
Virginia Dermatology Society

CC: Members of the House Health, Welfare and Institutions Committee

[1] https://www.dhp.virginia.gov/media/dhpweb/docs/studies/2020_Naturopathic.pdf

AMERICAN ACADEMY of DERMATOLOGY | ASSOCIATION

ASDSA American Society for Dermatologic Surgery ASSOCIATION

July 27, 2020

Jeffrey J. Mesaros, PharmD, J.D.
Florida Board of Pharmacy, Rules Committee
3052 Bald Cypress Way
Tallahassee, FL 32311

Re: Implementation of HB 389

Dear Members of the Rules Committee,

On behalf of the undersigned organizations representing approximately 14,000 U.S.-based members of the American Academy of Dermatology Association ("Academy") and American Society for Dermatologic Surgery Association, we urge the Florida Board of Pharmacy ("Board") to prohibit pharmacists from managing chronic skin conditions pursuant to a collaborative pharmacy practice agreement (CPPA). Skin disease is a leading cause of global disease burden, affecting millions of people worldwide.[1] Skin disease is a significant and serious public health consideration for the U.S. population. According to the 2016 Burden of Skin Disease report, skin disease resulted in direct health care costs of $75 billion, and indirect lost opportunity costs of $11 billion in a single year.[2] In addition to the economic consequences, misdiagnosing a skin condition can result in serious complications. As such, the accurate and efficient diagnosis and treatment of skin diseases require the medical education and training of a board-certified dermatologist.

We urge the Board to carefully consider the ramifications of HB 389, which authorizes a pharmacist to enter into a collaborative pharmacy practice agreement (CPPA) with a physician to manage chronic health conditions. There are enormous differences between pharmacy and medical education, as outlined below. Pharmacists will inevitably misdiagnose chronic skin diseases, resulting in significant patient safety threats and increased costs to the health care system. While there are numerous examples, we have highlighted four chronic skin conditions requiring a board-certified dermatologist to accurately differentiate numerous skin diseases.

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[1] Hay R.J Johns N.E. Williams H.C. et al. The global burden of skin disease in 2010: an analysis of the prevalence and impact of skin conditions. *J Invest Dermatol.* 2014; **134**: 1527-1534

[2] Lim Henry W, et al. The burden of skin disease in the United States. *J American Academy of Dermatol.* 2017; Vol 76; Issue 5: 958-972

Pharmacists lack the clinical training and experience to diagnose and treat chronic skin conditions.

Board-certified dermatologists diagnose and treat over 3,000 different diseases and conditions. Our members see patients of all ages, from newborns to the elderly. Board-certified dermatologists undertake a minimum of 8 years of exhaustive medical education and training (4 years of medical school, 1 year of internship, 3 years (minimum) of dermatology residency), during which they complete 12,000 to 16,000 hours of direct patient care, before they can practice independently.

In stark contrast, pharmacists attend four years of pharmacy school, which includes 1,700 hours of practice experience. Pharmacists are trained to function as the medication expert within a collaborative health care team. Pharmacy school does not prepare pharmacists to develop the clinical judgment to diagnose or develop a treatment plan. A physician's medical education includes a comprehensive understanding of multiple organ systems, which allows them to order and interpret tests within the context of a patient's overall health condition.

By any measure, the differences in training are significant. Given the wide array of challenges and complexity that confronts health care practitioners, particularly during a public health emergency, board-certified dermatologists' additional training and expertise allows them to accurately and efficiently diagnose and treat chronic skin conditions.

Chronic skin conditions should be treated by a board-certified dermatologist due to its complexity and likelihood of misdiagnosis.

1. **<u>Common skin cancers are hard to diagnose and may resemble harmless skin conditions</u>**

Certain skin cancers may masquerade as warts. Warts are common benign skin growths that appear when the human papillomavirus infects the top layer of the skin. Pharmacists and other individuals who lack extensive knowledge and expertise in cutaneous medicine, surgery, and pathology, may easily mistakenly diagnose various forms of skin cancer as warts. Squamous cell carcinoma (SCC) is a common type of potentially serious skin cancer. SCC of the skin can appear on the skin very similar to a harmless wart. The majority of SCCs can be successfully treated when diagnosed early; however, if SCCs grow into deeper layers of the skin and spread to other areas of the body, it can be life-threatening.

Dry patches of irritated skin or eczema can resemble basal cell carcinoma (BCC), the most common type of skin cancer. An untreated BCC can grow deep into the skin and destroy areas of the body such as the nose and the ear. The cancer cells can develop into large tumors and possibly reach the bone. This can require extensive surgery which, for some people, it may be disfiguring.

