RACHAEL A. CABRAL-GUEVARA

STATE REPRESENTATIVE • 55TH ASSEMBLY DISTRICT

Testimony before the Senate Committee on Health

Representative Rachael Cabral-Guevara

July 28th, 2021

Hello, Chairman Testin and members of the committee. Thank you for allowing me to testify on Senate Bill 394, an important bill that will bring Wisconsin up-to-date in providing high-quality, affordable healthcare for people across the state. I am proud and excited to present this bill and to represent the Advanced Practice Nurses of Wisconsin today.

I am a Nurse Practitioner (NP) who own a direct access clinic in Appleton. This clinic accepts no insurance which provides affordable and cost transparent healthcare to folks with high deductibles, business owners, and their employees. We post all prices online and provide healthcare at affordable costs less than surrounding facilities. My clinic has helped 2 others clinics establish themselves in rural Wisconsin (one in Tomahawk and the other in Palmyra).

Eliminating the collaborative physician agreement would positively impact patients with no insurance or high deductibles and the businesses in our area because the fear of closing my facility would be eliminated. If my collaborative MD would die or decide they couldn't fulfill this role, then I would be forced shut down tomorrow. Having provided eight years of care to many families, this clinic is essential to their well-being, and in many cases their family budget. Having to close this clinic would also put staff out of work. Two of my staff members have disabilities and we accommodate to their working restrictions and provide work for them weekly. Just last week, I attempted to order supplies and they refused to send supplies without a written contract with this company and the collaborative MD. Basic supplies shipments were refused.

Collaborative physicians are physicians that can be contacted within 15 minutes of an electronic device for questions. This individual does not have to be onsite and does not see the patient. The challenge with finding a collaborative MD has a lot to do with costs to retain them.

When I started my clinic it took a year and a half to find a collaborative MD. The first was in Michigan, the second was in Minnesota and now the third and fourth are here in WI. The first two were residents and when they got job offers they terminated their agreement. Costs for a collaborative MD can be hundreds or thousands of dollars each month and some even ask for a percentage of the ownership and yet never see the patients. If you do not pay, you shut your doors.

P.O. Box 8952 • Madison, WI 53708-8952 • (608) 266-5719 • Toll Free: (888) 534-0055

Rep.Cabral-Guevara@legis.wi.gov

RACHAEL A. CABRAL-GUEVARA

STATE REPRESENTATIVE • 55TH ASSEMBLY DISTRICT

The biggest concern I hear for eliminating these collaboration agreements is safety. However, collaboration happens with or without an agreement or obligated payment. I call specialty MDs weekly and ask how to manage a challenging patient prior to referring them out, just as any physician would do. There is no contract nor payment involved.

Another argument I often hear is related to education requirements. NPs receive Masters or Doctorate degrees upon graduation and then yearly we complete continuing education hours to qualify for recertification. In addition, NPs go through rigorous training programs before receiving their license and are held to the highest standard of patient care.

Thank you again for your time. I am hopeful you are able to support this bi-partisan piece of legislation which will expand access to affordable healthcare and allow us nurses to do what we do best: care for our patients.

P.O. Box 8952 • Madison, WI 53708-8952 • (608) 266-5719 • Toll Free: (888) 534-0055

Rep.Cabral-Guevara@legis.wi.gov

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PATRICK TESTIN
STATE SENATOR

Senator Patrick Testin

Testimony on Senate Bill 394

July 28, 2021

I'm so happy to be here today to finally have to opportunity hear testimony on this legislation. And I'm proud to be the author of this bill and to chair the committee that finally brought this bill to a public hearing.

For a couple of sessions now, this common-sense legislation has gone without even a hearing. Today, we'll have a chance to hear both sides of the issue, and tomorrow our colleagues in the Assembly will hear the bill as well. I just want to start by saying 'It's about time!'

This bill allows advance practice nurses – that means nurses who have met advanced educational and clinical requirements so they have more expertise and a broader scope of practice than an RN.

They may provide primary care or acute care. They may be midwives. They may be nurse anesthetists. They may be clinical nurse specialists. They have different areas of expertise, but they are all at the forefront of providing health care to their patients.

These highly-educated and trained medical professionals provide access to quality, affordable health care across the country, with even more profound impact in states that do not place artificial restrictions on their ability to do the jobs they were trained to do.

There are about five thousand APRNs working in Wisconsin, which is around 7% of the nurse workforce in the state. About 90% of these APRNs are women.

By contrast, according to the Kaiser Family Foundation, about 2/3 of professionally active physicians in Wisconsin are men.

I expect that we are going to hear a lot of alarm today from the male-dominated profession about how letting primarily female medical professionals practice to the full extent of their education and training – and no farther – will result in lower quality care. Interestingly, a recent report in the Journal of American Medicine found that Medicare patients are less likely to die or be readmitted to the hospital when their doctors are female.

We hear these assertion any time there is an effort to expand access to quality care by allowing any advanced practitioners to treat patients. Sometimes it has seemed the opposition would rather see patients go without care than to see qualified professionals provide appropriate care to their patients. It sometimes seems that the debate is more about territory than it is about patients.

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This bill doesn't make advanced practice nurses into doctors. To the contrary, it lets them practice only to the full extent of *their own* training and scope, with all the responsibilities that go with that. It simply removes restrictions that stop them from doing the jobs they were trained to do.

Twenty two states, including our neighbors in MN and IA already allow nurse practitioners to fully practice to the limit of their scope. For nurse-midwives even more states – 28 – allow independent practice. Some of these states have had this model for decades – and not one state that's allowed trained medical professionals to fully practice their scope has ever returned to a more restrictive model.

That's worth repeating. Over the course of decades, no state that has allowed advanced practice nursing professionals to fully practice to the limits of their training has ever rolled back their laws.

In fact, the model continues to expand, because states see what numerous studies have found – and I have here some of those - that there is no evidence that advance practice nurses provide inferior care. In fact, when they practice to their full scopes, nurse practitioners provide equal or better quality at lower cost for comparable services. And they provide greater access – and are more likely than physicians to be located in areas of lower socioeconomic and health status.

Opponents have pointed to studies of their own – some using data a quarter of a century old, and which CMS has said cannot be used to make conclusions about quality comparisons. The data is there, and it's on the side of removing unnecessary restrictions on these trained professionals.

I know my colleague and co-author from the assembly will have a lot to add as one of these highly trained nurse practitioners. Thank you for your attention and I will turn it over to Rachel, and we can take questions after she's completed her testimony.

GAE MAGNAFICI

STATE REPRESENTATIVE • 28th ASSEMBLY DISTRICT

Good morning,

Chairman Testin and members of the Senate Committee on Health. Thank you for holding a hearing on Senate Bill 394, which modernizes the Advanced Practice Registered Nurse (APRN) scope of practice.

In my time as a nurse, I have worked with certified registered nurse anesthetists, nurse practitioners, and clinical nurse specialists. Nurses are professional healthcare providers who hold the health of their patients as their top priority.

When you receive healthcare from a nurse, you know the nurse is acting within their scope of practice and will reach out to a physician when needed. We as nurses are taught what our scope of practice is, and in my experience, nurses adhere to that.

As a nurse, I have also seen firsthand the many constraints Wisconsinites have to access healthcare. SB 394 combats these constraints by expanding healthcare qualified nurses can provide to their patients, while instituting safeguards to ensure the safety of patients.

SB 394 sets a standard of safety through oversight from the Board of Nursing of all APRNs. The bill also requires a nurse to receive education from an accredited institution before being licensed as an APRN. Lastly, it requires collaboration with physicians when going outside of an APRNs scope of practice, just as nurses are required to today.

Numerous other states have adopted similar legislation to combat the same issues Wisconsin faces. Wisconsin has the opportunity to provide quality, affordable healthcare through SB 394. I ask that the committee support this bill for the good of Wisconsin.

P.O. Box 8953 • Madison, WI 53708-8953 • (608) 267-2365 • Toll Free: (888) 529-0028
Rep.Magnafici@legis.wi.gov

ROB STAFSHOLT

STATE SENATOR • 10th SENATE DISTRICT

(608) 266-7745
Toll Free: (800) 862-1092
Sen.Stafsholt@legis.wi.gov

P.O. Box 7882
Madison, WI 53707-7882

TO: Senate Committee on Health
FROM: Senator Rob Stafsholt
DATE: July 28, 2021
SUBJECT: Testimony in Favor of Senate Bill 394

Thank you, Chairman Testin and members of the Senate Committee on Health for allowing me to submit testimony in favor of Senate Bill 394.

One of the major benefits of this legislation is that it seeks to address a major health care issue facing our communities which is access. This optional licensure will lower compliance costs and reduce barriers for specialized nurses. Recognizing Advanced Practice Registered Nurses (APRNs) and focusing on streamlining licensure will increase access to healthcare, and help attract specialists to alleviate the provider shortage in our state, especially in rural areas like the 10th Senate District.

I want to thank Senator Testin and Representatives Magnafici and Cabral-Guevara for their great work on this legislation.

Thank you, members. I ask for your support.

WNA
WISCONSIN NURSES ASSOCIATION

July 28, 2021

Senator Patrick Testin
Chair, Senate Committee on Health
Room 8 South
State Capitol
Madison, WI 53707

RE: Wisconsin Nurses Association Support of SB394 and SB396 – Advanced Practice Registered Nurses

Dear Chairperson Testin and Members of the Senate Committee on Health,

On behalf of the members of the Wisconsin Nurses Association I want to thank you for holding this hearing. My name is Gina Dennik-Champion, I am a RN and the Executive Director of the Wisconsin Nurses Association. I am here today to testify in support of SB 394 and the companion bill AB 396. I would like to share our appreciation to you Chairperson Testin and Representative Rachael Cabral-Guevara for being the Sponsors of these bills. I also want to bring to your attention a letter from the nursing associations in Wisconsin asking for your support and ten pages studies demonstrating the cost-effectiveness, quality and contributions to increased access to care when utilizing APRNs at the top of their license.

Wisconsin's population an aging and we are seeing others with significant health disparities. The workforce predictions from Wisconsin Hospital Association show a dire need for health care providers now–and worsening in the near future. Advanced Practice Registered Nurses (APRNs) have proven themselves ready and able to fill those needs, particularly in rural and urban underserved areas. APRNs provide access to care at no added cost to the state. APRNs provide primary and preventive health care to the public and prescribing medications and tests when needed. APRNs treat and diagnose illnesses, advise the public on health issues, manage chronic disease, and coordinate care. They work in a variety of interprofessional and multisector teams.

Wisconsin's Nurse Practice Act, State Statute 441, is relatively silent when it comes to defining the role and responsibility of advanced practice registered nurse (APRNs). SB394/AB396 addresses this issue. Currently, the only statutorily recognized advanced practice nurse are those who have prescriptive authority APNP. This is problematic as there are approximately 500 other registered nurses who are practicing as advanced practice nurses but because they do not prescribe, they cannot hold an APNP certificate. This bill brings all advanced practice nurses whether they prescribe or not under one umbrella. The language in SB394/AB396 modernizes current statutes by removing antiquated language and clearly describing the conditions to be licensed or relicensed as an APRN in Wisconsin.

Creating a separate license for those registered nurses who meet the identified criteria to practice as an Advanced Practice Registered Nurse (APRN) is not a new concept. There are 23 states and the District of Columbia that have adopted a nationally recognized regulatory model.

Through the creation of separate licensure for APRN practice, SB394/AB396 promotes protection of the public as it clarifies the responsibility and accountability of the practicing APRN and the responsibility and authority of the Board of Nursing. The criteria and expectations laid out in the bill supports public protection and is as follows:

- Provides formal licensure for advanced practice registered nurses (APRN), recognizing the four different practice roles which are
  - Certified Nurse Midwife,
  - Certified Registered Nurse Anesthetist,
  - Clinical Nursue Specialist and
  - Nurse Practitioner.
- Requires the licensee to hold national board certification.
- Requires the licensee to have a master's degree or higher in one of the four APRN roles
- Graduated from a school of nursing with national accreditation.
- Provides a scope of practice for each role
- Requires demonstration of medical malpractice and liability insurance coverage.
- Supports a practice standard of the APRN to consult, collaborate and refer patients to other health care providers and/or health systems when the needs of the patient exceed their expertise.
- Grants title protection for APRN and the four specialties.
- Standardizes the APRN professional titles to be consistent with the other states
- Provides grandfathering for those APRNs for those advanced practice nurses who are currently practicing in an APRN role.
- Repeals §441.15 – Nurse Midwife Practice Act
- Repeals §441.16 – Prescription Privileges for Advanced Practice Nurses
- Sets the stage for future APRN Compact agreements with other states.
- Gives the Wisconsin Board of Nursing greater authority in regulating APRNs and APRN graduate schools.
- Provide technical amendments to replace Advanced Practice Nurse Prescriber (APNP) with APRN.

According to reports on the activities of the U.S. Federal Trade Commission (FTC). FTC has forwarded correspondence to state legislatures commenting on the requirements for physician collaboration for APRN licensure. Their comments include such regulations create scope of practice restrictions, and gives one group of health care professionals the ability to restrict access to the market by another, competing group of health care professionals, thereby denying health care consumers the benefits of greater competition and access to care. Such a reduction of competition may lead to a number of anticompetitive effects.

In the case of Wisconsin, currently Advanced Practice Nurses that have prescriptive authority cannot provide pharmacologic-related care without having a documented collaborative

relationship with a physician. Studies show that mandatory collaboration does not contribute to better care. This was demonstrated when the APRN physician collaboration requirement was suspended during the COVID-19 public health emergency. Collaboration agreements also create economic burdens for those APRNs practicing outside the walls of a health system. The cost of paying a physician collaborator can be substantial, that is if you can find a physician who is not bound by employer conflict of interest contracts.

Wisconsin is witnessing a shortage of physicians in our population dense and rural communities prior to, during, and post COVID-19 public health emergency. This is creating long wait times for individuals to access quality care in the most appropriate cost-effective setting. You are finding utilization of APRNs to meet the health care needs in the majority of Wisconsin's communities including yours. Research repeatedly demonstrates that APRNs provide increase access to safe, high-quality care with equivalent outcomes to their physician counterparts. This is why they are in such high demand.

WNA and our other APRN colleagues have worked diligently over many legislative sessions to produce legislation that is acceptable to many. We believe we have accomplished this. SB394/AB396 will better support the health needs of Wisconsin's population which is why WNA is requesting your support in passing the bill out of committee as soon as possible.

I thank you Chairperson Testin for holding this hearing and for the Committee member's interest. I would be more than happy to answer any questions.

Sincerely,

Gina Dennik-Champion, MSN, RN, MSHA
WNA Executive Director
608-228-3300

Testimony on the Advanced Practice Registered Nurses Modernization Act – SB 394

Submitted by: Barbara L. Nichols, PhD (H), MS, RN FAAN
Wisconsin Center for Nursing
Email: nicholsbarbara1938@att.net

July 28, 2021

Chairperson Testin and members of the Committee, thank you for allowing me the opportunity to offer testimony on behalf of SB 394. My name is Barbara Nichols, I live in Madison and serve as the Executive Director of the Wisconsin Center for Nursing (WCN). The center is a non-profit organization statutorily created in 2005 to engage public and private nursing, healthcare, business, and academic organizations to work together to ensure an adequate, competent, and diverse nursing workforce for the people of Wisconsin.

Our mission is to critically assess and monitor nursing workforce and education trends by conducting annual surveys about the Wisconsin Nursing population.

I have been a practicing nurse since 1959 in a variety of healthcare settings including the military. It is my military experience, this level of nursing practice, in particular, that confirmed the value.

I am speaking to provide data regarding the APRN Nurse population in Wisconsin. Out of 91,422 RNs, 6047 or 7% of the overall RN workforce encompass the four different rales of APRNs: Nurse Practitioner, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists and Certified Nurse Midwives.

A highlight of facts – documents that:

- Most are Nurse Practitioners or APRNs
- The majority of APRNs work in ambulatory care (52.6%) followed by hospitals (28.8%).
- The numbers certified in adult psychiatrics and mental health slightly increased.
- The average age of APRNs is 45 years with a nurse life of 24-82 years.
- The majority are white females
- The highest numbers are employed in the Southeast region of the state with the lowest employed in the Northern region.
- Educational preparation for the APRN Role is at Master Doctorate of Nursing practice program.

The demand for APRNs is driven by five Wisconsin interrelated major factors

- Population growth
- Annual nursing retirements
- Healthcare needs by the exploding elderly population
- Healthcare needs by the increasing at-risk individuals with health disparities
- Multiple and complex impacts of healthcare reform

With regard to the issues of safety frequently raised by opponents there is over 40 years of evidence showing safe and cost-effective provision of care by APRNs by the National Academy of Medicine, American Association of Retired Persons, the National Governor's Association, the Veterans Health Administration and the Federal Trade commission. Here in WI, their safety to practice was recently documented by the Governor's Executive Order #16 and #20 during the Covid -19 Pandemic. These Organizations along with many national organizations are also calling for removal of all barriers that prevent APRNs from utilizing the knowledge, skills and judgement to practice to the full extent of their education and training.

APRNs can and must be allowed to meet the healthcare needs of Wisconsin citizen's where they live regardless of age, race, ethnicity, and/or disability. Now is the time to eliminate inappropriate language that ultimately leads to under utilization of a much needed resources during a time when all providers are needed to practice. APRNs represent a knowledgeable and much needed provider to meet the delivery of patient centered, primary and community based health care.

I would be please to address any questions that you may have.

2021 APRN Modernization Act

Registered Nurses in Wisconsin are currently prevented from delivering the highest quality care. Their outdated license structure does not reflect the reality of who is practicing as an Advanced Practice Registered Nurses.

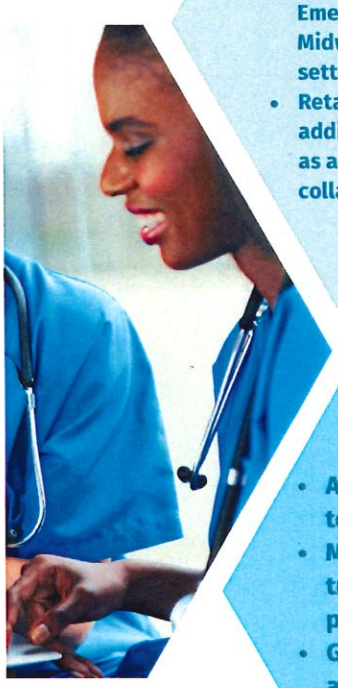
The goal of this legislation is to remove the outdated titles of Advanced Practice Nurse (APN) and Advanced Practice Nurse Prescriber (APNP) to create a new more accurate and inclusive title of Advanced Practice Registered Nurse (APRN).