Malignant melanoma of the foot can be misdiagnosed as a wart. Melanoma is the deadliest form of skin cancer. While it is highly treatable when detected early, advanced melanoma can spread to the lymph nodes and internal organs, and can be fatal. The average five-year survival rate for individuals whose melanoma is detected and treated before it spreads to the lymph nodes is 98 percent. The five-year survival rates after regional (lymph nodes) and distant (other organs/lymph nodes) spread are 64 percent and 23 percent, respectively.[3] [4] [5]

2. Hidradentitis Suppurative (HS)

Hidradenitis Suppurativa (HS), a chronic systemic inflammatory disease, usually develops around hair follicles. An overactive immune system contributes to inflammation below the skin. HS may be mistaken for a bacteria linfection, ingrown hairs or pimples. Painful bumps or large abscesses in the armpit, groin and genital areas may develop. Because HS may worsen over time, it is critical that the patient and board-certified dermatologist closely monitor any changing symptoms. Additionally, HS may have multiple comorbidities, including diabetes, anxiety and depression, inflammatory bowel diseases, inflammatory arthritis, acne conglobate, and polycystic ovarian syndrome. HS has no cure, and its treatment can involve many treatments and surgeries, and a myriad of medications. The skin manifestations do not provide the full picture, and pharmacy education and training do not provide the knowledge required to diagnose and treat HS. The potential risks of a misdiagnosis can be life-threatening and should not be ignored.

3. Mycosis Fungoides

Mycosis Fungoides (MF) is a cutaneous lymphoma, and if not treated appropriately during the early stages, this maligannncy has the potential to progress and result in death. MF can be easily misdiagnosed as dry irritated skin patches known as eczema. At a minimum, a medical education is necessary to obtain the appropriate clinical history to differentiate MF from eczema and recognize the features that distinguish it from eczema. Prompt recognition, the ability to perform a biopsy of the skin and access to a board certified dermatopathologist is essential.

Once diagnosed, a board-certified dermatologist stages the disease and develops a comprehensive treatment plan, which requires interpreting clinical, lab and imaging data. A board-certified dermatologist must also understand potential side effects of the various choices of therapy, including topical creams, and oral and radiation therapy.

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[3] American Cancer Society. Cancer Facts & Figures 2019. Atlanta: American Cancer Society; 2019.
[4] Siegel RL, Miller KD, Jemal A. Cancer statistics, 2019. CA Cancer J Clin. 2019; doi: 10.3322/caac.21551.
[5] Noone AM, Howlader N, Krapcho M, Miller D, Brest A, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). SEER Cancer Statistics Review, 1975-2015, National Cancer Institute. Bethesda, MD, https://seer.cancer.gov/csr/1975_2015/, based on November 2017 SEER data submission, posted to the SEER web site, April 2018.

Understanding and managing potential side effects of these drugs will lead to safer and improved patient outcome.

4. Psoriasis

Psoriasis is a chronic, inflammatory, multisystem disease that affects approximately 7.5 million people in the United States.[6] It is a condition that causes the body to make new skin cells in days rather than weeks. A person's immune system and genes play a role in causing psoriasis. Psoriasis cannot be cured and is often a life-long disease. There are different types of psoriasis, and a patient may have more than one type concurrently.

Because the immune system is overactive and can cause inflammation elsewhere in the body, psoriasis is associated with multiple comorbidities. Some inflammation is visible (skin and joints), but it may also impact other organs and tissues in the body. The comorbidities that can accompany psoriasis include psoriatic arthritis, cardiovascular problems, obesity, high blood pressure, and diabetes. Psoriatic arthritis is the most common comorbidity, which affects approximately 1 in 3 psoriasis patients.[7]

Like other chronic skin condition, psoriasis can be difficult to diagnose because it looks like other skin diseases. A study conducted in Australia found that most children who had psoriasis were initially diagnosed by their primary care doctor as having another disease, often eczema.[8] An accurate diagnosis has likely considered multiple factors, including the skin's appearance, location on skin, itchiness, and a skin biopsy. Psoriasis may look different on skin of color, so it is important to know the signs of psoriasis to prevent misdiagnosis.[9]

Once diagnosed, a board-certified dermatologist develops a treatment plan that enables patients to manage psoriasis and avoid triggers. Due to recent advances in psoriasis treatment, there are a number of options (topicals, traditional systemics/oral, phototherapy, biologics, biosimilars). A board-certified dermatologist knows which treatments can be safely combined and when a treatment is unacceptable for a patient. Some cases of psoriasis are so severe that patients do not respond to an FDA-approved psoriasis medicine. For those patients, board-certified dermatologists may prescribe off-label medicines.[10] The physician must know the patient's complete medical history to effectively evaluate the risks and benefits of the medicine.

Our organizations appreciate the opportunity to provide written comments on this important public health issue. It is a common goal of both physicians and pharmacists to

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[6] Menter A, Gottlieb A, Feldman SR, Van Voorhees AS et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 1. Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. J Am Acad Dermatol 2008 May;58(5):826-50.

[7] https://www.psoriasis.org/sites/default/files/comorbidities_fact_sheet_3.pdf

[8] https://www.aad.org/public/diseases/eczema/childhood/child-have/difference-psoriasis

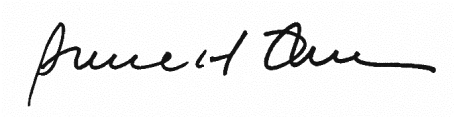
[9] https://www.psoriasis.org/sites/default/files/diagnosing_psoriasis_fact_sheet_1.pdf

[10] https://www.aad.org/public/diseases/psoriasis/treatment/medications/off-label

ensure that patients receive the highest quality care. Pharmacists play an instrumental role in the delivery of health care, but their education does not prepare pharmacists to treat chronic skin conditions. As discussed above, dermatologists receive many years of advanced training in correctly identifying conditions that affect the hair, skin, and nails. Correctly identifying the condition is crucial to determining the proper treatment.

Lastly, the physician-patient relationship differs from the relationship patients have with pharmacists. A pharmacist does not have access to the patient history or to provide a thorough evaluation of the patient, followed by the necessary patient monitoring. For the reasons stated above, we urge members of the Board to prohibit pharmacists from managing chronic skin conditions pursuant to a collaborative pharmacy practice agreement. For further information, please contact Lisa Albany, director of state policy, at lalbany@aad.org or 202.712.2605.

Sincerely,



Bruce H. Thiers MD, FAAD
President
American Academy of Dermatology Association

Marc D. Brown, MD
President
American Society for Dermatologic Surgery Association

Testimony by DERMATOLOGIST[1]
on behalf of the
State Dermatology Society

Committee Name
State of XX
Opposition to Bill #
DATE

Thank you Chair XX and members of this committee for the opportunity to provide testimony in opposition to Bill #. My name is XX and I am a board-certified dermatologist from city/town. I represent the State Dermatology Society, which represents ## of dermatologists in STATE.

Physician and nurse practitioners have long worked together to meet patient needs. The physician-led team approach to care works and is supported by patients. The legislation would eliminate physician-led team-based care. All members of the health care team are important, but the roles are not interchangeable. This legislation will also not resolve access issues or reduce health care costs as claimed by supporters of this legislation.

{Personalize your testimony: provide examples of how this bill would negatively impact your patients.)

Public Preference

When it comes to receiving high-quality health care, patients want and assume physicians will be involved in medical diagnoses and treatment. Data shows that patients both want and expect a physician to lead the care team. A national survey revealed 95 percent of U.S. voters believe it is important for physicians to be involved in diagnoses and treatment.

In focus groups, education, training, and experience were widely cited as essential to quality care; treatment and diagnosis without physician involvement caused grave concern.

Education

There are substantial differences in the education of a physician as opposed to a nurse practitioner in both depth of knowledge and length of training. After completing college, board-certified dermatologists complete 4 years of medical school, followed by 3 – 7 years of residency and 12,000-16,000 hours of patient care training, followed by passing a rigorous a Board certification examination. Some

[1] **Dermatologists should confirm the amount of time allowed to testify. Direct legislators to issues raised in written comment letter that cannot be covered verbally.**

dermatologists continue to complete an additional 1to 2 year fellowship training in a subspecialty.

In stark contrast, nurse practitioners receive 2 – 4 years of education and 500 – 720 hours of patient care training. (*For PA bills: Physician assistants obtain a master's degree in approximately 27 months after college, are only required to provide 2,000 hours of patient care and have no internship or residency.)*

Given the wide array of challenges that confront the independent practitioner, physicians' additional training and expertise allows them to substantively reduce the incidence of complications and to recognize and treat them appropriately when they do occur.