Licensure

- Creates a simplified system of licensure for Advanced Practice Registered Nurses (APRNs), administered by the Board Of Nursing.
- Establishes 4 recognized roles under an APRN License
  - Certified nurse-midwife
  - Certified registered nurse anesthetist
  - Clinical nurse specialist
  - Nurse practitioner
- Eliminates outdated titles
- Does not add any new requirements for licensure

Relationships

- Requires an APRN to collaborate and refer when managing situations beyond the APRN's expertise
- Establishes a required "High Acuity Emergency Care Plan" for a Certified Nurse Midwife that practice outside of a hospital setting, as a condition of licensure
- Retains employers ability to place additional practice requirements on APRN as a condition of employment, including collaboration with a physician



Four Roles under one License

Prescribing

- Allows trained and qualified nurses to continue to prescribe
- Maintains current educational and training requirements for prescribers
- Grandfathers current prescribers and non-prescribers

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The Wisconsin Nurses Association is urging you to support this effort which will bring clarity to patients and allow nurses to practice at the top of their license.

St. Croix Tribal Health Clinic

CHS • Medical • Pharmacy • Behavioral Health • Optical • Dental • Community Health

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(715) 349-8554 • 877-455-1901

Testimony for APRN Modernization Act of 2021

July 28th and July 29th, 2021

Dear Chairman Tessin and members of the Senate Health Committee

Dear Chairman Sanfelippo and members of the Assembly Health Committee

My name is Jean Roedl and I live in Frederic WI, I have practiced in Webster WI for the past 20 years. I have been a nurse for 37 years and Nurse Practitioner for 22 years. Thank you for holding a hearing on the two Companion bills SB 394 and AB 396 and I am speaking in support of this legislation.

I have been employed by the St Croix Chippewa Indians of Wisconsin for the past 7 years as a Family Nurse Practitioner and Director of the Medical Clinic the past two years. I am board Certified as a Family Nurse Practitioner and Advanced Diabetes Management. The Native American population has the highest rate of Diabetes than any other ethnic population. The knowledge in Diabetes management is critical due to lack of access to Endocrinologist. The St. Croix Tribal Health Clinic Diabetes outcomes surpass our Bemidji area and Indian Health Services annually.

The St Croix tribe is the smallest tribe in Wisconsin but has a five-county service area of Barron, Burnett, Polk, Washburn and Pine Co, MN. In March of 2019, our Medical Director, who was a physician and served also as our collaborating physician, turned in his resignation. This action gave the tribal clinic one month to find a physician collaborator replacement. It is very difficult to recruit medical providers, specifically physicians, to rural areas in Wisconsin and especially in a one- month period of time. Without a collaborative physician for the Nurse Practitioners, the clinic would have been forced to close on April 11, 2019. The clinic would have to remain closed until a collaborating physician was found. The closure of the clinic would also suspend our medical assisted treatment for opioid and alcohol use disorders. The clinic Health Director and myself contacted retired physicians and area clinics to find a collaborative physician. At the last possible hour, 4pm on April 11, 2019, we were able to find a physician in independent practice from Hudson WI to sign a collaborative agreement. This last hour collaborative agreement allowed us to remain open and serving the St Croix Native American population. Our collaborative physician had no interest in being the Director of the Medical Clinic and I assumed this role May 2019. The St Croix Tribal Health clinic currently employs 3 full-time Nurse Practitioners.

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SENATE COMMITTEE ON HEALTH

411 SOUTH

STATE OF WISCONSIN

TO: Chairman Testin. Senator Kooyenga, Senator Bradley, Senator Erpenbach, and Senator Carpenter

DATE: July 28, 2021

RE: Testimony in Support of Senate Bill 394, APRN Modernization Act

Good morning. My name is Tim Johnson, thank you for the opportunity to appear before you today and discuss my support for Senate Bill 394, the Advance Practice Registered Nurse (APRN) Modernization Act. This important health care legislation addresses the four (4) licensed Advance Practice Nurse (APNs) specialties and our clinical expertise that serve the citizens and veterans within the state of Wisconsin.

As one of the 1000+ Certified Registered Nurse Anesthetists (CRNAs) in Wisconsin and one of the APN specialties, I wish to describe why this legislation is imperative for the current and future health care delivery system in our state. CRNAs have practiced and been an established profession in Wisconsin for close to 85 years.

CRNAs are the primary anesthesia provider in nearly every county and practice setting in Wisconsin with specific importance in rural critical access hospitals. Our training and scope of practice prepare CRNAs to be versatile APNs however some barriers exist that can impede our ability to provide anesthesia services. This bill seeks to alleviate those barriers.

The acronym APRN is established and recognized in more than half the states in the country. By updating our current terminology of APNs, we can streamline the licensing process for new and experienced APNs that wish to practice in Wisconsin. Like many health professions, CRNAs are facing projected shortfalls in staffing needs. This legislation will significantly increase the strength of Wisconsin healthcare employers for recruitment.

The education requirements for APNs are also evolving. Current APN residents graduating from accredited university programs will now have a doctoral of Nursing degree. This terminal degree incorporates aspects of leadership, business and health care policy to prepare our future APRNs to be executives, professors, entrepreneurs and politicians as evident in our current state legislature.

One other provision in the bill that impacts CRNA's specifically is language to encourage Wisconsin to permanently opt out of the federal physician supervision requirement. In 2001, the Centers for Medicare and Medicaid Services (CMS) published a final rule concerning the federal Medicare and Medicaid supervision requirement for CRNAs in the Federal Register. This rule allows individual states to opt out of physician supervision requirements to permit CRNA's to direct bill under Medicare, Part B. Starting with Governor Doyle in 2005, and each Governor since, they have sent letters to CMS stating that, after appropriate consultation, opting out of this supervision requirement is both consistent with Wisconsin law and in the best interest of Wisconsin citizens. This opt out clearly states that CRNAs can and do provide care within the full scope of their education, training, and experience. Unnecessary and costly supervision by anesthesiologists can be avoided when hospitals elect to deliver care by independently practicing CRNAs. The opt out is even more important today than it was in 2005, given the aging of Wisconsin's population demographics, the number of rural hospitals that solely rely on CRNA's to run their anesthesia departments and the greater need for cost-effectiveness in delivery of high-quality health care services.

Several studies have been recently released proving the quality, safety, and cost-effectiveness of care given by CRNAs practicing to the full scope of their education and training. A study published in Nursing Economics stated that nurse anesthesia care is extremely safe and at least 25% more cost effective than other anesthesia staffing models.

With the high quality, accessible and cost-effective care that CRNAs provide in all settings throughout Wisconsin it is clear that the current state of Wisconsin's opt out of federal supervision requirement continues to be in the best interests of the citizens of Wisconsin and should be made permanent.

Personally, I live and practice in the Green Bay area. I'm very proud of my profession and the expertise we deliver to patients every day. It's our vision that with passage of SB 394, Wisconsin can be one of the best states for anesthesia delivery models in the nation. We respectively asked for your consideration of SB 394 and welcome any questions or comments from the committee.

Thank you.

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11801 West Silver Spring Drive, Suite 200
Milwaukee, WI 53225

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TO: Chairman Testin and Members of the Senate Committee on Health
DATE: July 28, 2021
RE: Testimony in support of Senate Bill 394, APRN Modernization Act

Good morning Chairman Testin, and members of the Senate Committee on Health. Thank you for the opportunity to testify on Senate Bill 394, the Advanced Practice Registered Nurse (APRN) Modernization Act.

My name is Jenna Palzkill and I am a Certified Registered Nurse Anesthetist (CRNA) and member of the Wisconsin Association of Nurse Anesthetists (WIANA).

WIANA respectfully requests that you pass SB-394, which formally defines and describes the role, responsibility and accountability of Advanced Practice Registered Nurses (APRNs). An APRN is a registered nurse who has completed graduate-level education and acquired the clinical knowledge and skills required to provide direct patient care. CRNAs are amongst those who will qualify as an APRN under the bill. By recognizing all practicing APRNs in statute, Wisconsin will help protect its citizens through a law that defines and describes the requirements to practice as an APRN.

Nurse anesthetists have been providing anesthesia care in the United States for more than 150 years in every setting in which anesthesia care is delivered including hospitals, ambulatory surgical centers, office-based practices, obstetric units, U.S. military and VA healthcare facilities. The CRNA credential came into existence in 1956 and CRNAs became the first nursing specialty accorded direct reimbursement rights from Medicare. In 2001, the Centers for Medicare & Medicaid Services changed the federal physician supervision rule for nurse anesthetists to allow state governors to opt-out of this facility reimbursement requirement. This bill will make Wisconsin's opt-out permanent to allow CRNA's to continue to bill Medicare for their services.
The services provided by CRNAs are especially important in Wisconsin, which has a well-documented healthcare worker shortage. For example, the utilization of CRNAs is essential for providers' bandwidth in providing surgery anesthesia care. CRNAs are highly educated, experienced, qualified and capable. As a crucial source of anesthesia care in Wisconsin, Nurse anesthetists deserve to be recognized as Advanced Practice Registered Nurses and the consumers of their services deserve to be protected by the safeguards that the requirement for APRN licensure provides.

Thank you again for your time and consideration of this important piece of legislation.

AANA | GET THE FACTS

Quality of care.

WIANA
WISCONSIN ASSOCIATION OF NURSE ANESTHETISTS

There is overwhelming evidence that CRNAs provide superb anesthesia care.

Research shows there is no difference in safety between CRNAs and anesthesiologists. The safety record of CRNAs is demonstrated by recent studies published in leading health policy journals and an independent review by Cochrane, a world-renowned organization that supports evidence-based decision-making in healthcare.

KEY STUDIES OF PATIENT SAFETY

Dulisse & Cromwell, 2010 (Health Affairs)

METHODS
Analysis of Medicare data for 1999–2005 in opt-out and non-opt-out states comparing CRNA solo, MDA solo, and Team anesthesia delivery models for over 481,000 hospitalizations.

KEY FINDINGS
No evidence that opting out of the Medicare supervision requirement resulted in increased inpatient deaths or complications.

POLICY IMPLICATIONS
"Despite the shift to more anesthetics performed by nurse anesthetists, **no increase in adverse outcomes was found in either opt-out or non-opt-out states ...** These results do not support the hypothesis that allowing states to opt out of the supervision requirement resulted in increased surgical risks to patients." (p. 1474)

Dulisse, B., & Cromwell, J. (2010). No harm found when nurse anesthetists work without supervision by physicians. Health Affairs (Project Hope), 29(8), 1469–1475.

Negrusa et al., 2016 (Medical Care)

METHODS
Analysis of 5.7 million commercial claims from 2011-2012 by state SOP and delivery models including CRNA alone, MDA alone, and various direction and supervision models.

KEY FINDINGS
The odds of a complication did not differ based on degree of state SOP restrictions or by delivery model.

POLICY IMPLICATIONS
"...there is no statistically significant difference in the risk of anesthesia complications based on the degree of restrictions placed on CRNAs by state SOP laws. Nor is there evidence that the risk of complications varies by delivery model. This evidence suggests that there is **no empirical evidence for SOP laws that restrict CRNAs** from practicing at levels that are below their education and training based on differences in anesthesia complication risk." (p. 7)

Negrusa, B., Hogan, P. F., Warner, J. T., Schroeder, C. H., & Pang, B. (2016). Scope of Practice Laws and Anesthesia Complications: No Measurable Im-pact of Certified Registered Nurse Anesthetist Expanded Scope of Practice on Anesthesia-related Complications. Medical Care, 54(10), 913–920.

Lewis et al., 2014 (Cochrane)

METHODS
Systematic review conducted by independent organization of 6 studies evaluating physician and non-physician anesthesia providers.

KEY FINDINGS
This evaluation of currently available scientific evidence was unable to draw conclusions about the superiority of any particular type of anesthesia provider. While the evaluation noted important limitations of the existing studies, the bottom line is that evidence to support the claim that physicians provide better anesthesia care compared to CRNAs is just not there.

POLICY IMPLICATIONS
"Overall, while some studies have shown small and inconsistent differences in some outcomes, the quality and nature of the **evidence are insufficient to draw firm conclusions about relative benefits and risks** of the different models of anaesthetic provision." (p. 14-15).

Lewis, S. R., Nicholson, A., Smith, A. F., & Alderson, P. (2014). Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. The Cochrane Database of Systematic Reviews, (7), CD010357.

AANA | GET THE FACTS

Quality of care.

WIANA NURSE ANESTHETISTS

The American Society of Anesthesiologists tries very hard to discredit the critical research on anesthesia safety funded by the AANA.

They would have you believe there is clear evidence of superior care when it's supervised by an anesthesiologist. **But there isn't.** These studies are all published in ASA or other medical anesthesiology-sponsored journals.

ASA-PREFERRED STUDIES OF PATIENT OUTCOMES

Silber et al, 2000 (Anesthesiology)

Inaccurately touted as the "gold standard", this study has significant methodological problems including:

- The data is 25+ years old
- The use of a 30-day mortality measure, which cannot assess anesthesia care where outcomes are measured within 48 hours
- No determination of provider type in the majority of undirected cases
- The large reported differences in mortality and failure-to-rescue are widely inconsistent with other reported rates of anesthesia-related mortality and complications, suggesting that these differences are not due to anesthesia care at all, but rather to unrelated perioperative care processes

HCFA determined this study to be irrelevant as evidence supporting physician supervision of CRNAs. According to HCFA/CMS published in the Federal Register, **"One cannot use this analysis (Silber) to make conclusions about CRNA performance with or without physician supervision."**

Silber, J. H., Kennedy, S. K., Even-Shoshan, O., Chen, W., Koziol, L. F., Showan, A. M., & Longnecker, D. E. (2000). Anesthesiologist direction and patient outcomes. Anesthesiology, 93(1), 152-163.

Memtsoudis et al, 2012 (Journal of Clinical Anesthesia)

This study tries to demonstrate that poorer outcomes and higher costs are associated with CRNA-provided anesthesia care based on selected years of data 10 years apart. However, an editorial in the same issue describes the problems with the methods and assumptions of this study:

- No adjustment for patient-level risk such as comorbidities
- No adjustment for geography despite known regional variation in discharge to residence based on research
- Outcome is not anesthesia specific and ignores many other factors that might affect discharge status like duration and end time of the procedure or complications unrelated to anesthesia
- Advancements in perioperative care and anesthesia techniques 1996-2006 indicate these should not be treated as comparable populations
- Only two types of procedures were analyzed, severely limiting generalizability

Memtsoudis, S. G., Ma, Y., Swamidoss, C. P., Edwards, A. M., Mazumdar, M., & Liguori, G. A. (2012). Factors influencing unexpected disposition after orthopedic ambulatory surgery. Journal of Clinical Anesthesia, 24(2), 89-95.

Miller et al, 2016 (A&A Practice)

The ASA uses this study to show that anesthesiologists are "affiliated" with hospitals exclusively billing with the QZ modifier (i.e. CRNA without medical direction), but the ASA inaccurately concludes that "potential" MDA involvement translates to "actual" involvement in CRNA cases. Other notable findings of the study include:

- The median number of MDAs at QZ only hospitals is 0.5 MDAs compared to 2.3 CRNAs, suggesting that MDAs often are not readily available and it actually is CRNAs providing the bulk of anesthesia care at those facilities, most likely without substantial involvement of MDAs

Miller, T. R., Abouleish, A., & Halzack, N. M. (2016). Anesthesiologists are affiliated with many hospitals only reporting anesthesia claims using modifier QZ for medicare claims in 2013. A&A Practice, 6(7), 217-219.

AANA | GET THE FACTS

Access to care.

WIANA NURSE ANESTHETISTS

ASA research on opt-out and access to care misses the point.

- **Despite the true intent of this regulation,** a series of studies funded by the ASA and largely published in ASA journals has attempted to demonstrate that this policy has no beneficial effect on patients' access to anesthesia or surgical services.
- **However, increased access** was not the intended goal of opt-out policy.
- **These studies found that a state's decision to 'opt-out'** of the Medicare supervision requirement has no measurable impact on access to services in that state as measured by utilization of surgical services and distance traveled by patients.[12-15]
- **Such outcomes are highly complex phenomena** unlikely to be causally linked to any single policy initiative, particularly one that was never intended to produce such effects.

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AANA | GET THE FACTS

Access to care.

WIANA NURSE ANESTHETISTS

CRNAs are critical to the provision of rural surgical and obstetric care and to the sustainability of rural hospitals.

- **County-level analysis** of the availability of CRNAs and Anesthesiologists demonstrate greater availability of CRNAs in counties with more vulnerable populations including uninsured, Medicaid eligible, and unemployed.[1]
- **CRNAs represent more than 80%** of the anesthesia providers in rural counties. There are also more CRNAs per population in less restrictive and opt-out states.[2]
- **50 percent of rural hospitals** use a CRNA-only model for obstetric care.[3]
- **CRNA delivery models** predominate in rural areas: 61% in ASCs, 55% in small hospitals, and 35% large hospitals.[4]
- **Surgical volume is directly associated** with the financial viability of rural hospitals.[5]
- **Rural hospitals are essential to the local economy** in many rural communities. Many of these are Critical Access Hospitals (CAH) which are often reliant on independently practicing CRNAs for anesthesia care.
- **Surgical outcomes** including mortality and serious complications in CAH are better than or similar to outcomes in non-CAHs and have lower costs.[6]
- **CRNAs can also safely deliver pain management care** in areas where there are no physician providers available saving patients long drives of 75 miles or more.[7]

Opt-out allows expanded options to hospitals, ambulatory surgical centers, and other providers in delivery of anesthesia.

- **According to the regulation,** the intent was to "provide hospitals, CAHs, and ASCs, with more flexibility in how they provide quality anesthesia services, and encourage implementation of the best practice protocols."[8]
- **Hospital administrators are often confused** about the complexities of anesthesia supervision and reimbursement policy and take great care to establish facility regulations that ensure compliance with these laws.[9]

CRNAs report less restrictive SOP in opt-out states and when practicing in rural areas.[10]

- **This is necessary due to the lack of anesthesiologists** available to supervise in many areas – 81% of counties have no anesthesiologist, 55% of counties have no surgeon, and only 58% have no CRNA.[4]
- **There is a weaker relationship between CRNA and anesthesiologist availability** in less restrictive and opt-out settings due to the potential for greater substitution.[2] The current shortage of anesthesia providers may be partially alleviated with less restrictive supervision policies that make more efficient use of the available anesthesia workforce.
- **Anesthesia services are not reported as a current limitation** to care delivery in rural areas because CRNAs have strong, diverse skills sets and many hospitals already allow a high level of CRNA autonomy.[11]

CRNA Education and Training

Certified Registered Nurse Anesthesists (CRNAs) are highly educated, advanced practice registered nurses who deliver anesthesia to patients in exactly the same ways, for the same types of procedures and just as safely as anesthsiologists.

CRNAs have a minimum of **7 to 8½ years of education and training specific to nursing and anesthesiology** before they are licensed to practice anesthesia.

Baccalaureate prepared RN

Average 2.9 Years

Critical care nursing experience prior to entering nurse anesthesia program[1]

24 – 42 Months

Classroom and clinical education and training

Master's or Doctoral Degree from a COA-accredited nurse anesthesia educational program[2]

By 2025, all anesthesia program graduates will earn doctoral degrees

Nurse anesthetists obtain an average of

9,369 Clinical Hours

of training prior to becoming a CRNA.

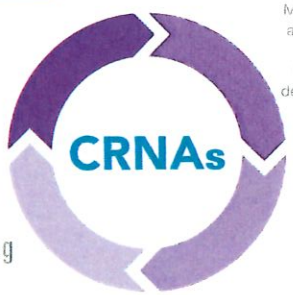
Constant Learners

CRNAs must pass a **National Certification Examination** for entry into practice and be recertified every 4 years so they are current on anesthesia techniques and technologies. They must also pass a Continued Professional Certification exam every **8 years**. Anesthesiologists are recertified **every 10 years.**

Minimum **60 hours** of approved continuing education and **40 hours** professional development activities every 4 years

Documentation of substantial anesthesia practice

Maintenance of current state licensure



CRNAs are qualified to administer **every type of anesthesia in any healthcare setting**, including pain management for acute or chronic pain.

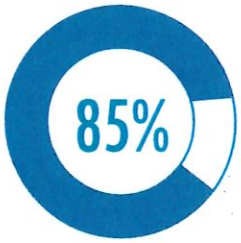
Manage difficult cases

Use advanced monitoring equipment

Interpret diagnostic information

Respond appropriately in any emergency situation

Research shows that CRNAs are



less costly to educate and train than anesthesiologists.[3]

As the demand for healthcare continues to grow, increasing the number of CRNAs will be key to containing costs while maintaining quality care.

1 CRNAs are the only anesthesia professionals with this level of critical care experience prior to entering an educational program.

2 Council on Accreditation of Nurse Anesthesia Educational Programs

3 Update of Cost Effectiveness of Anesthesia Providers, Lewin Group Publications, May 2016

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CRNAs: Ensuring Safe Anesthesia Care

WHY SURGEONS AND OTHER HEALTHCARE PROVIDERS RELY ON CRNAs

Certified Registered Nurse Anesthetists (CRNAs) are advanced practice registered nurses who collaborate with surgeons, obstetricians, anesthesiologists, dentists and other healthcare providers to deliver safe, high-quality and cost-effective anesthesia care to patients in virtually every healthcare setting.

Access to Care

CRNAs practice in **all 50 states** and in the military, safely providing more than 49 million anesthetics each year.

Patient Safety

A landmark study confirms that anesthesia care is equally safe regardless of whether it is provided by a CRNA working alone, an anesthesiologist working alone or a CRNA working with an anesthesiologist.*

Anesthesia care is **nearly 50x safer** than it was in the 1980s.**

This is due to **advancements in monitoring** technology, anesthetic drugs, provider education, and standards of care.

Risk Management

CRNAs are **educated, trained** and experienced in providing anesthesia care for complicated medical procedures and handling emergency situations.

As licensed professionals, CRNAs are responsible and accountable for decisions made and actions taken in their professional practice.

Case law shows that surgeons and other healthcare providers face no increase in liability when working with a CRNA versus an anesthesiologist.

For a surgeon (or other healthcare provider) to be liable for the acts of an anesthesia professional, the surgeon must control the actions of the CRNA or anesthesiologist and not merely supervise or direct them.

Courts apply the same standard to judge whether a surgeon is liable for the acts of a CRNA or an anesthesiologist.

CRNA malpractice liability premiums are **33 percent lower** than 30 years ago, **68 percent lower** when adjusted for inflation. CRNAs carry insurance coverage for all the services they provide.

Cost Savings

Healthcare facilities that hire anesthesiologists to supervise CRNAs in an effort to manage risk may more than triple the costs of anesthesia delivery without improving patient outcomes, lowering risk or reducing liability coverage costs.

*RTI

**Institute of Medicine

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CRNAs

Certified Registered Nurse Anesthetists

Are the Most **VERSATILE** and **COST-EFFECTIVE ANESTHESIA PROVIDERS**

Cost Effectiveness of Anesthesia Models

Autonomous/CRNAs Collaborating with Surgeons

CRNA: 12

Staffing Cost[2]: **2.00M**

CRNAs Collaborating with Anesthesiologists

CRNA: 12 | ANES[1]: 1

Staffing Cost[2]: **2.40M**

Physician Anesthesiologist Only

ANES[1]: 12

Staffing Cost[2]: **5.04M**

Anesthesia Care Team

(3:1 Ratio)

CRNA: 12 | ANES[1]: 4

Staffing Cost[2]: **3.68M**

- CRNAs are qualified to work in any practice setting/model
- CRNAs are not required to practice under a physician anesthesiologist; by law, CRNAs can work independently of OR together with physician anesthesiologists
- CRNAs have a proven safety record
- CRNAs in Anesthesia Care Team Model ensure **NO LOSS IN REVENUE, NO RISK OF FRAUD**, no delays in delivery of care even when there is a supervision lapse (up to 70%[3] of the time) as long as **QZ billing** is utilized
- In such cases, the facility simply bills exclusive of the anesthesiologist for the procedure (QZ vs. medical direction). **The QZ modifier** is exclusive to CRNAs

1 Physician anesthesiologist

2 Staffing costs are based on salary only. The median CRNA salary ($166,547) was taken from the 2018 AANA Compensation and Benefits Survey. Salary costs for physician anesthesiologists are based on the 75th paid salary ($420,284) according to HFI Reported data as of March 26, 2018 from Salary.com

3 Epstein R, Dexter F (2012). Influence of supervision ratios by anesthesiologist on first case starts and critical periods of anesthetics. Anesthesiology, 116(3):683-691.

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ANESTHESIA AND THE CHANGING HEALTHCARE LANDSCAPE:
CRNAs' Valuable Role

THE CHANGING HEALTHCARE LANDSCAPE

As the U.S. patient population ages and becomes more diversified, **Certified Registered Nurse Anesthetists (CRNAs) play a vital role in ensuring access to safe, cost-effective anesthesia care for all Americans.**

WHO ARE CRNAs?

CRNAs are highly educated anesthesia experts who provide **EVERY TYPE OF ANESTHESIA, FOR PATIENTS OF ALL AGES, FOR ANY KIND OF PROCEDURE, AND IN EVERY HEALTHCARE SETTING** where anesthesia is required

- General anesthesia
- Regional anesthesia
- Sedation
- Pain management

CRNAs ARE SAFE

Anesthesia is **50 TIMES** safer today than in the 1980s.
National Academy of Medicine

There is a **0%** difference in safety between CRNAs and anesthesiologists.
Research Triangle Institute

CRNAs ARE COST EFFECTIVE

Research shows that CRNAs are the most cost-effective anesthesia providers with an exceptional safety record.

25% More Expensive
anesthesiologist directing 4 CRNAs

BEST VALUE
CRNA as sole anesthesia provider

110% More Expensive
anesthesiologist directing 1 CRNA

CRNAs IMPROVE ACCESS TO CARE

MILLIONS OF AMERICANS rely on CRNAs for their anesthesia care, especially:

CRNAs ARE TEAM PLAYERS

Like all anesthesia professionals, CRNAs collaborate with other members of a patient's healthcare team:

surgeons | obstetricians | endoscopists | podiatrists
pain specialists | other qualified healthcare providers

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Wisconsin Hospitals by Anesthesia Delivery Model

September 2019

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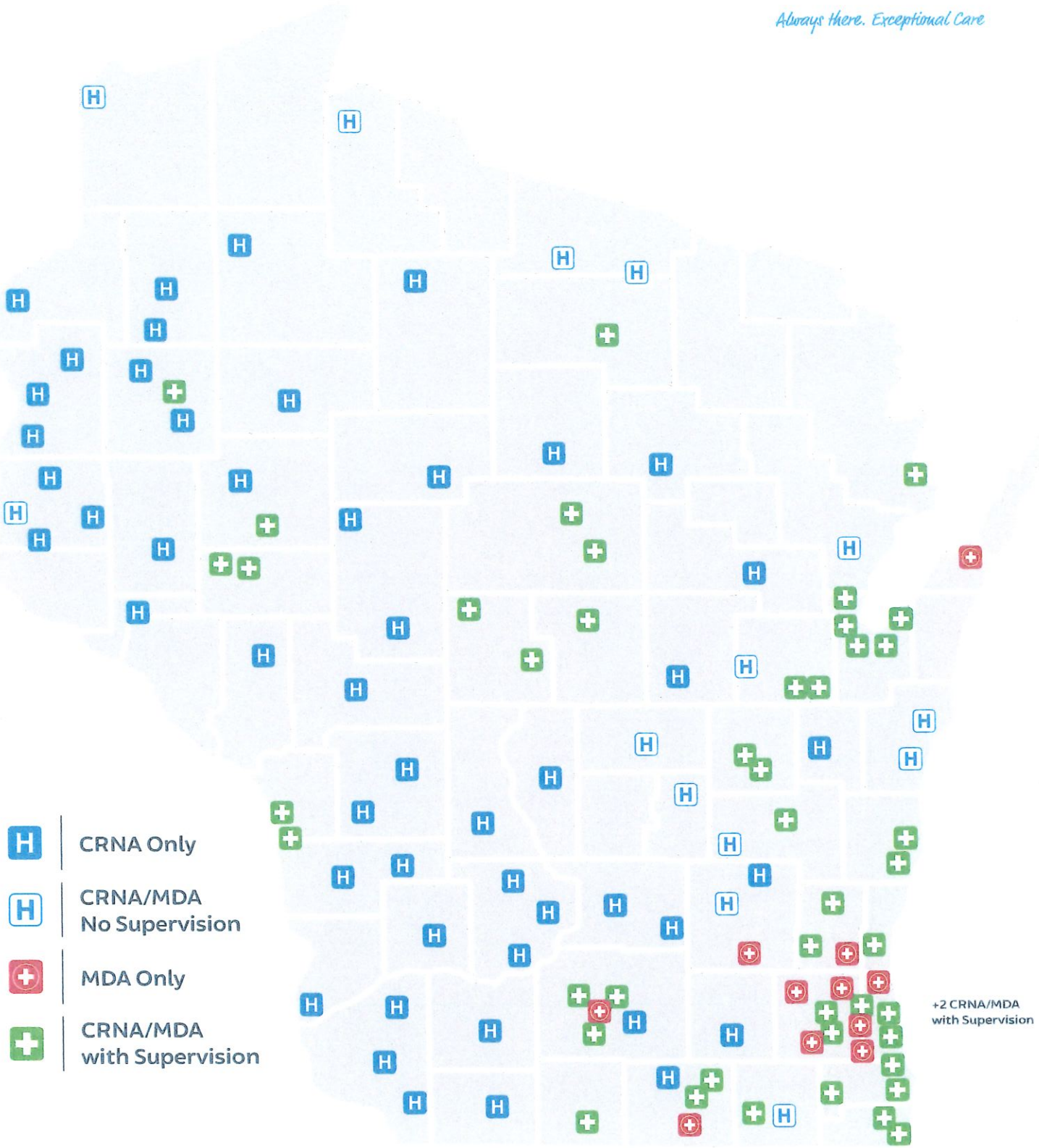
Always there. Exceptional Care



Source: WI Association of Nurse Anesthetists

Testimony of Dr. Elizabeth Yun, Pediatric Anesthesiologist and WSA Board President

Good morning. My name is Dr. Elizabeth Yun and I am a pediatric anesthesiologist, practicing for over 20 years at the University of Wisconsin in Madison. I am also the current president of the Wisconsin Society of Anesthesiologists.

I am here to express my opposition for Senate Bill 394, especially as it impacts the anesthesia care for Wisconsinites. It eliminates all forms of physician collaboration and supervision of APRNs. Specifically for the practice of anesthesia, this bill expands the scope of practice of CRNAs to include pain management and codifies the state's opt out of the federal supervision requirement for nurse anesthetists for Medicaid reimbursement. I greatly respect my CRNA colleagues that I work with every day at UW and the American Family Childrens Hospital here in Madison. In this team care model, I supervise one to two residents, CRNAs or anesthesiology assistants as we take care of pediatric patients having surgery. In fact, I have spoken to the board chair for the Wisconsin Academy of Anesthesiologist Assistants and I'm sharing a letter from another CAA, Laura Wyatt, with my own testimony. They too have serious concerns with this bill. In short, the anesthesia care team model works.

As a pediatric anesthesiologist, I see every day how vital this physician led team approach is for the safe anesthetic management of pediatric patients. For instance, a tonsillectomy is a procedure that is commonly performed in many community and academic hospitals. On the surface, these patients seem healthy. However, many of them have obstructive sleep apnea, That means they have disordered breathing patterns due to the apnea that can get worse under anesthesia. If not managed properly, these patients can develop respiratory complications that may require an unintended hospital admission. As an anesthesiologist, I am closely watching these patients' respiratory patterns throughout the entire case and I work with my team to make sure everything goes well. If a pediatric patient starts to have problems breathing, we perform maneuvers to make sure the patient's airway is open so they can breathe better and get much needed oxygen. We give medications to try and improve the breathing. If the patient still has issues, there are at least two of us, the resident, CRNA or AA and me working together to rescue the situation so the patient recovers uneventfully and can go home. If there is only one anesthesia provider, a situation like this can quickly spiral out of control and the patient could die from a respiratory complication. Nothing is more terrible than having a child suffer from this critical respiratory complication because there were not enough anesthesia providers to rescue the patient.

My fellow WSA board member, Dr. Barb Meinecke from CHW describes, in her written testimony to the committee, another example of the critical importance of the physician led team model. Malignant hyperthermia is a severe reaction to commonly used anesthesia drugs, the paralytic drug, succinylcholine and inhaled anesthesia gases, sevoflurane, desflurane and isoflurane, due to a genetic mutation that leads to a hypermetabolic cascade. Oftentimes, the first indication that a person has this mutation is when they undergo an anesthesia with these drugs. Fortunately, this mutation is rare but when it happens, it can be unexpected and lethal for a patient. On a day in March, she and her anesthesiologist colleagues rescued an otherwise

healthy 28 year old patient who develop this condition during surgery that the nurse anesthetist in the room was slow to recognize. Dr. Meinecke and her colleagues took charge of the situation, turning off the inhaled anesthesia drugs, giving a drug called Dantrolene to stop the cascade and resuscitating the patient. Afterwards, she continued her involvement with the case by providing critical information to the ICU team caring for the patient and counseling the family about the need for further testing.

These two examples highlight how critical the physician led anesthesia team care model is for the safe care of all patients. Yet this proposal will severely weaken this healthcare team model.

Deep in this bill, on page 42, is a new expansive scope of practice statement for nurse anesthetists that reads:

"Practice of a certified registered nurse anesthetist" means providing anesthesia care, pain management care, and care related to anesthesia and pain management for persons across their lifespan, whose health status may range from healthy through all levels of acuity, including persons with immediate, severe, or life-threatening illness or injury, in diverse settings, including hospitals, ambulatory surgery centers, outpatient clinics, medical offices, and home health care settings.

The whole paragraph is extremely alarming, especially when considered with the provisions of this bill that would eliminate collaboration and supervision required under current law. But especially troubling is the inclusion of "pain medicine". Chronic pain is a complex medical syndrome that involves a high level of expertise and skill by a board certified chronic pain physician to ensure that the patient has the best chance for a better quality of life and recovery. Without a chronic pain physician oversight, these patients are at high risk of being exposed to inappropriate medications and procedures. Dr. Amit Singh, a chronic pain physician at MCW has submitted eloquent testimony explaining the negative impact of this bill on pain management. As he states "Patients suffering from chronic pain suffer from a complex chronic disease that requires appropriate medical training, including a fellowship, along with years of experience and a drive to become the best physician possible by learning from each patient interaction. The opposite of this approach is to focus only on the procedural aspects of pain management, thus being a technician generating reimbursable procedural codes. ". The WSA is deeply troubled by this provision and has great concerns with patient safety should nurse anesthetists practice chronic pain medicine without chronic pain physician' – let alone anesthesiologist – involvement.

The bill, on page 53, codifies the federal opt-out of physician supervision for Medicaid and Medicare reimbursement of nurse anesthetists. By codifying the federal opt out, nurse anesthetists can bill for their services from Medicaid without needing physician supervision. This codification incentives hospitals to eliminate the anesthesiologists in a short-sighted attempt to decrease costs. However, the procedures and care will still cost the same. Studies also have shown that having an anesthesiologist involved in the care of a surgical patient decreases the risk of death and complications, saving patients' lives and saving the hospital

money. Nationally, a statutory codification of the opt-out has never been attempted in any other state. Not only would it permanently put a decision in state law that was supposed to be made by a governor - any governor - in consultation with the state's Medical Examining Board and Board of Nursing, it would nullify the existing physician supervision requirement in Wisconsin law.

Finally, proponents of the bill argue that this bill will lead to increased numbers of providers in underserved areas. This bill does not solve provider shortages, it expands practice for existing providers and removes physician involvement. Incentivizing anesthesia care without anesthesiologists only jeopardizes patients and will reduce the quality of care provided in less served areas of the state. Instead of trying to cut out a vital member of the health care team, we should be looking for solutions to attract BOTH physicians and nurse practitioners to these places. By doing so, we can ensure that all Wisconsin patients have access to physician led care.

Thank you for your time.

TO: MEMBERS OF THE SENATE HEALTH COMMITTEE
FROM: DR. BARBARA J. MEINECKE, PEDIATRIC ANESTHESIOLOGY
DATE: JULY 28, 2021
RE: OPPOSITION TO SB 394: APRN BILL

There was a day in March 2013 that started like any other. I was a senior resident at the Medical College of Wisconsin on rotation at Froedtert Hospital. After finishing my five scheduled cases, I finally got a lunch break. While having lunch with three of my attending physicians, one of the techs handed a piece of paper to one of them and hurriedly whispered to her. What she was handed was a venous blood gas report. A look of shock came over her face as she asked "Uh guys, have any of you seen MH before?", as we all instantly got up and sprinted to that operating room.