Access

This bill will not alleviate existing access issues. A geographic mapping initiative of the American Medical Association demonstrates that non-physician health care providers are not located in rural or underserved areas; they are concentrated in the same geographic areas as physicians. There are currently no legal or regulatory hurdles that prevent nurse practitioners from practicing in rural areas.

Increased Cost

Expanding the scope of practice of nurse practitioners may actually increase the cost of care due to inappropriate prescribing, unnecessary referrals to specialists, unnecessary orders for diagnostic imaging studies such as x-rays, and more biopsies performed compared to physicians.

A 2015 study from the University of Wisconsin comparing malignancy rate of biopsies performed by dermatologists versus non-physicians suggests that an increased use of biopsies may increase the morbidity and cost of care provided when provided by non-physicians. The authors found the number needed to biopsy per malignant neoplasm of any skin cancer for non-physicians was double that of physicians, and that difference was most pronounced in younger patients and those without a history of skin cancer.

Conclusion

Thank you for the opportunity to provide testimony. Eliminating physician-led team-based care will not increase access and will likely increase health care costs. The best way to ensure patient safety and lower costs is to keep physician experts at the helm of the health care team.

I urge committee members to oppose Bill ##.

Scope of Practice: Summary of Existing Studies

Cost and Quality of Care

Expanding the scope of practice of nurse practitioners may actually increase the cost of care due to inappropriate prescribing, unnecessary referrals to specialists, unnecessary orders for diagnostic imaging studies such as x-rays, and more biopsies performed compared to physicians. Below is a brief summary of these findings.

"Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants," Open Forum Infectious Diseases.
The study found that ambulatory visits involving nurse practitioners and physician assistants more frequently resulted in an antibiotic prescription compared with physician visits.

"Patient, Provider and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices," Infection Control & Hospital Epidemiology
The study found that adult patients seen by APPs were 15 percent more likely to receive an antibiotic than those seen by a physician. The rate of prescribing for pediatric patients was similar.

"Comparison of the Quality of Patient Referrals from Physicians, Physician Assistants, and Nurse Practitioners," Mayo Clinic Proceedings
A 2013 study by the Mayo Clinic found inappropriate referrals to tertiary referral centers by nurse practitioners and physician assistants could offset any potential savings from the increased use of nurse practitioners and physician assistants. The study compared the quality of physician referrals for patients with complex medical problems against referrals from nurse practitioners and physician assistants for patients with the same problems. Blinded to the source of the referrals, a panel of five experienced physicians used a seven-instrument assessment to determine the quality of each referral. Physicians referrals received "significantly higher" scores in six of the seven assessment areas. Physician referrals were also more likely to be evaluated as necessary compared to nurse practitioner and physician assistant referrals which were more likely to be evaluated as having little clinical value.

"A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits," JAMA Internal Medicine
The authors of this study found that nurse practitioners and physician assistants were associated with more ordered diagnostic imaging than primary care physicians following an outpatient visit. The authors noted, the findings suggest that expanding the authority and use of nurse practitioners may alleviate physician shortage, but the increased imaging may have ramifications on care and overall costs.

"National Trends in the Utilization of Skeletal Radiography," Journal of the American College of Radiology
This study found skeletal x-ray ordering increased substantially – by 441 percent – among non-physician providers, primarily nurse practitioners and physician assistants.

"Biopsy Use in Skin Cancer Diagnosis: Comparing Dermatology Physicians and Advanced Practice Professionals," JAMA Dermatology

This study compared the number needed to biopsy (NNB) per malignant neoplasm between dermatology physicians and advanced practice professionals (APPs). The dermatologists and APPs in the study practiced in the same institution. APPs treated new and established patients, most of whom were not evaluated by a physician; however, a physician was available in the clinic. The authors found the NNB of any skin cancer for APPs was double that of physicians, and that difference was most pronounced in younger patients and those without a history of skin cancer.

"Accuracy of Skin Cancer Diagnosis by Physician Assistants Compared with Dermatologists in a Large Health Care System." JAMA Dermatology

This study compared the accuracy of dermatologists with physician assistants in diagnosing skin cancer, finding physician assistants performed more skin biopsies per case of skin cancer diagnosed and diagnosed fewer melanomas in situ, suggesting that the diagnostic accuracy of PAs may be lower than that of dermatologists. The study found, "compared with dermatologists, physician assistants have lower diagnostic accuracy for melanoma." Authors from the study opined that although the availability of PAs may help increase access to care and reduce waiting times for appointments, these findings have important implications for the training, appropriate scope of practice, and supervision of PAs and other nonphysician practitioners in dermatology.