What is MH? MH stands for malignant hyperthermia. MH is a severe reaction to commonly used drugs for anesthesia (the paralytic drug succinylcholine and the volatile gas family – sevoflurane, isoflurane, desflurane, halothane) due to a genetic mutation of the ryanodine (RYR1) receptor. This causes a disruption in normal cellular calcium metabolism, causing a hypermetabolic cascade that can quickly be lethal. Signs and symptoms include increased carbon dioxide production (which is seen on the ventilation monitors), tachycardia, hypertension, muscle rigidity, renal damage, and severe temperature increases (>104F). Some patients carry a new gene mutation and have no family history, however, it commonly runs in families. Wisconsin does have a known cluster population in the north central part of the state with many affected families.

When the four of us got to the room, we called for more help and got to work. We stopped the anesthetic Desflurane that was running, turned on high oxygen flows from a bag-valve circuit and disconnected the patient from the anesthesia machine ventilator. We told the surgeon to quickly put a dressing over the surgical site – we had to stop! Additional IVs were placed to start administering a large volume of the drug Dantrolene to start reversing the process. An Arterial line was placed. A Foley catheter was placed – where we saw brown urine due to myoglobin – a tell-tale sign of severe muscle breakdown. Ice packs were placed all over the patient. Room temperature was dropped. With treatment in progress, we started seeing the tide turning - vital sign moving toward normal. The job was not done yet – he could re-trigger at any time in the next hours to days and would likely need more doses of Dantrolene to keep that at bay.

This is a scenario Anesthesiologists are trained to spot a mile away. Books, lectures, simulator sessions – this is the anesthesia scenario most tightly taught because there is no room for error. The most disturbing thing about this case was not that it happened, but what was happening when we got to the room. A nurse anesthetist was in the room as this unfolded. With the increases in carbon dioxide, he turned up the ventilation rate. This only helped for a few minutes. With the hypertension and tachycardia, he then thought the patient was "light" (under-anesthetized) and turned up the anesthetic agent. When we all got to the room, the patient was being ventilated at a rate and volume that would surely cause lung injury *and the*

anesthetic Desflurane was turned on as high as it would go. The nurse anesthetist completely did not recognize the singular lethal complication to delivery of anesthesia. I cannot stress this enough: without physician supervision and intervention, this otherwise healthy, 28-year old patient, would have died.

This story does not end there. He was admitted to the intensive care unit, intubated and sedated, for on-going treatment. He required multiple rounds of Dantrolene before his symptoms finally resolved. When the ICU had questions over the next 2 days, I was paged, ***not*** the nurse anesthetist. When it was time to counsel the family, I was there, ***not*** the nurse anesthetist. When the family needed help setting up muscle biopsy testing at the University of Minnesota, I was there, ***not*** the nurse anesthetist. When I got a call from my program director to present this case at a Grand Rounds, the nurse anesthetist said he was not interested in helping with that presentation. This patient was not my patient, but I took ownership. I was there for him and for his family. The nurse anesthetist on the case did not.

In the last week, another incident occurred that again evidences the vital importance of physician involvement in patient care. In this case, I was looking through my assigned cases on Thursday night for Friday. I had a 6-month old scheduled for elective circumcision. I noticed "Congenital Pulmonary Airway Malformation" (CPAM) on the child's problem list. Now, I know that we take those out really early in life (first 3-4 months) because of the problems they can cause if left in. I knew to review the chart closely to find the surgery that must have been performed. It turns out the surgery had been done 7 weeks prior at a hospital in another network. This child was seen by the APNP in the urology clinic, acting independently. The history and physical as documented by the NP provided: "no pertinent surgical history." There was not even a mention of healing scars on the physical exam. **The NP did not catch that this baby had a lobe of a lung removed recently and should not be receiving this elective surgery.**

In consultation with the urologist, when I brought this to his attention, and with one of our general surgeons who performs this operation, we all agreed that enough time had not passed to be sure that the lung was fully healed and able to tolerate ventilator-assisted ventilation without causing injury at the surgery site. Furthermore, this baby was scheduled at the surgery center 5 miles away from the main hospital. If an emergency such as pneumothorax, (air collecting in the chest, outside the lung) occurred, our resources to stabilize and treat the issue are limited and it is an ambulance ride to more advanced care.

This is something an astute clinician SHOULD catch, but this NP did not. It should have generated a call to confer with the surgeon and appropriate timing for a safe surgery discussed rather than me, the anesthesiologist, catching it the night before.

These examples are exactly why physician involvement should NEVER be removed from patient care. Please oppose Senate Bill 394.

TO: **MEMBERS OF THE SENATE AND ASSEMBLY HEALTH COMMITTEES**
FROM: **DR. AMIT SINGH, ANESTHESIOLOGIST AND PAIN MANAGEMENT SPECIALIST**
DATE: **JULY 28, 2021**
RE: **OPPOSITION TO SB 394/AB 396: APRN BILL**

It required five years of hands- on education and training after medical school to learn the basics of anesthesiology and pain medicine. This included internship, anesthesiology residency, and finally a fellowship in Pain Medicine, which I completed in 2010. However, the learning does not stop to this day, as this is an active effort to ensure that I am more than a technician generating billable insurance codes. It is an active effort to ensure I treat every patient as a whole person and not just the sum of individual medical complaints and associated body parts.

In chronic pain, we approach it as a chronic disease, like diabetes, within a biopsychosocial model for diagnosis and treatment. This means that while pain is a complaint, factors that contribute to it include medical diseases, psychological problems/ disorders, and social factors, such as lack of sleep or homelessness. This distinction is important about chronic pain because it takes a fellowship with hands- on clinical training and experience to diagnose pain complaints accurately.

When pain is treated by practitioners that are not appropriately trained, the following are guaranteed to happen: misdiagnosis of the pain causing condition; misutilization of diagnostic tests such as MRIs; overutilization and misutilization of pain procedures (epidural steroid injections); opioid overutilization in chronic pain patients, patients that are often more vulnerable to the undesired effects of opioids because of higher rates of co-existing depression, anxiety and other mental health diseases.

Misdiagnoses occur because of the lack of knowledge about pain circuitry in the body, spinal cord, and brain. They occur because untrained practitioners treat the findings on the MRI of the spine, instead of taking a thorough history and correlating the imaging findings to the physical examination of the patient.

Misutilization of imaging studies, consultations, and procedural overutilization from other specialists occur because of the lack of knowledge of the location of pain complaints and its associated symptoms. An obvious example is that not all pain going down the arm or leg is coming from the spine or sciatica. Too often, the complaint of arm or leg pain leads to unnecessary MRIs of the spine resulting in unnecessary epidural steroid injections and other specialty consultations.

With unnecessary and high-risk spine procedures, complications are difficult to recognize and treat. Death as a complication of pain procedures from untrained practitioners is a distinct probability. I will also state that weekend and online courses claiming to teach pain related procedures is a farce at best. I urge you to visit the website for the University of South Florida Advanced Pain Management Fellowship Graduate Certificate program (https://health.usf.edu/nursing/painmgmt). The only procedural training in this program is a 3-

credit hour course at a simulation center: *"NGR 6473C Interventional Procedures/Simulations in Pain Management* ***Credit Hours: 3*** *(Partially online), Students must come to campus for a weekend simulation activity at the Center for Advanced Medical Learning and Simulation - CAMLS."*

Yet currently there are certified registered nurse anesthetists (CRNAs) with this certification independently performing high- risk spine procedures in Wisconsin. Other procedures supported within the American Association of Nurse Anesthetists Chronic Pain Guidelines include sympathetic nerve blocks, peripheral nerve blocks and joint injections. Many of these injections involve placing the needle tip near other critical structures such as the spinal cord, the phrenic nerve (allows the diaphragm to function so we can breathe), the carotid artery (critical for the blood supply to the brain), internal abdominal structures, and the lungs. I would argue that a 3- credit hour course within a 15- credit hour certification program does not equip any individual to perform these types of procedures. Even one preventable death or paralysis should be enough to ensure that untrained providers do not perform procedures only to generate billable procedural codes.

I hope we can all agree that there still exists an opioid epidemic. There were a record number of opioid overdose deaths last year. By stating this obvious fact, I want to ensure that we do not unintentionally worsen the opioid epidemic in Wisconsin. Medical knowledge that is gained in a medical pain medicine fellowship is critical to ensuring that opioids are prescribed appropriately. The current collaboration model of practice with APNPs allows physicians to ensure appropriate opioid prescribing and monitoring. Finally, if there are concerns for misuse for specific patients, supervision/ collaboration allows for early recognition and appropriate referrals for opioid use disorder (aka addiction).

As a recent example, A patient was referred to me for injections of the joints of the lower spine. This patient was seen as a new patient by a nurse practitioner for complaints of worsening chronic low back pain over the past few months. The decision was made to send this patient for an injection based on the complaints of low back pain and based on an MRI of the low back showing degenerative changes within these joints. I would like to point out that these degenerative changes are often normal in all of us with age, and most of us are asymptomatic. Upon evaluating this patient, the patient stated that in fact she was having pain in the Left mid-back, low back, buttocks, and the outside of the left thigh. Just based on this history, I knew the joint injections were not the right diagnosis and injecting them with cortisone was not the right treatment. Instead of injections, I referred her to physical therapy with a diagnosis of pain from her sacroiliac joint because of a chronic dysfunction of this joint. In turn, this joint dysfunction was causing dysfunction of the gluteal muscles, which was causing a bursitis of the hip, resulting in pain radiating into the outside of the thigh.

Patients suffering from chronic pain suffer from a complex chronic disease that requires appropriate medical training, including a fellowship, along with years of experience and a drive to become the best physician possible by learning from each patient interaction. The opposite

of this approach is to focus only on the procedural aspects of pain management, thus being a technician generating reimbursable procedural codes.

In the interest of safety for some of the most complex patients and to ensure we treat every patient as a whole person, I implore each member of this committee to not support SB 394/AB 396. Additionally, I ask the committees to begin conversations about improving physician- led care in Wisconsin so we can improve the health of our friends and neighbors.

TO: Senate Health Committee Members
FROM: Laura Wyatt, Certified Anesthesiologist Assistant
DATE: July 28, 2021
RE: Opposition to SB 394

My name is Laura Wyatt and I am a Certified Anesthesiologist Assistant. I have been practicing for almost 8 years, and currently practice at the University of Wisconsin-Madison.

I am here to express my opposition for Senate Bill 394 specifically as it impacts the anesthesia care for the residents of Wisconsin. It eliminates all forms of physician collaboration and supervision of Advance Practice Registered Nurses. Specific to anesthesia, the bill expands the scope of practice of Certified Registered Nurse Anesthetists to include pain management and codifies the state's opt out of the federal supervision requirement for nurse anesthetists for Medicaid reimbursement. I am here to support the model of anesthesia care that has been proven to be the safest way to deliver anesthesia: the Anesthesia Care Team model.

The Anesthesia Care Team is a team of anesthesia providers that is led by a Physician Anesthesiologist. At the University of Wisconsin-Madison, the Physician Anesthesiologist directly supervises an anesthesia resident, Certified Anesthesiologist Assistant, or Nurse Anesthetist. Within the University of Wisconsin Anesthesia Department, Certified Anesthesiologist Assistants and CRNA's have the same job description, duties, and call responsibilities. As a Certified Anesthesiologist Assistant, I have been trained to work in collaboration with physician anesthesiologists to provide safe anesthesia care to our patients.

Last month I was involved in an emergency craniotomy on a 9 year old patient. While I set up the room for the case, my physician anesthesiologist was in contact with the emergency room physicians and surgeon. When the patient arrived in the emergency department, I was involved in the initial anesthesia evaluation and emergent transport to the operating room. In a trauma situation like this, more than one trained anesthesia provider is necessary to provide the safest care. We were able to work together as a team to put this patient to sleep, get the necessary intravenous and monitoring lines placed, and facilitate the surgery start as quickly as possible to save this child's life. I was working with a physician anesthesiologist with whom I have mutual respect and understanding, and our communication and expediency saved this child's life. This is just one recent personal example that illustrates the need for the physician anesthesiologist-led Anesthesia Care Team.

The Anesthesia Care Team model is the safest model of anesthesia care. I am proud to work alongside physician anesthesiologists as a member of the Anesthesia Care Team. I urge you to keep physician anesthesiologists at the forefront of anesthesia care for the safety of all Wisconsinites.

Thank you for your time.

Testimony of Dr. Joe Strosin, Anesthesiologist, Opposed to SB 394

Good Morning Chairperson Testin and Members of the Senate Health Committee,

My name is Dr. Joe Strosin and I am a board-certified anesthesiologist who practices in Waukesha, Wisconsin with ProHealth Care. I am a constituent of senator Chris Kapenga. I appreciate the opportunity to speak in opposition of companion bills SB394/AB396. My goal today is to discuss three key factors in the state of Wisconsin that relate to your Senate Bill 394.

The first is education. Anesthesiologists across the state, and me personally, are very concerned with this bill's attempt to move toward independent practice for nurse anesthetists. This is extremely alarming and dangerous to Wisconsin citizens and patients. Anesthesia is the practice of MEDICINE, not nursing, and all forms of anesthesia for Wisconsin citizens should include a highly trained anesthesiologist, an expert in the field.

The difference in education between anesthesiologists - physicians who have completed medical school and residency, and nurse anesthetists is vast. Anesthesiologists have between 12,000 and 16,000 hours of clinical patient care compared to a nurse anesthetist who has only 1,650 hours. This difference is huge and is why the American Society of Anesthesiologists has instituted a national campaign to educate patients on how the education of an anesthesiologist prepares them for the comprehensive care of patients in all situations especially when emergencies arise. This detailed comprehensive knowledge of the anesthesiologist allows for better and safer care for our patients.

An anesthesiologist is prepared to handle any situation that arises in the OR. You may have heard stories of how the education, experience, and quick thinking of an anesthesiologist has saved lives; even stories where anesthesiologists have stepped in to prevent deaths at the hands of less experienced providers.

Part of our training is in intensive care as we often provide ongoing critical care to patients who require urgent or emergent surgery. This training has been highlighted during the COVID pandemic when many anesthesiologists, including myself, were asked to step out of the OR and into the ICUs to care for the massive influx of COVID patients. As I'm sure you all know, this pandemic was a massive drain on our resources, including the staff who care for patients everyday. When called to assist, anesthesiologists did not let down! In contrast, during the pandemic, the American Association of Nurse Anesthetists came out with a position statement that they do NOT endorse nurse anesthetists returning to the ICUs to assist in nursing duties, which is the core of their education.

A common practice for providing anesthesia care in the state of Wisconsin is through a care team model. In this model an Anesthesiologist will oversee the care provided by a few anesthesiologist assistants and/or a few nurse anesthetists. Senate Bill 394 aims to remove the anesthesiologist from the care team model; to remove their expertise and knowledge from patient care. It is the right of all Wisconsinites to have the most highly trained individual available before, during, and after their surgeries. This bill would also allow independent practice for nurse anesthetists in pain management, which is a sub specialty offered via additional fellowship

training to all anesthesiologists. A nurse anesthetist simply is not trained to care for these often complex patients.
Further, this bill would increase the number of nurses in the state of Wisconsin that would be able to prescribe opiate pain medication to our patients. We have made great strides over the past few years to educate our citizens and reduce the amount of opioid dependent and opioid addicted citizens in this state, and this bill is a huge step backwards.

Another section of this bill aims to remove the anesthesiologist from training nurse anesthetists. Currently at our two very large academic institutes at the University of Wisconsin and the Medical College of Wisconsin, anesthesiologists are training both nurse anesthetists and anesthesiologist assistants. Again, Anesthesiologists are the expert in this field, and removing them from training nurse anesthetists would further degrade their knowledge in this field.

The second consideration of this bill that some may argue is to increase access to care. Currently in the state of Wisconsin there is not a lack of critical access to anesthesia care. In fact, four large studies that looked at states that opt-out of physician led anesthesia care each found NO benefit to increasing access to care. Some northern Wisconsin areas do lack local pain management care, however allowing nurse anesthetists to, again, practice medicine with their nursing degree to provide this pain management care is not the answer.

The third consideration of this bill is cost to Wisconsin patients. All anesthesia related services are reimbursed the same no matter the provider, so patients receive the same bill regardless. Simply put; there are NO cost savings to allowing nurse anesthetists to practice independent of an anesthesiologist. The contrary, however, is that anesthesiologists actually REDUCE costs given improved patient outcomes and lives saved, along with reduced medical consultations, unnecessary tests, and cancelled surgeries due to medical reasons.

Anesthesia is complex and hazardous, and, according to the World Health Organization, its administration "requires a high level of expertise in medical diagnosis, pharmacology, physiology, and anatomy…therefore," they view "anesthesiology as a medical practice." When it is possible to do so, anesthesia should always be "provided, led, or overseen by an anesthesiologist." Why does Wisconsin deserve any different?

There is no reason that a patient in Wisconsin should ever receive substandard care. This bill aims to reduce quality care in the state and puts patients lives at risk. Thank you again for the opportunity to share my thoughts. I respectfully ask that you do not support SB 394.

Thank you,
Joe Strosin, MD
W298N408 Kings Way
Waukesha, WI 53188
Cell: (262)442-8590
Email: strosinmd@gmail.com

Senator Patrick Testin
Chairman, Senate Health Committee
8 South, State Capitol
Madison, WI 53707

July 28, 2021

Dear Chairman Testin and Senate Health Committee Members,

As a former C.R.N.A. now practicing as a board-certified Anesthesiologist, I am part of a small "club" with a unique perspective from which to weigh in on Senate Bill 394 and Assembly Bill 396 in Wisconsin. These bills, if passed, would remove the requirement for physician involvement in anesthesia care, setting up a situation in which non-physician anesthesia providers could practice at a level beyond the limits of their individual training and experience.

There is no doubt there are C.R.N.A.'s who are capable of providing high-level anesthesia care independently. However, these bills would grant the ability of **any** C.R.N.A. to practice independently, which neglects major differences in their capabilities and the non-uniformity of the training compared to that of physicians who train at accredited programs.

A few examples: During my training as a nurse anesthetist, the requirement for obstetric cases was 15, and I did 16. During anesthesiology residency I placed hundreds of labor epidurals and did dozens of Cesarean deliveries. The difference was similar for pediatric cases: I provided anesthesia for 35 patients aged $\leq$ 12 years during the nurse anesthetist training, compared to hundreds of pediatric cases during 9 months of pediatric rotations during anesthesia residency, many of them newborns with complex medical issues.

I was in no way prepared for the independent practice of anesthesia upon graduation from training as a nurse anesthetist. While current C.R.N.A. training programs are longer than mine was, leading to an advanced degree, there remains a gap between the clinical experience level between C.R.N.A. graduates and anesthesiology residency graduates that is overlooked in these bills. That is dangerous.

One potential solution would be the creation of a pathway through which C.R.N.A.'s desiring independent practice could achieve this through a combination of case documentation, additional education, and passing the same written and oral board examinations required of anesthesiologists. But such a system does not currently exist, and the bills now before the Senate and the Assembly are an unnecessary and unwise alternative to medical school and a rigorous anesthesiology residency in terms of preparation for independent anesthesia practice given an increasingly elderly and medically complex patient population.

Please oppose SB 394 and AB 396 as drafted. Thank you very much for your consideration of my perspective.

Cathy Drexler, M.D.
Department of Anesthesiology
Medical College of Wisconsin

ACCESS, SAFETY, and QUALITY - Independent Nurse Practice 2021 - July 27

Thank your time today. I am a Madison native, Nursing is a second career. I attended Madison College for my associate degree and Walden University online for my BSN and soon-to-be Master's in Psychiatry; I have worked in peer review with top physicians in Dane county. I had a six-year career with UW, five years at SSM, and ten years at GHC. Recently, I ended an assignment with 3M as an occupational health nurse. I start as a Psychiatric NP with the SandRidge Facility in Mauston. I bring a wealth of experience and knowledge to the topic of Nursing.

Nurse independent practice circles around the topics of access, safety, and quality. In 2020, a report was presented to this legislature about the Primary Care Shortage we are facing in Wisconsin. Both the National Governors Association and the Institute of Medicine (IOM) have argued that nurses should practice to the full extent of their education and training. Nurses are the most trusted profession by a Gallup poll for 19 years in a row. We are the solution to accessing lower cost, quality, and safe care. We do not undermine access, quality, and safety when we are allowed to practice independently. In fact, in limiting NP, you deny access, which compromises safety and drives up cost.

On my husband's state insurance plan, there were no locations close to home taking patients; I had to travel from Waunakee to Park Street. I learned that our provider did not allow NP or PAs to be PCP providers even in having a doctor present. In the Neurology clinic, waiting to be seen were as many as 300 patients. The rule was they must be seen by a Medical Doctor first. In psychiatry, there were long wait lists with minimal access to mental health care. I saw no effort to bring in NP to fill the gap. When people are waiting for care, health is compromised - that is a safety issue. In mental health, it can be devastating. The practitioner I am working with now has patients paying cash for care because providers have a three-month waitlist. Yet, local insurance companies will not approve her as a provider. To me, this sounds like market control vs. access, quality, and safety.

Medical providers have ethical rules, education, and codes of conduct. The Hippocratic oath is "do no harm." I have seen great care provided Nurse Practitioner's who are not rushing to see someone in 15 minutes at a rate of anywhere from $200 - 300 vs. a 30-minute visit with an NP, whose cost is far less.

Also, the nursing model is more conducive to the current patient population's needs. Patients are more educated, engaged, asking more questions, and need time to sort out complicated problems. Also, Doctors, on average, receive less than 24 hours of nutritional training. NP are not only trained in diagnosis and treatment, but the core of our work is patient education which entails nutrition and incorporating health care needs into a patient's life. We are the most trusted because we take care of the patient in mind, body, and spirit. Nurses bring down the cost of health care, provide easy access to quality, lower-priced products. Tying us to a physician does not offer a benefit. Like any controlled market, it limits access, causes safety issues, and drives up costs. Those are all things we can't afford. Nurse Practitioners need independent practice now. Over 23 states have full practice. It's time Wisconsin becomes counted among those giving greater access to high quality, safe, low-cost care by a profession voted the most trusted for 19 years.

Dr. Jay Mesrobian, Anesthesiologist
Testimony Against SB 394

Good morning. My name is Dr. Jay Mesrobian. I am an Anesthesiologist and currently practice at Ascension All Saints Hospital in Racine. I also serve currently as Assistant Treasurer of the American Society of Anesthesiologists, as past Chair of its Committee on Practice Management, and as a Past President of the Wisconsin Society of Anesthesiologists.

I appreciate the opportunity to provide comments to this committee, and promise to keep my testimony brief.

Over the past twenty-seven years, I have practiced in many different types of facilities and practice models: in an academic department at Medical College of Wisconsin, in private practice in both South Carolina and Milwaukee, and as an employee of Aurora Healthcare. In all of those settings, I have had the privilege of participating in the anesthesia care team, in which an Anesthesiologist or other Physician supervises the care of a Nurse Anesthetist or Anesthesiologist Assistant.

My understanding of Senate Bill 394 is that it would:

- *Eliminate all physician supervision and even collaboration requirements for delivery of anesthesia and chronic pain care care*
- *Put full authority of expanding providing privileges and scope of practice expansion with Board of Nursing*
- *Codify the federal "opt out" of federal supervision requirement for nurse anesthetists to be reimbursed for Medicare and Medicaid.*
- *Eliminate anesthesiologist supervision of nurse anesthetists in training.*
- *Give APRNs authority to delegate care to other non-physician providers*

My understanding of Senate Bill 394 is that it would not:

- *Reduce the costs of anesthesia care in Wisconsin. There is no difference in payment for anesthesiology services from Medicare or Medicaid, whether provided by an Anesthesiologist, a nurse anesthetist, or an Anesthesiologist and nurse anesthetist working together in the care team model. By eliminating supervision of nurse anesthetist practice, this bill more likely would increase overall costs due to higher utilization of unnecessary care and significant decrease in surgical outcomes.*
- *Increase patient access to anesthesia care. In 2006, Governor Doyle chose to opt out of the Federal requirement that a nurse anesthetist needs physician supervision to bill Medicare for services. At that time, we heard multiple arguments that the opt out would improve access to anesthesia care for WI citizens. Fifteen years later, there is no evidence of any improvement in access. Now we are being told that elimination of all supervision or collaboration requirements of nurse anesthetist care again will improve access. It simply is not true.*

- *Increase the number of anesthesia providers in Wisconsin: this bill does nothing to increase the number of providers and will serve only to expand the scope of practice and business opportunities for existing providers.*

As you consider this legislation, I am reminded of a statement made by then American Society of Anesthesiologists President Dr. Roger Litwiler in 2004: "It is all about the patient, for we have no other reason to exist". At the time, he made that statement in reference to Anesthesiologists, but it truly applies to all of us.

As you consider this legislation, I ask that you keep in mind that anesthesia care is different than primary care in its immediacy, its need for the highest level of patient assessment, and its potential for devastating outcomes.

As you consider this legislation, I ask that you remember that the supervision model of anesthesia care has a proven track record of more effective risk assessment, improved patient safety, and reduced complications.....and reduced costs. When Anesthesiologists provide care, hospitalization after surgery is far less likely. When Physicians supervise and lead anesthesia care, lives are saved and costs are reduced.

This bill jeopardizes patient safety, exacerbates already disturbing trends in healthcare delivery in our state, no likelihood of improved care or better access. I ask that you oppose this bill and work with all healthcare providers together to improve access and maintain strong patient care.

Thank you for your time today and for allowing me the opportunity to speak at this hearing.

To: Members, Senate Committee on Health
From: American College of Nurse Midwives, Wisconsin Affiliate
RE: Support for Senate Bill 394

The American College of Nurse Midwives – Wisconsin affiliate supports Senate Bill 394. Here are a few key points for your consideration.

Wisconsin Workforce Development
We lose Wisconsin residents who graduate as certified nurse midwives to other states with full practice authority, specifically Minnesota, Iowa and Illinois. Currently 97% of Wisconsin Certified Nurse Midwives (CNMs) work in the hospital/clinic setting.

Provider Shortage/Access to Quality, Affordable Care

- 27 out of Wisconsin's 72 counties do not have an Ob-Gyn.
- 11 rural hospitals have closed their OB units in the last 10 years.
- The number of Ob-Gyn physicians has not increased since 1980.
- The population of women in Wisconsin has increased by 26% since 1980.

We are facing provider shortage and maldistribution. Obstacles like practice restrictions keep over half of all nurse-midwives from working to our full potential. When we work to the full extent of our education and training it improves access to care in under-resourced areas, like Wisconsin's rural communities.

States and nations that have fully integrated full practice authority CNMs into their healthcare systems have the following outcomes: less preterm birth, fewer c-sections, satisfied patients, higher rates of breastfeeding and effective utilization of healthcare resources leading to lower healthcare costs.

Scope of Care
Current day to day practice of certified nurse midwives will not change. Collaboration, consultation and referral are an integral part of nurse-midwifery practice. CNMs like all APRNs stabilize, communicate and transport patients as necessary to assure safety and optimal outcomes. In every state that has adopted full practice authority, there are more nurse-midwives and healthier mothers and babies.

ACOG (American College of Obstetricians and Gynecologists) and ACNM (American College of Nurse Midwives) have published a Joint Statement of Practice Relations that supports the independent practice of CNMs, calls for national uniformity of practice authority and recognizes our responsibility in increasing the number of Ob-Gyns and CNMs in our states. In 2014, the General Assembly recommended removing physician supervision of nurse-midwives.

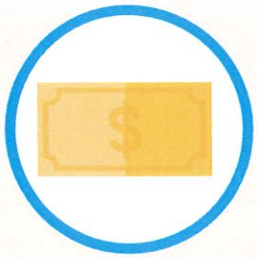
Compliance Issues
If a CNM's designated collaborative physician unexpectedly dies or moves, she/he is immediately out of compliance to practice. The patient seeking care with that CNM are suddenly left without a provider.

The citizens of Wisconsin need your support!

Senate Bill 394 & Assembly Bill 396

Certified Nurse-Midwives (CNMs) are advanced practice registered nurses providing primary care in women's health, including maternity care. After completing an accredited midwifery program and earning a Master's or Doctoral degree, graduates are certified through the American Midwifery Certification Board. This national certification ensures that CNMs are held to the highest standards of safety and competence prior to seeking licensure to practice in WI. After licensure, 97% of Wisconsin CNMs work in a hospital setting, with 3% working in an out-of-hospital setting, like the home or a freestanding birth center.[1,5,6]

Wisconsin's 200 CNMs are required to have a written collaborative agreement in order to practice.[1,6] Collaborative agreements limit a CNMs ability to practice and establish new practices in Healthcare Shortage Areas. Many professional organizations support full practice authority of CNMs.[5] Wisconsin is one of only 16 states requiring a written collaborative agreement.[1] Let's support our citizens and join with the 23 states offering full practice authority for CNMs.



Wisconsin Workforce

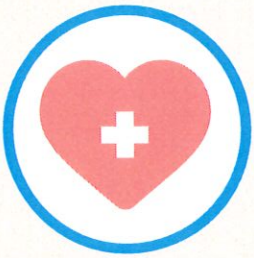
Minnesota, Iowa, and Illinois all offer full practice authority to CNMs.[1,2] The Twin Cities area and the Chicago area employ some of the highest concentrations of CNMs in the midwest.

Offering full practice authority will make Wisconsin a competitive market for CNM jobs and keep Wisconsin CNMs working in Wisconsin!

Provider Shortage

Wisconsin has not had an increase in Ob-Gyn physicians since 1980. However, Wisconsin's population of women has increased by 26% since 1980.[3,4]

27 out of 72 counties in Wisconsin do not have an ObGyn physician. 11 rural hospitals have closed their OB units in the last 10 years [4]



Scope of care

Removing the requirement for a collaborative agreement will not change the day-to-day care women of Wisconsin receive.

Midwifery programs, guided by the Accreditation for Commission of Midwifery Education, incorporate competencies to ensure CNMs are prepared to practice within their state scope and consult, collaborate, and refer patients to a higher level of care when necessary.[5]

Compliance

Under current legislation, if a collaborating physician unexpectedly dies, or moves, that CNM is immediately out of compliance.[6]

This leaves the patients unexpectedly without a healthcare provider.

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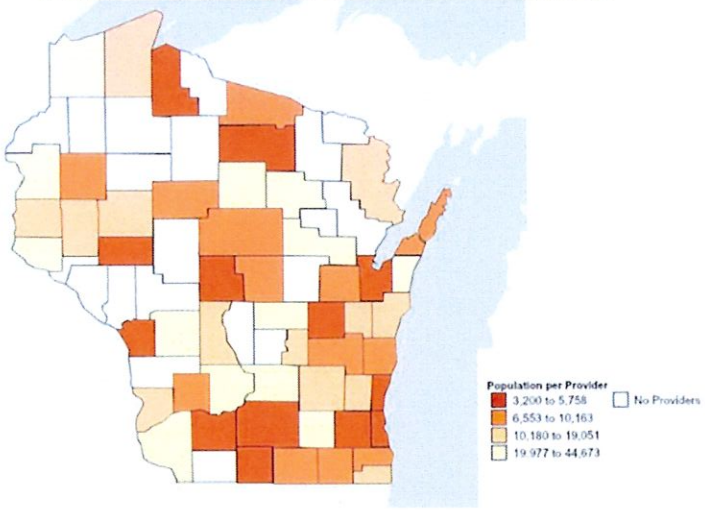
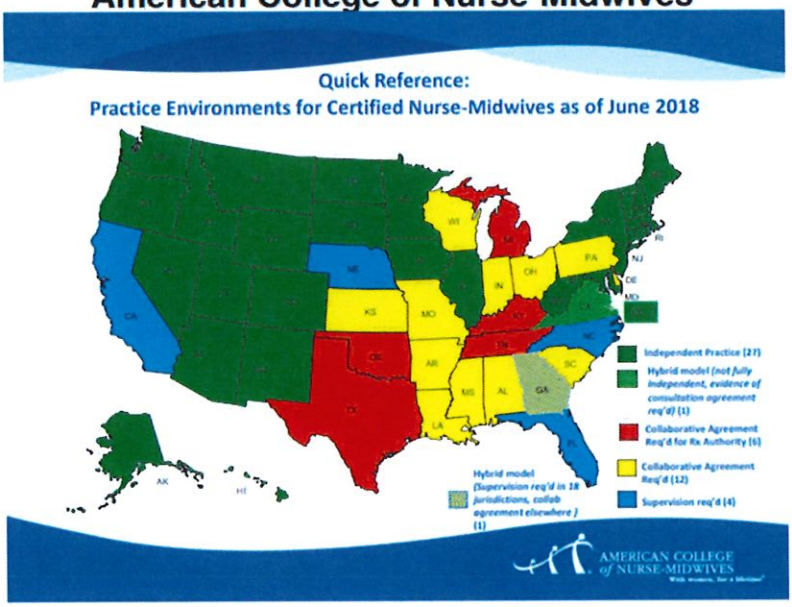
Wisconsin Affiliate
American College of Nurse-Midwives



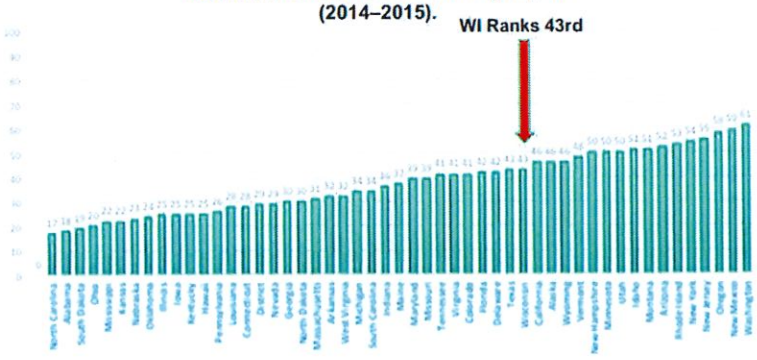
- 27 counties in Wisconsin do not have an Ob-Gyn.
- 10 counties have one Ob-Gyn per 19,977 - 44,673 residents.
- Many women face a 45-60 minute drive for routine maternity care.
- Women are usually seen 12-13 times during their pregnancy.
- Women with a high-risk pregnancy may have to drive 2 hours to seek care with an Ob-Gyn at a tertiary care facility.

Wisconsin Affiliate
American College of Nurse-Midwives



Wisconsin Affiliate
American College of Nurse-Midwives

Rank-ordered integration of midwives scores for 50 states and Washington, DC (2014–2015).



Vedam S, Stoll K, MacDorman M, Declercq E, Cramer R, et al. (2018) Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. PLOS ONE 13(2): e0192523. https://doi.org/10.1371/journal.pone.0192523
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0192523

APRN Modernization Act

Testimony of S. Mark Tyler, Founder and Chairman of OEM Fabricators, Inc.

2021 Senate Bill 394 Hearing

2021 Assembly Bill 396 Hearing

OEM Fabricators supports this legislation for the following reasons:

- Supports the easier development of employer sponsored clinics.
- Reduces regulatory issues that don't provide value.
- Reduces the loss of Advanced Practice Nurses to neighboring states.
- Reduces costs for citizens that access employer sponsored clinics.
- Increases access to affordable healthcare.
- Removes barriers to independent providers in rural areas.
- Helps address underserved groups like Amish communities.
- Helps employers address out of control healthcare costs

From an employer's view, it's really all about workforce, access, and costs.

Mark Tyler Testimony SB394

Good morning and thank you for the opportunity to share some thoughts with you.

My name is Mark Tyler and in the spirit of full disclosure I feel I'm obligated to share with you some of the roles I fill in Wisconsin. It will give you some context for why I support SB394.

I chair the Governor's Council on Workforce Investment

I'm the Board Vice President for the Wisconsin Technical College System

I serve on the Executive Committee for Wisconsin Manufacturers and Commerce

It would be easy to argue for this bill as a representative of any of these roles, but I want to be clear that today, I am not representing them, but here as a manufacturer, I'm the owner of OEM Fabricators, Inc. based in northwestern Wisconsin.

Operating a small business is challenging, operating one in rural Wisconsin is, well, even more challenging.

Aside from being able to hire new Team Members, one of the most difficult issues we face is providing affordable and high quality healthcare. Employers really don't want to be in the healthcare business, but difficulties with access and cost can be overwhelming. Some employers in our neighborhood have experienced 35% year over year increases in insurance premiums.

OEM along with two plastic molding companies and the Baldwin Woodville school district collaborated to develop a near site clinic to improve our Team Members access to basic healthcare at an affordable price. The popularity of the on-site and near-site clinics is growing because they are effective and affordable.

These clinics are typically staffed by Nurse Practitioners. In a recent visit to our near site clinic I questioned my provider about a sore on my ear that wasn't healing, she examined it and immediately referred me to a dermatologist and advised that I see them sooner rather than later. Turned out to be skin cancer. Our Team Members have experienced similar situations where if something is out of the scope of the Nurse Practitioners practice, they refer to an appropriate provider.