"Opioid Prescribing by Primary Care Providers: a Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns," Journal of General Internal Medicine

Using 2015 Medicare claims data, the authors conducted a retrospective cross-sectional analysis to determine the opioid prescribing patterns of physicians, nurse practitioners and physician assistants who worked in primary care and prescribed at least 50 prescriptions. Based on their analysis, the authors found a greater number of NPs (8.0%) and PAs (9.8%) overprescribed opioids compared to physicians (3.8%). They also found NPs/PAs in states with independent prescription authority for schedule II opioids were 20 times more likely to overprescribe opioids than NPs/PAs in states with restricted prescription authority. Of note, the study also found from 2013 to 2017, when almost every medical specialty decreased opioid prescribing, NPs/PAs significantly increased opioid prescribing. The authors opined on potential solutions for reducing NP/PA prescribing, such as implementing mandatory continuing education in safe opioid prescribing and restricting NPs/PAs prescribing authority.

Workforce Studies

Vermont Secretary of State, Office of Professional Regulation, Study of Optometric Advanced Procedures, Jan. 2020.

New York State Nurse Practitioners, Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners, 2017. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health,

SUNY Albany; October 2017.
South Dakota Center for Nursing Workforce (April 10, 2019). South Dakota Nursing Workforce: 2019 Supply and Employment Characteristics.

The Graduate Nurse Education Demonstration Project: Final Evaluation Report, Centers for Medicare and Medicaid Services. August 2019. https://innovation.cms.gov/files/reports/gne-final-eval-rpt.pdf. Accessed Oct. 9, 2020

[Add State Dermatology Society Logo]

KEEP the TEAM!

6 Reasons to Retain Physician-Led Team-Based Care
Oppose Bill ##!

1. **The best and most effective care occurs when a team of health care professionals with complementary—not interchangeable—skills work together.**

Dermatologists and nurse practitioners have long worked together to meet patient needs because the physician-led team approach to care works. All members of the health care team are important, but the roles are not interchangeable. Independent nurse practitioner practice is both challenging and risky for patients.

2. **The education and training of a nurse practitioner falls significantly short of the education and training of a physician.**

After completing college, board-certified dermatologists complete 4 years of medical school, followed by 3 – 7 years of residency and 12,000-16,000 hours of patient care training, followed by passing a rigorous a Board certification examination. Some dermatologists continue to complete an additional 1 to 2-year fellowship training in a subspecialty.

In stark contrast, nurse practitioners receive 2 – 4 years of education and 500 – 720 hours of patient care training. (*For PA bills: Physician assistants obtain a master's degree in approximately 27 months after college, are only required to provide 2,000 hours of patient care and have no internship or residency.)*

3. **Existing law does not prevent nurse practitioners from currently practicing in rural and underserved areas.**

A geographic mapping initiative of the American Medical Association demonstrates that non-physician health care providers are not located in rural or underserved areas; they are concentrated in the same geographic areas as physicians. There are currently no legal or regulatory hurdles that prevent nurse practitioners from practicing in rural areas.

4. **Increasing the responsibility of nurse practitioners is not the solution to a shortage of physicians.**

Allowing nurse practitioners 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 nurse practitioners full clinical autonomy; and an increased demand for services should not marginalize appropriate medical education and training.

5. **Public Supports Physician-Led Team-Based Care**

The public supports the physician-led team care model. A national survey revealed 95 percent of U.S. voters believe it is important for physicians to be involved in diagnoses and treatment.

6. **Independent Practice Could Increase Health Care Costs**

A 2015 study from the University of Wisconsin comparing malignancy rate of biopsies performed by dermatologists versus non-physicians suggests that an increased use of biopsies may increase the morbidity and cost of care provided when provided by non-physicians.