More and more companies are working to add clinics to their operations. In our case, our Woodville facility has access to a clinic, but our Neillsville and Phillips operations (both in rural areas) don't have access. This bill would make it easier to stand up a clinic in those locations.

In speaking with a Nurse Practitioner about her experience, she indicated that her prior relationships made it easy to get a collaborative agreement at a low cost, but went on to say it was essentially a piece of paper in a drawer that provided little value to patients.

I'd like to finish with a comment about the ability of midwives to serve underserved populations. I live in an area that has a substantial Amish population and they typically don't access our traditional health system because it's too expensive, and many of our qualified midwives leave the area for work in Minnesota where they have more freedom to practice. If we could level the field with Minnesota and other states, I would expect that we would see more midwives stay and serve Wisconsin residents.

This is truly a workforce issue, an access issue, and a cost of care issue.

Thank you for your attention and please give strong consideration to supporting SB394.

TO: Senate Committee on Health
Senator Patrick Testin, Chair

FROM: Wisconsin Medical Society
Wisconsin Academy of Family Physicians
Wisconsin Academy of Ophthalmology
Wisconsin Chapter – American Academy of Pediatrics
Wisconsin Chapter – American College of Emergency Physicians
Wisconsin Dermatological Society
Wisconsin Psychiatric Association
Wisconsin Radiological Society
Wisconsin Society of Anesthesiologists
Medical College of Wisconsin

DATE: July 28, 2021

RE: **Opposition** to 2021 Senate Bill 394

On behalf of Wisconsin's major physician-led entities – representing more than 12,000 physicians statewide – thank you for this opportunity to testify on 2021 Senate Bill 394, related to Advanced Practice Registered Nurses (APRNs). Nurses are an important part of the physician-led health care team, and physicians value the care they give patients. Our **opposition** to Senate Bill 394 should not be interpreted as criticism of the nursing profession; rather, the legislation's significant expansion of APRN scope coupled with removing physicians from the patient care equation is not in the best interests of the public and could threaten Wisconsin's status as one of the nation's health care quality leaders.

SB 394 Removes Collaboration Requirements; Dramatically Expands APRN Scope of Practice
The current collaboration requirements for advanced practice nurses are currently under attack at the state's Board of Nursing, which for the past several months has discussed its desire to alter the nursing administrative code provisions requiring collaboration: N 8.02(5) provides the definition of the collaboration requirements, which attach to advanced practice nurses through N 8.10. Nursing board member statements coupled with public comments from the state's major nursing groups have revealed a desire to remove these provisions altogether or to redefine "collaboration" to essentially mean unofficial consultation with any health care professional.

Running alongside this collaboration-canceling effort are proposed scope of practice definitions for advanced practice nurses that would for the first time grant broad powers along the entire spectrum of an episode of care. For example, the proposed definition for the "practice of nurse practitioner" appears to mimic much of the breadth that the layperson would assume is what is within physician scope. Section 95 of SB 394 (p. 43) creates a new statute:

> 441.001 (3r) PRACTICE OF A NURSE PRACTITIONER. "Practice of a nurse practitioner" means practice in ambulatory, acute, and long-term care settings as a primary and specialty care provider who assesses, diagnoses, treats, and manages acute, episodic, and chronic illnesses.

The coordination is likely not coincidental. As the Board of Nursing – at the nursing organizations' urging – attempts to remove collaboration requirements for advanced nurses from the administrative code, the same organizations are pushing legislation that establishes broad, physician-like scope of practice definitions.

The bill also defers any future scope expansions to the nursing board, removing the state legislature from its usual policy-deliberating role – see the newly-created §441.09(6) (p. 53), which grants the nursing board the ability to "further define" the scope of practice for all APRNs, as well as the scope of issuing prescription orders.

The legislation also explicitly removes §441.15 WI STATS, which requires certified nurse midwives to practice in collaboration with a physician who has experience in obstetrics (such as an obstetrician or a family practice physician). While the bill now includes an "in case of emergency" provision (p. 52, lines 3-8) for births that devolve into emergency situations beyond the midwife's scope, we believe it is wiser to continue requiring midwife-physician collaboration to better help prevent those emergency situations from occurring in the first place.

But while the advanced nursing scope of practice language the bill proposes appears similar to that level of care entrusted to physicians, a major difference between the two professions remains: the level of education, training and experience necessary before becoming a fully-licensed and practicing professional.

Patients Deserve Care from Professionals with the Most Education and Training: Physicians
Of all health care professions, none require as much rigorous education and post-graduate training as it takes to become a practicing physician. While nurses require additional education to become advanced practice nurses, the curriculum and experience is nowhere near that required of physicians.

The American Academy of Family Physicians (AAFP) has an excellent two-page background memo (see Exhibit A attached to this memo) summarizing the different paths to becoming a family practice physician vs. becoming a nurse practitioner. A primary care physician completes between **12,000 to 16,000 hours** of competency-based, clinical training following four years of medical school and three years of residency. A nurse practitioner, in comparison, will complete perhaps 500 to 1,500 hours of post-graduate experience. While admirable, these additional hours are far from equivalent, and therefore should not allow for the opportunity to provide independent primary care.

Independent diagnosing, treatment and prescribing is the practice of medicine, and physicians spend nearly 11 years to properly hone those skills. Wisconsin's patients deserve to receive care from the most highly educated, fully-trained health care professionals: physicians.

Studies Show Disparities in Physician vs. Non-Physician Prescribing, Imaging, Referrals
Various studies comparing physician-led care with non-physician led care show differences in the quality and efficiency of care provided – which is perhaps not surprising considering the education and training differences inherent between physicians and advanced nursing.

As seen in Exhibit B attached to this memo, primary care provided by non-physicians can result in more drugs being prescribed, more tests being ordered and more referrals to expensive specialists than if a physician would have given the care.

Some excerpts:

- A report from the Infectious Diseases Society of America studying nurse practitioner and physician assistant antibiotic prescribing found that ambulatory visits involving those professions resulted in **significantly more antibiotic prescribing** than visits with physicians.

- A study utilizing 2015 Medicare claims data compared opioid prescribing patterns of physicians, NPs and PAs working in primary care settings. Analysis showed that while just 1.3 percent of physicians **prescribed opioids** to more than 50 percent of their patients, 6.3 percent of nurse practitioners did so.

- A Mayo Clinic study in 2013 concluded that nurse practitioners and physician assistants made **inappropriate referrals to tertiary referral centers** for patients with more complex medical problems to a level that could offset any alleged "savings" when substituting non-physician care for that of physicians.

- A 2014 *JAMA Internal Medicine* study found that nurse practitioners and physician assistants were associated with **more ordered diagnostic imaging** than were primary care physicians following an outpatient visit. Overuse of diagnostic imaging exposes patients to unnecessary radiation and is another example of offsetting any potential "savings."

- A University of Wisconsin study from 2015 compared the malignancy rate of biopsies performed by dermatologists versus non-physicians. The findings suggest that **non-physicians perform more biopsies** than do physicians – increasing patient morbidity and the cost of care.[1]

Physician-led care has consistently contributed to Wisconsin's status as a high-quality health care leader among the states. The examples of inefficient and more expensive care provided above suggest that moving away from physician-led care could endanger Wisconsin's high-quality status.

The Bill Increases non-Physician Prescribing Opportunities While Deferring Future Scope to BON
The bill would enable all nurse practitioners who obtain the new APRN designation to diagnose, treat and prescribe medications independently. The bill also authorizes nurse anesthetists to provide full anesthesia care with no supervision or even collaboration with an anesthesiologist or other physician. And as it does with future APRN general scope of practice decisions, the bill offloads to the Board of Nursing future decisions about what drugs APRNs will be allowed to prescribe – once again removing the legislature as the gatekeeper on important policy.

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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.

Furthermore, the bill as drafted contains a provision which would codify a choice allowed by the U.S. Centers for Medicare & Medicaid Services (CMS) to opt-out of a federal requirement that nurse anesthetists be supervised by a physician to receive Medicare and Medicaid reimbursement for anesthesia services. Wisconsin would be the first state in the nation to codify what is usually an administration's decision. And in doing so, the bill locks the legislature into supporting this questionable policy statement [see the bill's creation of §441.09 (5m), p. 53]:

> The legislature finds that allowing certified registered nurse anesthetists to administer anesthesia without supervision or direction from an operating practitioner, physician, or anesthesiologist increases access to quality anesthesia services throughout the state and is in the best interests of the citizens of the state.

Currently, Wisconsin opts out of the supervision requirement related to Medicare reimbursement but continues to require physician supervision for Medicaid reimbursement – a requirement strongly supported by the Wisconsin Society of Anesthesiologists. There is no sound public policy justification for this provision – and in establishing this "opt-out" in statute rather than following the CMS procedure, it may not be allowable under federal rule.

Experiences in Other States Show that Nursing Independence Does Not Increase Rural, etc. Access
A common justification for allowing nursing independence despite the concerns noted above is that doing so will bring primary care to areas where it is not readily available, such as rural locations. Evidence from other states appears to show otherwise, as you can see from Exhibit C attached to this memo: physicians and advanced practice nurses tend to practice in the same areas – even in the states where some level of non-physician independence is allowed.

In fact, as also cited in Exhibit C, an Affordable Care Act-mandated study tracking employment choices of APRN students upon graduation found that only 25% of APRNs in the study chose to work in medically underserved communities, with the vast majority of those working in urban settings. Only 9% of those APRN graduates went to work in rural areas, and only 2% worked in Federally Qualified Health Centers.

Instead of proposals such as SB 394, policymakers should instead continue to support initiatives and programs that will help spur physicians and other health care professionals to work in our state, and especially in rural Wisconsin. For example, the Medical College of Wisconsin has successfully created two new medical schools, both in central Wisconsin and in Green Bay. The legislature has also provided additional funding for Graduate Medical Education, expanding opportunities for medical residents to stay and practice in Wisconsin. But the real gains in improving access to and coordination of patient care will come largely from solidifying and expanding the use of physician-led teams.

For the above reasons, physicians across the state oppose Senate Bill 394. Thank you for your consideration.

EXHIBIT A

AAFP

Education and Training:
Family Physicians versus Nurse Practitioners

Most Nurse Practitioners (NP)—also known as Advanced Practice Nurses (APN) and Advanced Registered Nurse Practitioners (ARNP)—receive their education typically through a one-and-an-half to three-year degree program that confers a Master of Science in Nursing (MSN), depending on the prior education of the student. While many nurses have a MSN degree, there are alternate pathways available in a state to achieve NP licensure without advanced collegiate education. There is no single national accreditation agency for NP programs. Rather, NP education programs are housed within graduate programs accredited by one of several accreditation entities, including the American Association of Colleges of Nursing's (AACN) Commission on Collegiate Nursing Education (CCNE), the Accreditation Commission for Education in Nursing (ACEN), and the National Association of Nurse Practitioners in Women's Health Council on Accreditation. As of August 2015, there were 264 Practice Doctorate in Nursing programs enrolling students at schools of nursing, and an additional 60 DNP programs in planning stages. Typically, master's level nursing programs require students for entry at least to have passed the National Council Licensure Exam for Registered Nurses (NCLEX-RN) and satisfactorily completed the Graduate Record Examination (GRE).

Vanderbilt University's MSN program, for example, offers a Family Nurse Practitioner (FNP) specialization program. For registered nurses with a Bachelor of Science in Nursing (BSN), the MSN program is three semesters of 40 total credit hours, inclusive of didactic and clinical education. According to the program's handbook, MSN FNP candidates receive a total of 800 combined hours of didactic and lab education. Clinical education is estimated to amount to approximately 1,400 hours. For students with a bachelor's degree and no nursing experience, Vanderbilt offers a program of six semesters, or three full-time years, of education and training that leads to an MSN degree.

Family Physicians receive their education typically through a four-year degree program at one of the 175 accredited allopathic or osteopathic medical schools in the United States. Students must pass the Medical College Admissions Test for entrance into medical school. Medical students spend nearly 9,000 hours in lectures, clinical study, lab and direct patient care. The overall training process begins with medical school and continues through residency. During their time in medical school, students take two "step" exams, called the United States Medical Licensing Examination (USMLE) or the National Board of Osteopathic Medical Examiners COMLEX-USA exams, and must take core clerkships, or periods of clinical instruction. Passing both exams and the clerkships grants students the Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) degree, which entitles them to start full clinical training in a residency program.

Most family medicine residency programs, which are accredited by the Accreditation Council for Graduate Medical Education (ACGME), require three years of training. As with other specialties, family medicine residency programs have specific requirements with certain numbers of hours and patient care experiences that must be completed for board certification. They are designed to provide integrated experiences in ambulatory, community and inpatient environments during three years of concentrated study and hands-on training.

The first year of residency called the internship year, is when the final "step" of the USMLE or COMLEX (Step 3 exam) is taken. During their three years of training, residents must meet the program requirements for both residency education in family medicine

and certification by the American Board of Family Medicine (ABFM) or the American Osteopathic Board of Family Practice (AOBFP). Specific requirements for family medicine training vary by residency program. After three "program years" of training are completed and all requirements are met, residents are eligible to take the certification exam by the ABFM or AOBFP. Toward the end of residency, physicians also apply for licensure from their state medical boards, which determines where they can practice as a board-certified family physician. Although each state is different in their requirements for initial medical licensure, it is a necessity that physicians pass Step 3 of the USMLE.

The below tables offer a side-by-side comparison of the education and training involved in becoming a family physician versus the requirements to become a nurse practitioner.

Degrees Required and Time to Completion

	Undergraduate Degree	Entrance Exam	Post-Graduate Schooling	Residency and Duration	TOTAL TIME FOR COMPLETION
Family Physician (MD or DO)	Standard 4-year BA/BS	Medical College Admissions Test (MCAT)	4 years, doctoral program (MD or DO)	REQUIRED, 3 years minimum	**11 years**
Nurse Practitioner (NP, ARNP, etc.)	Standard 4-year BA/BS*	Graduate Record Examination (GRE) and National Council Licensure Exam for Registered Nurses (NCLEX-RN)	1.5 – 3 years, master's program (MSN)	NONE	**5.5 – 7 years**

Clinical Hours for Completion

	Combined Hours (Clinical Years)	Residency Hours
Family Physician	6,000	9,000 – 10,000
Nurse Practitioner	500 – 1,500	0
DIFFERENCE	5,500 – 5,000	9,000 – 10,000

*While a standard 4-year degree, preferably a BSN, is recommended, alternate pathways exist for an RN without a bachelor's degree to enter some master's programs.

Vanderbilt University Family Nurse Practitioner Program information retrieved from https://nursing.vanderbilt.edu/msn/fnp/index.php and the *Vanderbilt University School of Nursing Student Handbook 2016-2017* at https://nursing.vanderbilt.edu/students/current/pdf/handbook.pdf [Accessed March 2017].

AMA AMERICAN MEDICAL ASSOCIATION

Advocacy Resource Center

Advocating on behalf of physicians and patients at the state level

AMA Issue Brief: Expanding nurse practitioner scope of practice leads to increased utilization of health care resources

Studies have shown, nurse practitioners may end up increasing costs to the health care system due to inappropriate prescribing, unnecessary referrals to specialists, and unnecessary orders for diagnostic imaging studies such as x-rays.

Increased or inappropriate prescribing: antibiotics

A brief report by the Infectious Diseases Society of America examined NP and physician assistant (PA) antibiotic prescribing, compared with physician-only visits for both overall visits and visits for acute respiratory tract infections (ARTIs) between 1998-2011.[1] **The study found that ambulatory visits involving NPs and PAs more frequently resulted in an antibiotic prescription compared with physician visits**. Similarly, with ARTI visits, NPs and PAs prescribed antibiotics 61 percent of the time while physicians prescribed antibiotics 54 percent of the time. The authors noted that their findings were consistent with several previous studies.[2]

The authors suggested several reasons for this discrepancy.[3] First, antibiotic stewardship programs tend to focus on physicians rather than NPs or PAs. However, the authors noted that elements of antibiotic stewardship are often included in NP and PA educational curriculum, and concluded that differences in antibiotic prescribing are more likely due to practice environment, learned clinical behaviors, or differences in patient communication rather than medical education. **While the authors hypothesized that there may be significant differences in the patient mix between physicians and NPs or PAs, the authors found that higher rates of antibiotic prescribing persisted among NP and PA visits, even when the analysis was restricted to patients with the same diagnosis.** The authors concluded that, as the proportion of outpatient visits involving NPs and PAs continues to increase, interventions to reduce inappropriate antibiotic use should target these providers in addition to physicians.

A study from Infection Control and Hospital Epidemiology similarly found inappropriate antimicrobial prescribing among advanced practice providers (APPs) in ambulatory practices.[4] The study collected data regarding over 488,000 outpatient visits between 2014 and 2016 regarding common upper respiratory conditions that should not require antibiotics. The visits reflected urgent care, family medicine, internal medicine and pediatric providers. **The study found that adult patients seen by APPs were 15 percent**

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[1] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. Open Forum Infectious Diseases. 2016:1-4.
[2] Grijalva CG, Nuorti JP, Griffin MR. Antibiotic prescription rates for acute respiratory tract infections in US ambulatory settings. JAMA 2009; 302:758–66.
[3] *Supra* note 1.
[4] Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. Infection Control & Hospital Epidemiology. 2018:1-9.

more likely to receive an antibiotic than those seen by a physician. The rate of prescribing for pediatric patients was similar. Like the authors of the IDSA study, the authors of the ICHE study recommended that future education and antimicrobial stewardship efforts should target APPs.

Increased or inappropriate prescribing: opioids

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.[5] Based on their analysis, **they found 6.3 percent of nurse practitioners and 8.4 percent of physician assistants prescribed opioids to more than 50 percent of their patients compared to just 1.3 percent of physicians.** They also **found NPs and PAs in states with independent prescription authority for schedule II opioids were 20 times more likely to overprescribe opioids than NPs and 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 and PAs significantly increased opioid prescribing. The authors opined on potential solutions for reducing NP and PA prescribing, such as implementing mandatory continuing education in safe opioid prescribing and restricting NPs and PAs prescribing authority.

These findings are also supported by an analysis of prescribing data from IQVIA, a worldwide data science and market research firm, which shows that between 2018 and 2019 opioid prescribing by nurse practitioners increased year-over-year in the vast majority of states, while opioid prescribing declined overall.[6] There was also an increase in opioid prescribing by nurse practitioners in the 22 states that AANP declares as "independent" or "full practice authority."

Unnecessary referrals

According to a 2013 study by the Mayo Clinic, inappropriate referrals to tertiary referral centers by NPs and PAs could offset any potential savings from the increased use of NPs and PAs.[7] 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. Physician referrals received "significantly higher" scores in six of the seven assessment areas: (1) referral question clearly articulated, (2) clinical information provided, (3) documented understanding of the patient's pathophysiology, (4) appropriate evaluation performed locally, (5) appropriate management performed locally, and (6) confidence returning patient to referring health care professional. Physician referrals were also more likely to be evaluated as necessary than NP or PA referrals, which were more likely to be evaluated as having little clinical value.

The study's authors suggested that these differences be considered with respect to interacting patient, health care professional. and system-related factors. The authors observed that patients who require

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[5] MJ Lozada, MA Raji, JS Goodwin, YF Kuo, Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns. Journal General Internal Medicine. 2020; 35(9):2584-2592.

[6] Source: *IQVIA Xponent market research services. (c) IQVIA 2020. All rights reserved.*

[7] 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.

referral to a tertiary medical center are typically more complex and undifferentiated in terms of a diagnosis. Although there is evidence that NPs and PAs can deliver effective primary care, the authors found little research on the ability of NPs and PAs to independently manage patients with undifferentiated and complex problems. However, the authors found many examples of excellent care of patients with complex medical problems within multidisciplinary teams in which NPs and PAs had immediate access to physician support—a level of support not necessarily available in all outpatient practice settings. The authors also noted that their survey of referring NPs and PAs indicated that they usually did not consult with a physician colleague before referring a patient.

Based on these results, researchers concluded that there is an opportunity to improve the quality of patient referrals from NPs and PAs in primary care practices by involving integrated health care teams that combine the skills of physicians, NPs, and PAs.

Inappropriate Diagnostic Imaging

A recent JAMA Internal Medicine study investigated diagnostic imaging, such as medical imaging, by NPs and PAs compared to primary care physicians, after office-based encounters.[8] The study controlled for imaging claims that occurred after follow-up care such as specialty referrals.

The study's authors noted that previous research[9] found that in 34 percent of emergency department cases, NPs and PAs recommended imaging studies when physicians had not, and offered a reminder that overuse of diagnostic imaging may expose patients to unnecessary radiation and offset some savings otherwise achieved by the expanded use of NPs and PAs.

The JAMA Internal Medicine study found that NPs and PAs were associated with more ordered diagnostic imaging than primary care physicians following an outpatient visit.[10] The difference was more pronounced for radiographs – a test for which larger numbers of NPs and PAs are authorized to order – than non-radiographs. Further, NPs and PAs were associated with more imaging than primary care physicians on both new and established patients, though results were more pronounced with new patients, where NPs and PAs were not found to order differently for advanced imaging examinations, but were associated with higher rates for radiography orders.

The findings suggest that expanding the authority and use of NPs may alleviate physician shortages, but the increased imaging may have ramifications on care and overall costs. While the authors could not discern whether the difference in ordering represented overuse by NPs, rather than underuse by primary care physicians, efforts to expand access to care by simply substituting NPs for physicians without careful imagining appropriate mechanisms may further elevate health care costs and potentially increase unnecessary radiation exposure.

In the end, the study's authors noted that their results do not mean that NPs and PAs cannot serve an important, growing role in primary care access. **Rather, the authors warned that any such expansion**

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[8] D.R. Hughes, et al., A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. JAMA Internal Med. 2014;175(1):101-07.

[9] Seaberg DC, MacLeod BA. Correlation between triage nurse and physician ordering of ED tests. Am J Emerg Med. 1998;16(1):8-11.

[10] *Supra* note 6.

must be mindful of the additional cost, safety, and quality implications it may incur. Greater coordination in health care teams may produce better outcomes than merely expanding NP scope of practice alone.

Similarly, a new study published in the Journal of the American College of Radiology found that skeletal x-ray utilization among Medicare beneficiaries increased among non-physicians, particularly NPs and PAs. The study, which analyzed Medicare Part B fee-for-service claims from 2003 to 2015, calculated utilization rates per 1,000 Medicare beneficiaries. While skeletal radiology is a basic and "low tech" form of imaging, it is the largest single category of imaging examinations, comprising 22.8 percent of all noninvasive diagnostic imaging performed in the Medicare population in 2015.

The study found that skeletal x-ray ordering increased substantially – by 441 percent – among non-physician providers, primarily nurse practitioners and physician assistants. Orders among primary care physicians decreased by 33.5 percent, which the authors hypothesized may reflect a tendency for PCPs to delegate NPs and PAs who work with them to take on the responsibility of interpreting x-rays. Still, the authors suggested that interpretations by NPs and PAs may warrant further scrutiny.

Source Notes: These materials include information derived from market research information provided by IQVIA, Inc. ("IQVIA"). IQVIA market research information is proprietary to IQVIA and available by subscription from IQVIA. The IQVIA Xponent® market research data includes estimates of dispensed drug prescription information from retail pharmacies (chain, mass merchandisers, independent and food stores) in the United States. IQVIA sources transaction information for +90% of the retail channel and uses a customized and patented estimation methodology to generate accurate market estimates. IQVIA employs various proprietary methodologies in data sourcing, data receipt, data editing and cleansing, creation and maintenance of reference files, data quality assurances processes, reference data bridging, database management and report creation to produce these estimates. More information about IQVIA can be found at www.IQVIA.com.

AMA AMERICAN MEDICAL ASSOCIATION

Advocacy Resource Center

Advocating on behalf of physicians and patients at the state level

Issue brief: Access to care

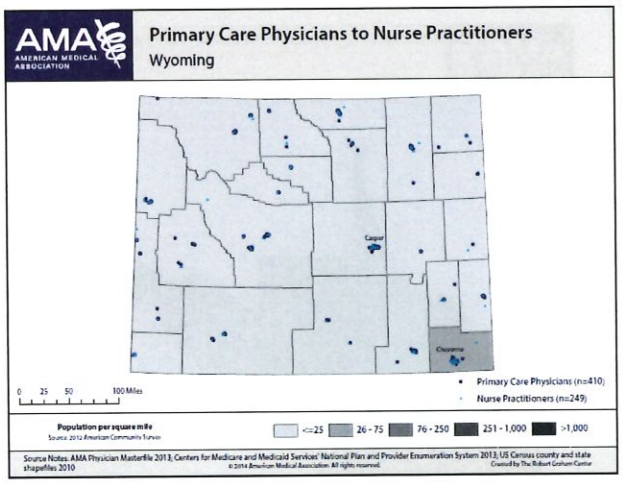
Proponents of scope expansions often claim such measures are necessary to expand access to care in rural areas. However, in reviewing the actual practice locations of primary care physicians compared to nurse practitioners, it is clear, that physicians and nurse practitioners tend to practice in the same areas of the state - even in those states where nurse practitioners can practice without physician supervision or collaboration. For the most part, state laws that have expanded the scope of practice of nurse practitioners have not necessarily led to more nurse practitioners in rural areas.

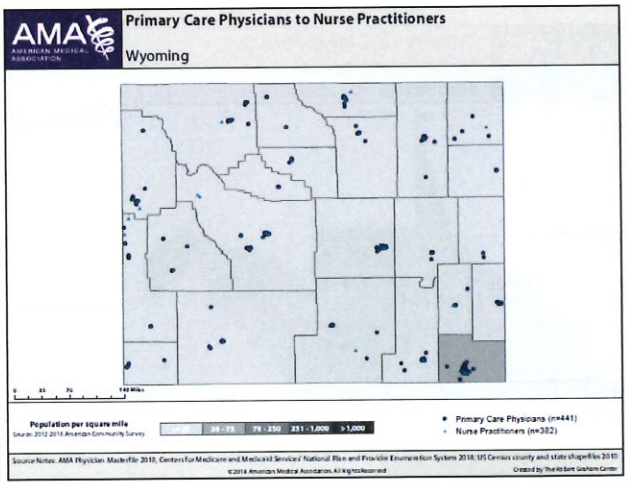
The AMA has mapped the actual practice locations of primary care physicians and nurse practitioners in all-50 states, DC and nationwide using data from the AMA Masterfile to determine the practice location of primary care physicians and data from the Centers for Medicare and Medicaid Services (CMS) for the location of nurse practitioners. Following are maps from 2013 and 2018 illustrating the practice location of nurse practitioners and primary care physicians from states with varying levels of nurse practitioner independent practice.

Independent Practice States

Wyoming

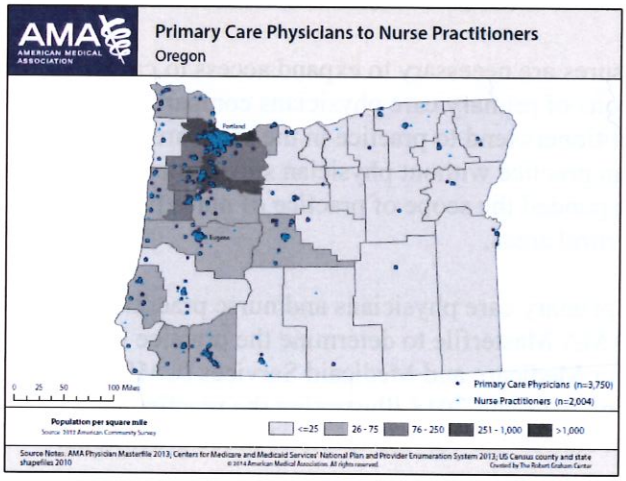
In 2018 there were only 382 nurse practitioners in Wyoming compared to 441 Primary Care Physicians. The number of nurse practitioners in the state has not increased since they allowed independent practice, nor have nurse practitioner moved into rural areas of the state.

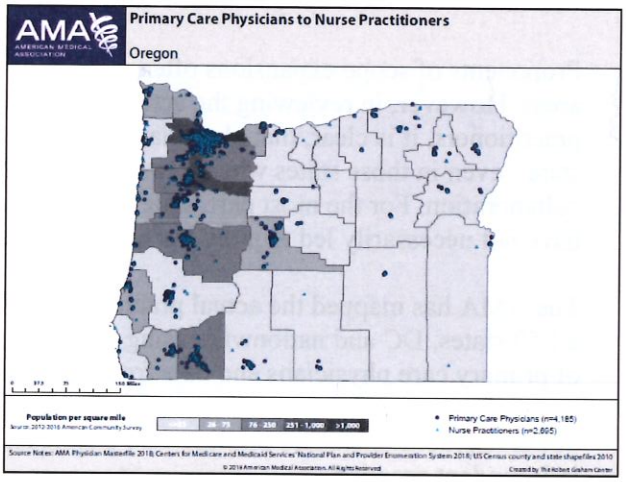




Oregon

Similar to Wyoming, while allowing independent practice for decades, nurse practitioners have not moved to rural areas of the state and continue to practice in the same areas of the state as physicians. The number of nurse practitioners in the state increased from 2,004 in 2013 to 2,695 in 2018 a slower rate of growth than other areas of the country.

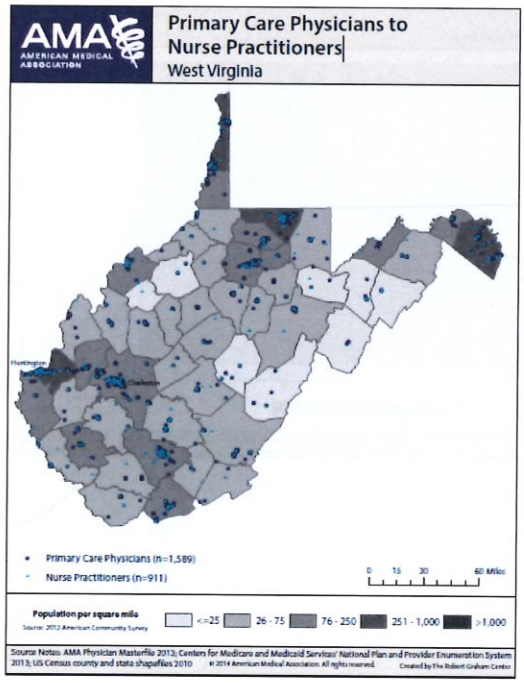


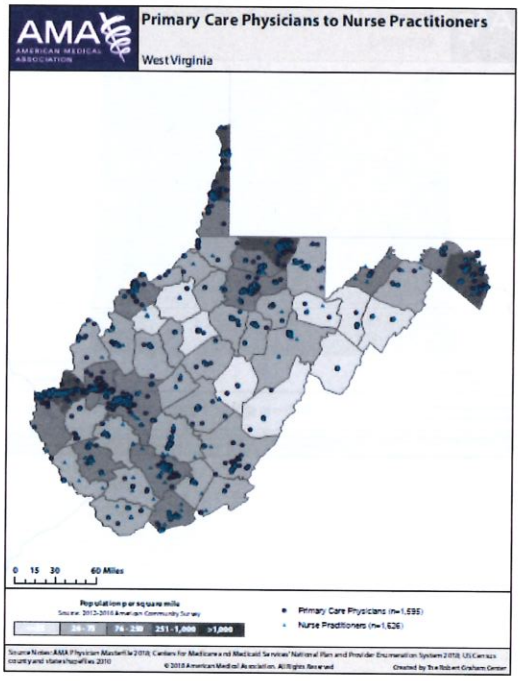


Physician involvement required for 3 years to prescribe

West Virginia

West Virginia enacted legislation in 2017 that allows nurse practitioners to diagnose and treat patients without physician involvement; they are still required to have a collaborative relationship for prescriptive practice with a physician for three years. While there was an increase in the overall number of nurse practitioner in the state, they continued to practice in the same areas of the state as physicians.

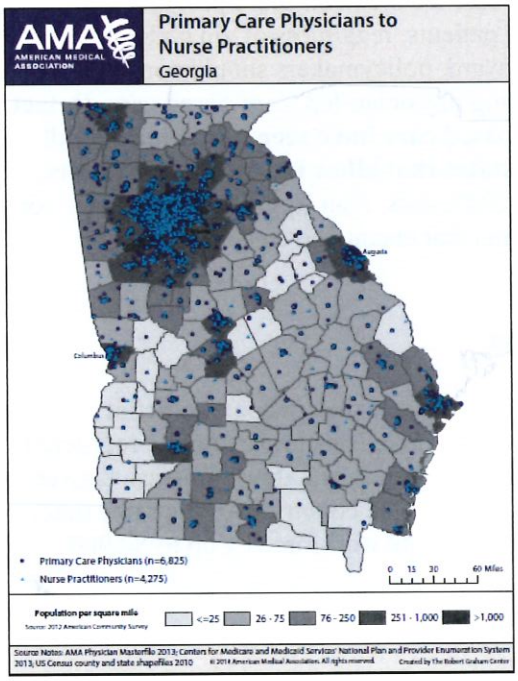


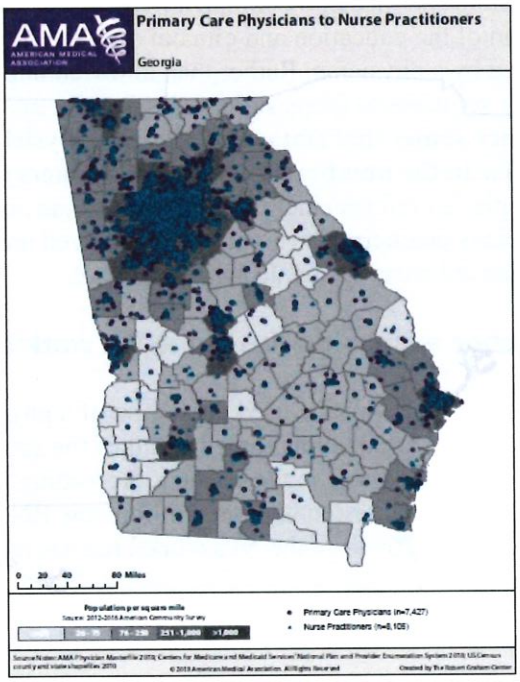


Physician supervision or collaboration required to diagnose, treat, and prescribe

Georgia

In Georgia, nurse practitioners practice pursuant to a protocol agreement with physician supervision and delegation. Supporting a physician-led team-based care approach, Georgia has seen tremendous growth in the number of nurse practitioners in the state, increasing from 4,275 in 2013 to 8,105 in 2018. This demonstrates that changes in nurse practitioner scope of practice laws are not the sole reason for growth of nurse practitioners in a state.





Other studies confirm our findings

The Graduate Nurse Demonstration Project which was mandated as part of the Affordable Care Act of 2010, involved the Centers for Medicare & Medicaid Services (CMS) providing payments to five eligible hospitals, each of which partnered with schools of nursing (SONs), community-based care settings (CCSs), and other hospitals to expand clinical education for additional APRN students.[1] One of the goals of the project was to determine if funding clinical APRN education would increase the number of APRNs and to determine the employment choices of APRNs following graduation. A study of alumni from this program found only 25% of alumni served medically underserved communities, however, the vast majority were in urban settings, as only 9% went on to work in rural areas and only 2% worked in FQHCs.[2]

[1] 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

[2] *Id.*

Fewer nurse practitioners are providing primary care

These maps likely overrepresent the number of nurse practitioners practicing in primary care. While the maps compare primary care physicians to all nurse practitioners in a state, data have shown a growing number of nurse practitioners are not practicing in primary care. For example, after examining state licensing renewal forms, the Oregon Center for Nursing found only 25% of nurse practitioners practice in primary care. This trend is also supported in recent workforce studies, which have found newly graduated nurse practitioners are more likely to enter specialty or subspecialty care rather than primary care.[3]

Physician-led team care is equitable care

The AMA is deeply concerned with the notion that patients in rural and underserved areas, often a vulnerable and medically complex population, should settle for care from a health care provider with a fraction of the education and clinical training of physicians. All patients, regardless of zip code, deserve care led by a physician. Rather than allow an unproven path forward, policymakers should consider proven solutions to increasing access to care, including supporting physician-led team-based care. **In fact, evidence shows that states that require physician-led team-based care have seen a greater overall increase in the number of nurse practitioners compared to states that allow independent practice.** Other proven reforms include telehealth expansion, expanding GME slots, loan forgiveness programs for physicians practicing in rural and underserved areas and programs that encourage students from underserved areas to pursue medical school.

NP scope expansion has led to RN workforce shortage

Nurse practitioners have used the notion of a physician shortage to advance their scope of practice, however, one often unmentioned result of the growth of the NP workforce, is its impact on the registered nurse (RN) workforce in the country. According to an analysis of the Bureau of Labor Statistics, between 2014 and 2024 an estimated one million new RNs will be needed across the country.[4] At this same time, however, the growth of the NPs workforce has reduced the size of the RN workforce by up to 80,000 nationwide.[5]

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[3] 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

[4] Health Care Employment Projections, 2014-2024: An Analysis of Bureau of Labor Statistics Projections by Setting and by Occupation, Center for Health Workforce Studies, School of Public Health, SUNY Albany; (2016).