AMA
AMERICAN MEDICAL ASSOCIATION

Scope of Practice: Myth vs. Fact

MYTH	VS	FACT
Changes to scope of practice expand patient access to care.		While the number of nurse practitioners doubled between 2010-2017, there has been no noticeable increase of nurse practitioners within rural, underserved areas. CMS data and countless state examples show nurse practitioners tend to practice in the same areas of the state as physicians, irrespective of state scope of practice laws.
Patients welcome scope of practice changes.		Sixty-eight percent of U.S. voters say it is very important to them for a physician to be involved in diagnosis and treatment decisions. Patients want and expect a physician to be present on their care team.
Scope of practice changes would decrease health care costs.		Studies from the Mayo Clinic and JAMA found nurse practitioners and physician assistants are more likely to make unnecessary referrals and imaging orders, resulting in higher costs for patients
Patients are the primary beneficiaries of scope of practice changes.		By allowing increased scope expansions, lawmakers are allowing for-profit entities to shape our health care system – regardless of what patients want – while also reducing patient choice in who provides their care. While some procedures seem simple and uncomplicated, there are too many examples of practitioners with less education and training having bad outcomes that harm patients for the rest of their lives. Studies from the Mayo Clinic and JAMA found nurse practitioners and physician assistants are more likely to make unnecessary referrals and imaging orders, resulting in higher costs for patients. While the number of nurse practitioners doubled between 2010-2017, there has been no noticeable increase of nurse practitioners within rural areas for those patients who are underserved.

It's clear, patients benefit least from changes to scope of practice.

Scope of Practice
(Sample messaging)

Patients are concerned about the cost and quality of health care. While there is certainly room for improvement in our current health care system, allowing non-physicians to provide physician-level care would be a step in the wrong direction that benefits for-profit entities – not patients.

The best way to alleviate patient concerns, protect patient safety, and lower costs is to keep physician experts at the helm of the health care team.

Physicians at the helm of the health care team:

- When it comes to receiving high-quality health care, patients want and assume physicians will be involved in medical diagnoses and treatment.
- Health care is about fixing a problem. Patients expect the most qualified person – physician experts with unmatched training, education, and experience – to deal with the unexpected.
- Data shows that patients both want and expect a physician to lead the care team.
    - o A national survey revealed 95 percent of U.S. voters believe it is important for physicians to be involved in diagnoses and treatment decisions with 68 percent of voters believing it is very important.
    - o In focus groups, education, training, and experience were widely cited as essential to quality care; treatment and diagnosis without physician involvement caused grave concern.
- Patients pay high insurance premiums and co-pays to "go to the doctor." Their belief and strong desire is that physicians will be involved in medical diagnosis and treatment.

Risks to patient safety:

- While some procedures seem simple and uncomplicated, there are too many examples of practitioners with less education and training having bad outcomes that harm patients for the rest of their lives. Working together as a care team – with physicians in the lead – is critical to having the best and safest outcomes.
- Removing physicians from the care team through changes to scope of practice puts patient safety at risk, and patients are very concerned about the quality of their care.
- Scope changes that would allow non-physicians to perform invasive procedures are particularly alarming to patients.
    - o 79 percent of U.S. voters surveyed oppose allowing optometrists without medical degrees to perform eye surgery.
    - o 67 percent of U.S. voters surveyed oppose allowing psychologists who don't have medical degrees to prescribe anti-depressants and addictive anti-anxiety medication.
    - o 66 percent of U.S. voters surveyed oppose allowing nurse practitioners to run an emergency department with no physician oversight.
    - o 63 percent of U.S. voters surveyed oppose allowing nurse anesthetists to perform anesthesia without physician oversight.
- The best way to maintain and improve quality of care is to keep physician experts at the helm of the health care team, working alongside nurses and other health care professionals.

Change benefits non-physicians and for-profit entities—not patients:

- It's clear: Changes to scope of practice are not in patients' best interests. Instead, this scope expansion benefits health insurance companies and other for-profit entities, offering them yet another way to increase profits.
- Studies from the Mayo Clinic and JAMA found nurse practitioners and physician assistants are more likely to make unnecessary referrals and imaging orders, resulting in higher costs for patients.
    - o By allowing scope of practice expansion, which removes physicians from the care team, for-profit entities can both decrease overhead (salaries), while simultaneously benefiting from increased profits as non-physicians order more diagnostic testing. This business only decision is not what's best for patients and not what patients want.
- In hospital settings, urgent care centers, nursing homes, and rehab facilities, patients do not necessarily have the option to choose their health care professional. These types of facilities often happen to be run by for profit entities.
    - o Unfortunately, when one is singularly focused on the bottom line and not what patients want, it can make sense to replace physicians with non-physicians.
    - o By allowing increased scope expansions, lawmakers are allowing these for-profit entities to shape our health care system while also reducing patient choice in who provides their care.

Scope changes do not improve access to care:

- Inflating the role of non-physician health care providers does not translate to increased access to care as some proponents have suggested.
- In states where nurse practitioners work independently from physicians (most of which has occurred at a rapid, untested approval pace over the last few years), it has not guaranteed increased service in rural and underserved areas.
- The state of Oregon provides the perfect example. While the total number of nurse practitioners in Oregon increased after gaining independent practice, there was no noticeable increase of nurse practitioners within rural, underserved areas.

Scope of Practice
(Sample posts)

Posts

It is recommended to link to relevant news articles or resources from your organization. Also consider tagging legislative targets so that they see the posts.

- Patients want and **EXPECT** physicians will be involved in medical diagnoses and treatment. But with changes to scope of practice, that might not be the case. #StopScopeCreep #AskForAPhysician
- Survey says: 95% of U.S. voters believe it is important for physicians to be involved in diagnoses and treatment decisions. #StopScopeCreep #AskForAPhysician
- Working together as a health care team with physicians in the lead is critical to having the best and safest outcomes for patients. Would you be okay with a non-physician performing an invasive procedure? #StopScopeCreep #AskForAPhysician
- Changes to scope of practice benefit non-physicians and for-profit entities – not patients. To protect patients' wallets and safety, we must #StopScopeCreep. #AskForAPhysician
- Did you know? In states where nurse practitioners work independently from physicians, it has not guaranteed increased service in rural and underserved areas. Keep the health care team together… #StopScopeCreep #AskForAPhysician
- Changes to scope of practice:
    - Remove physicians from diagnosis and treatment
    - Risk patient safety
    - Benefit for-profit entities
    - Do not improve access to care
- Patients are worried about non-physicians performing invasive procedures. 79% of U.S. voters surveyed oppose allowing optometrists without medical degrees to perform eye surgery. #StopScopeCreep #AskForAPhysician
- When you pay to "go to the doctor," you expect to see a doctor with unmatched training, education, and experience. In a move that benefits for-profit entities, not patients, scope of practice legislation seeks to limit access to physicians. #StopScopeCreep #AskForAPhysician
- You care about health care costs and your quality of care. Learn why defeating scope of practice bills is key. #StopScopeCreep #AskForAPhysician

Use and Distribution Guidelines

- The SOPP has created a series of Social Media Graphics as a resource for SOPP members. **The Social Media Graphics are advocacy tools to educate legislators, regulatory bodies and other governmental decision-makers** on the differences in education and training of physician and nonphysician health care providers.

- Each Social Media Graphic is intended to assist in educating physicians, physicians' organizations, and policymakers on the qualifications of a particular limited licensure health care profession, as well as the qualifications physicians possess that prepare physicians to accept the responsibility for full, unrestricted licensure to practice medicine in all its branches. It is within the framework of their respective education and training that health care professionals are best prepared to deliver safe, quality care under legislatively authorized state scopes of practice.

- Upon request, the AMA will distribute the Social Media Graphics to members of the SOPP **solely for members' use in social media campaigns in support of members' legislative and regulatory advocacy aimed at scope of practice expansions sought by nonphysician providers which threaten the health or safety of patients.**

- Social Media Graphics distributed by the AMA on behalf of the SOPP **may not be re-distributed to any other parties or used for any other purposes**.

- Acceptance of the file containing the Social Media Graphics constitutes acceptance of the Social Media Graphics Use and Distribution Guidelines.

- Parties supplied with the Social Media Graphics module shall mirror the intent, purpose, and standards of the Social Media Graphics Distribution Guidelines. Acceptance of the Social Media Graphics shall constitute agreement with these and conditions.

Best practices

- Do NOT
  - Post the graphics without an accompanying message
  - Use the graphics in any way that is unrelated to scope of practice legislative/regulatory advocacy
- DO use graphics as part of strategic advocacy campaign
- DO include the following:
  - Bill numbers
  - Legislator social media handle
  - Calls to action
    - Patient/physician directed – “Call @legislator and ask her to vote no on HB 123”
    - Legislator directed – “@legislator, please put patient safety first and vote no on HB 123”
  - Links to grassroots websites dedicated to scope of practice issues (e.g. MSV www.collaborate4care.org)


Every orchestra needs a conductor.
Nurse practitioners want to practice without physician supervision, collaboration, or oversight.
Don't let nurse practitioners practice independently.

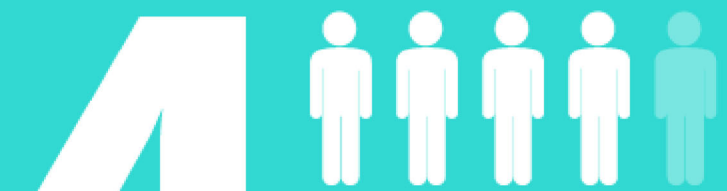

Every orchestra needs a conductor.
Physician assistant educational programs don't prepare graduates to practice without a physician.
Don't let physician assistants practice independently.

It's not just a shot.

Cosmetic medical procedures, including Botox, chemical peels, and laser hair removal, can cause permanent damage if administered by **an unqualified provider.**

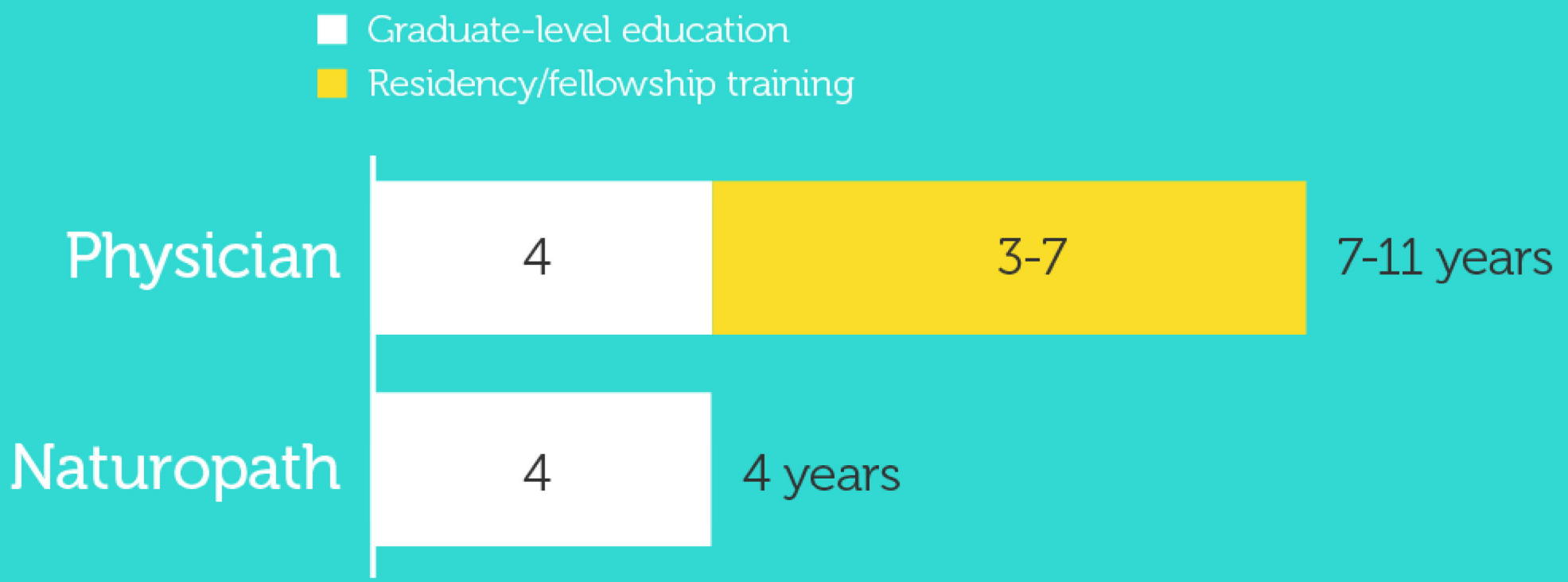
Education matters.

of physician assistant program medical directors agree that PA educational programs don't prepare graduates to practice without a physician.



4 out of 5 patients prefer a physician to lead their health care

The most powerful prescription is a well-trained physician.



Title: Don't accept care without a physician voice

STATE patients deserve the highest standard of patient care. But right now our lawmakers are considering legislation to allow nurse practitioners/physician assistants to diagnose and treat patients without any physician input, and they are being misled that this bill would improve access to care and reduce costs.

Physicians have been and should continue to be the leaders of health care teams. As a board-certified dermatologist practicing in STATE, my focus is on patients' health and safety, which is threatened by this bill.

While a nurse practitioner/physician assistant certainly plays an important role in the provision of care, their education and training are significantly less than mine. They did not go to medical school, or complete the extensive, years-long training in specialty care required of physicians. While some might argue that is a fair trade-off to lower the cost of healthcare, two Wisconsin studies published in JAMA Dermatology show mid-level providers with less training than physicians are more likely to order more imaging services, tests, and prescription drugs, contributing to rising health care costs.

This bill does nothing to alleviate access issues or reduce spending, instead it will leave STATE patients with less-than-ideal care. That's why I'm calling on our state legislators to prioritize patient safety and oppose BILL #.

Sincerely,
<<Dr. First Last, MD, FAAD, organization title and name>>