[5] David I. Auerbach, Peter I. Buerhaus, and Douglas O. Staiger, "Implications of the Rapid Growth of the Nurse Practitioner Workforce in the US," Health Affairs; 39, 2 (Feb. 2020).

July 28, 2021

Senator Patrick Testin, Chair
Senate Health Committee
Wisconsin State Legislature

Dear Honorable Members of the Senate Health Committee:

Thank you for the opportunity to present this testimony on behalf of colleagues' in support of SB 394. My goal today is to emphasize the importance of durable linkages between our public health and health care systems and emphasize how advanced practice registered nurses strengthen that linkage by providing services to at-risk populations to advance Wisconsin's public health system capacity to eliminate health disparities and support and improve the health of our 5.8 million Wisconsin residents and the communities where they live, grow, work, learn, and play.

The public health system has broad societal charges to promote health, prevent disease, and protect health that include health of the environment and our entire population. To achieve population health improvement, collaborative partnerships are required between government and the public, private, voluntary sectors, many professionals, and communities. Advanced practice registered nurses contribute directly and indirectly to population health improvement and are truly a partner to Wisconsin's public health system.

The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity (National Academies of Sciences, Engineering, and Medicine, 2021) identifies advancing health equity and addressing the social determinants of health as the key priority areas for nursing over the next decade. As one of the most trusted professions, nurses, including advanced practice registered nurses, are utilized to deliver nursing- focused, holistic, patient-centered care to address the multiple medical and social elements contributing to the person's health inequities. Advanced practice registered nurse health care outcomes will continue to demonstrate increased access and quality when antiquated barriers to their practice are removed.

> Conclusion 3-2: this report states: "eliminating restrictions on the scope of practice of advanced practice registered nurses and registered nurses so they can practice to the full extent of their education and training will increase the types and amount of high-quality health care services that can be provided to those with complex health and social needs and improve both access to care and health equity."

With this in mind, it is important to recognize that Wisconsin's two statutorily mandated state health plans, published by the Wisconsin Department of Health Services, *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public* and *Healthiest Wisconsin 2020: Everyone Living Better, Longer,* represent landmark reports that, early-on, identified the social determinants of health as critical factors that can promote good health and well-being or cause poor health with diminished well-being. The determinants are interwoven and include factors such as: the social environment; physical environment; genetic endowment; health and

function; disease; access to health care; prosperity; levels of education; and well-being. To impact on the determinants of health requires a full-system response!

Given the longstanding limits of governmental resources, partnerships are the critical pathway in which to reach population groups at increased risk of illness, injury, premature death, and disability in order to improve health, prevent disease, and eliminate health disparities. Advanced practice registered nurses are superb "disease detectives" and provide safe care through prevention, intervention, disability limitation, and care management. They improve health outcomes for individuals and families outside the direct reach of health departments. They support and advance Wisconsin's health care infrastructure. They contribute to the health of Wisconsin by providing services to at-risk population groups that include but are not limited to:

- School-aged children and youth
- Chronic disease management (including hypertension, diabetes)
- Vaccine preventable diseases including COVID-19
- Targeted services to at risk populations to include: African American, Hispanic Latino, Asian, LGBT, Native American, and homeless populations
- Population groups facing health disparities and the negative influence of the social determinants of health (e.g., low income, limited education, the physical and social environments, and lack access to care)
- Reproductive health care services for at-risk and high-risk young and aging women
- Elderly, aging, and persons with special health care needs including the disabled and infirm
- Primary care clinics
- Tribal health clinics
- Primary and specialty care in Federally Qualified Health Centers and similar entities.
- Specialty care in clinics, hospitals, long-term care, and extended-care settings
- Rural health and access to basic prevention and primary care services including mental and behavioral health, and substance use
- Healthy birth outcomes and reproductive health services to prevent unplanned pregnancies

Advanced practice registered nurses with public health expertise are also needed to partner with communities to focus on improving the systems and social structures that historically have limited the health and well-being of whole groups of people. This could include advanced practice public health nurses to work in organizational leadership roles or as community facilitators to bridge health care, public health, non-profit, and policy sectors to support reforms needed to create opportunities for health improvement (Bekemeier et al., 2021).

We are aware that Wisconsin physicians are not supportive of AB 396 or SB 394. No one health care discipline alone can address the health care needs of patients. It takes teams of physicians, advanced practice registered nurses, physician assistants, pharmacists, and others working together, and to the full capacity of their training and licensure (top of license), to move toward

value-based care, improved patient health and safety, and improved health of the population. This has been extensively documented in the literature and was recently put forth in *Patient-Centered Team-Based Care in Wisconsin – A Working Conceptual Model* (Wisconsin Nurses Association, 2016). From that publication, the hallmarks of effective patient-centered team-based care are characterized as follows:

- Carried out in concert with patients and family caregivers to achieve positive experiences and mutually agreed-upon outcomes" (Okun et al., 2014, p. 7).
- Grounded in the principles of shared goals, clear roles, mutual trust, effective communication, and measurable processes and outcomes (Mitchell et al., 2012).
- Guided by a set of core values: honesty, discipline, creativity, humility, and curiosity (Mitchell et al., 2012).
- Safe, competency-based (e.g., knowledge, skills, attitudes) and evidence-based care (Baker, Salas, King, Battles, & Barach, 2005)
- Keeps the patient as healthy as possible and proactively focused on all three levels of prevention (primary, secondary, and tertiary).
- Delivered on a continuum, where patient engagement transitions from care to me to care with me to care by me (Okun et al., 2014).
- Fosters patient engagement of patients to achieve patient outcomes and improve patient satisfaction (Okun et al., 2014).
- Coordinated and/or integrated across all elements of the complex health care system and the patient's community (Patient-Centered Primary Care Collaborative, 2007).
- Facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner" (Patient-Centered Primary Care Collaborative, 2007, p. 2).

These hallmarks benefit both patients and communities and advance "value-based" health care delivery instead of traditional "volume-based" care delivery. As individual professional disciplines, physicians and advanced practice registered nurses offer excellent care. However, when these two disciplines work together on patient-centered teams with other health care providers, improved patient health care outcomes and improved community health outcomes are achieved. This includes your community.

Just as health care professionals should not work alone, local and state health departments cannot achieve improved population health by working alone. Special consideration must be given to advanced practice registered nurses in closing gaps in some of the most compelling challenges and health disparities facing our public health system. Here we bring your attention to current and emerging explosion of need for chronic disease management (hypertension and diabetes), behavioral and mental health services, alcohol and substance abuse prevention and treatment, and access to health care. Advanced practice registered nurses continue to be at the front-lines in addressing these pressing and complex problems with patients and communities.

With regard to women's health, advanced practice nurses provided needed services to women and families in rural and urban settings that can be in clinics, homes, and schools. Reproductive health services range from prenatal and postnatal care, broad reproductive education, pregnancy planning, and prevention. Many practice in rural areas where such needs may not be fully addressed because providers are lacking or overworked. Additionally, there are barriers that often impede access to care because of cost or trauma experienced with prior health care encounters. Advanced practice nurses offer a continuum of care that is trusted and sought out.

As public health nursing leaders in Wisconsin, we urge you to understand the importance of fully utilizing the skills, talents, and training of Wisconsin's 6,000 advanced practice registered nurses on behalf of the health of people and the health care and public health systems in the state (*Wisconsin 2020 RN Workforce Survey*, 2021). Wisconsin needs these nurses and we need them to be functioning at their highest level.

We respectfully ask that you pass this bill out of your committee as soon as possible.

Respectfully submitted,

Judith K. Aubey, MSN, RN, Public Health Nursing Supervisor, Public Health Madison Dane County (retired)
Elizabeth Giese, MPH, RN, Public Health Nursing Policy Expert
Beth R. Peterman, FNP, MSN, MS-Business, Family Nurse Practitioner (retired)
Susan K. Riesch, PhD, RN, FAAN, Professor Emerita of Nursing, University of Wisconsin-Madison, School of Nursing
Margaret O. Schmelzer, MS, RN, Public Health Nursing Director, Wisconsin Department of Health Services, Division of Public Health (retired)
Susan J. Zahner, DrPH, RN, FAAN

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5510 Research Park Drive
P.O. Box 259038
Madison, WI 53725-9038
608.274.1820 | FAX 608.274.8554 | www.wha.org

TO: **Members of the Senate Committee on Health**

FROM: **Matthew Stanford, General Counsel**
Kyle O'Brien, Senior Vice President, Government Relations

DATE: **July 28, 2021**

RE: **WHA Testimony on SB 394 – For information only – APRN Modernization Act**

Patients throughout Wisconsin rely on advanced practice registered nurses (APRNs) as primary and specialty care providers that work within hospitals, clinics, and other health care settings. Over the years, as the education and training of advanced practice nurses has evolved so too has the practice of advanced practice nurses. Unfortunately, in many cases, both state and federal law has often lagged behind modern APRN practice, and in many cases state and federal law have evolved inconsistently.

Hospitals face under-appreciated, but quite significant compliance challenges unique to APRN practice. Not only must hospitals navigate Wisconsin's Chapter 441 professional licensure provisions impacting APRN practice, but also state and federal facility licensure regulations, state and federal Medicare and Medicaid payment requirements, private payor requirements, and other laws impacting care capable of being delivered by APRNs. And against that regulatory complexity, hospitals and health systems continually strive to utilize all of their health care workforce – physicians, advanced practice clinicians, and other professionals – at each of their professional "top-of-license" to provide accessible, efficient, high quality care to Wisconsin's communities.

To help navigate the challenging and highly complex regulatory environment impacting care delivery by APRNs, WHA has offered multiple education programs focusing on legal and practical considerations for APRN care delivery in hospitals and clinics. A key goal of such education has been to help reduce confusion and misunderstanding regarding current practice laws and authority, including nuances between supervision, collaboration, and collaborative agreements.

In addition to WHA's education efforts to mitigate regulatory complexity, WHA has also supported, and in some cases championed, multiple legislative and rulemaking efforts to remove regulatory barriers to advanced practice nursing and physician assistant practice that are no longer consistent with the modern education, training, and experience of those professions. For example:

- In 2005, WHA strongly supported Wisconsin's CRNA "opt out" status which continues to enable Certified Registered Nurse Anesthetists (CRNAs) and their hospitals to bill Medicare for anesthesia services provided by CRNAs without physician supervision. That critical policy continues today.
- Over the past 15 years, WHA has supported several federal regulatory changes ultimately enacted by the federal Centers for Medicaid and Medicare Services (CMS) that recognize overlapping practice authority of APRNs and physicians, thus enabling APRNs to have hospital privileges and perform services in hospitals previously limited to physicians.
- In 2013, WHA championed enacted, bipartisan legislation that removed outdated state hospital regulations that limited hospital privileges for APRNs.
- In 2017, WHA championed enacted, bipartisan legislation clarifying that Wisconsin's Medicaid program recognizes medical orders issued by APRNs.

- In 2019, WHA championed enacted, bipartisan legislation enabling APRNs to perform competency examinations to help families activate a patient's power of attorney wishes.
- In 2019 and again this year, WHA supported bipartisan legislation enacted earlier this year that modernized the licensing and scope of practice of physician assistants to recognize their modern education, training, and experience.
- Just this year, WHA championed changes to DHS 75 substance use disorder certification rulemaking to recognize the modern practice of APRNs and physician assistants.

WHA has prioritized addressing regulatory complexity regarding APRN practice because it impacts not only APRNs, the hospitals and clinics they work in, and our patients, but in many cases adds unnecessary regulatory burden on physicians. As one example, concerns from physicians regarding the need for physicians to co-sign orders issued under the scope of practice of an APRN helped lead to Medicaid changes clarifying overlapping practice authority between physicians and APRNs to issue medical orders. WHA's member physicians have also expressed frustrations with having to perform clinical tasks that are within the scope of practice of an APRN but that require physician action due to outdated regulatory provisions that refer only to physicians. Such concerns, for example, led to changes recognizing the ability of APRN's in Wisconsin's power of attorney statute. Similarly, impacts on physician administrative tasks and documentation burden – including documentation of a collaborative relationship - has been a key consideration in WHA's evaluation of the APRN Modernization Act.

With that backdrop, WHA appreciates the APRN Coalition continuing to work with WHA to make some additional technical improvements to the APRN Modernization Act, including improving technical clarity in the bill, such as that licensed APRN practice will not require physician supervision or a written collaborative agreement, reducing regulatory complexity, preserving the freedom of hospitals, clinics, and others to establish their own higher standards of practice within their organizations, placing the responsibility and burden of licensure oversight fully on the board of nursing and not on individual physicians, ensuring timelines for implementing the new APRN license are reasonable and provide meaningful opportunity for public comment, and preserving certified registered nurse anesthetists' long standing ability in Wisconsin to provide and be reimbursed for anesthesia services performed without physician supervision.

Welcome Senator Testin and members of the Senate Committee on Health and Human Services
Welcome Representative Sanfilippo and members of the Assembly Committee on Health
I would like to thank you ahead of time for the opportunity to testify in support of the Advanced Practice Registered Nurse or APRN Modernization Bill-Senate Bill 394 and Assembly Bill 396.

My name is Tina Bettin. I am president of the Nurse Practitioner Forum of the Wisconsin Nurses Association, representing the nearly 5000 nurse practitioners in the State. I am also the State Representative for the American Association of Nurse Practitioners though I am not acting in that role today as you have received written testimony from the AANP President April Kapu.

I am a doctoral prepared Family Nurse Practitioner. I have been a nurse practitioner for over 30 years, over 25 years of those years working in rural Wisconsin. The APRN Modernization Act is needed for citizens of Wisconsin. Our State currently faced a healthcare workforce challenge. 70 of our 72 counties face primary care provider shortages per HRSA data on Rural Health Information Hub as of April 2021, and patients of Wisconsin need more choice and access to cost-effective care. There are multiple changes needed to move our State forward. However, this legislation is the only option with no-added cost and no delays to help the State safely address that need. With the shortage of primary care providers in Wisconsin, it is imperative to allow Wisconsin patients full and direct access to nearly 5000 nurse practitioners in Wisconsin who have a track record of safe, cost effective care by retiring the unneeded and expensive collaborative agreements.

I have been providing high-quality health care to the nearly 2000 patients that I care for in Waupaca County and surrounding counties. The majority of my years in practice have been in rural Wisconsin as a solo provider in a clinic with a health system. Every day I evaluate patients, diagnosis diseases, manage treatments and prescribe medications for my patients. Patients that are exclusively seen and managed by me. If the patient needs additional specialty care, I refer them to the appropriate specialist just like my primary care physician colleagues. I care for three and four generations of families on a daily basis. My employer tracks quality metrics on a monthly basis and this data is transparent within our health care system. Consistently, my metrics for quality data has been high resulting in some of the highest quality within the entire health system all while caring for rural individuals. On an annual basis, I am typically one of the top three quality performers within my call group that is presently 14 providers but has been up to 19, and our call group is usually first or second in quality metrics annually within my health care system. But I am not an anomaly. The other nurse practitioners also consistently earn high quality outcomes-quality is our tradition.

The problem is that while our education and national certification prepare us to diagnose, treat and prescribe it's currently illegal for us to practice our profession without a regulated agreement with a physician--in essence a permission slip to provide care. This outdated requirement needlessly bottlenecks our State workforce and creates barriers to getting more care to more places. The collaborative agreement negatively impacts the citizens of Wisconsin in that at any time they could be without a provider in 30 days when the collaborator rescinds the agreement and can do so without providing any reason.

This model of licensure is not new. It's the model in 23 other states soon to be 24, DC and 2 US territories. There is over 50 years of data on nurse practitioners, from the time of our birth in 1965 with Loretta Ford and Dr. Henry Silver in Colorado to present. This data overwhelmingly shows that nurse practitioners provide quality care. Multiple single studies and numerous systematic reviews reveal the quality of care provided by NPs and APRNs is comparable to physicians. One study in 2018 by Adams and

Markowitz, in their Hamilton Project showed that NPs care is equal in quality but at a lower cost, and that removing restrictions on their practice can help alleviate shortages and improve efficiencies. This has been recognized by the Federal Government as NPs within the VA system have full practice authority. The Federal CARES Act of 2020 opened the door to sign for home health care on the patients we care for, instead of having physician sign for home care on patient's they don't even know. In Wisconsin, since the end of March 2020, nurse practitioners have been working under full practice authority under Governor Evers's emergency orders and there has been no practice issues per the Board of Nursing. Though this was not the intent, Wisconsin has had an experimental period which no one was concerned about and again there were no issues identified.

The Bill will also provide title protection and delineate the educational and national certification requirements needed to practice as an APRN in Wisconsin. The practice requirements or scope of practice do not expand the types of services APRNs provide now but would make the language of State Law be consistent with national recommendations from the "Consensus Model for APRN Regulation" published in 2008 by the National Council of States Board of Nursing and the 48 nursing groups that made up the APRN Consensus Work Group. This directive is further supported by the 2010 and 2020 Institute of Medicine/National Academy of Medicine reports "The Future of Nursing" which stated that APRNs' scope of practice 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."

Over 25 years ago, I testified in support of the passage of the 1993 Wisconsin Act 138, which created the section in Statute 441 authorizing prescriptive language for advanced practice nurses, at which time Wisconsin was a leader. In this legislation as well as the associated rules and regulations from the Board of Nursing (N8), there was no mention of collaboration as it was an assumed professional attribute just like our physician counter parts collaborate. Collaboration was added in 2000. Multiple federal agencies have recommended APRNs should be practicing to the full scope of their education and training. This includes the Federal Trade Commission's 2014 report, "Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses," and the 2018 publication "Reforming Americas Healthcare System Through Choice and Competition." A quarter of a century later, it's time to again step forward.

As Wisconsin continues to fight the opioid epidemic, the healthcare work force in not poised to take on this public health emergency. Research shows States that are full practice authority have a higher percentage of nurse practitioners with the prescribing waiver for medically assisted treatment. In States, like Wisconsin, where there are restrictions on nurse practitioner practice, there are fewer nurse practitioners with the waiver thus impacting the ability to treat this unique population. In 2019, Wisconsin was in the bottom 12 States of nurse practitioners having this lifesaving treatment option.

In closing, I ask that you support APRN Modernization Bill for the citizens of Wisconsin. There is a health care workforce ready to help. According to the 2018 report "Reforming Americas Healthcare System," collaborative agreements do not foster collaborative care. Instead, they negatively impact care because of the various constraints that the agreement puts in place-access, financial, and lack of innovation. The report also states that "economic analysis indicates that expanding APRN SOP (scope of practice), consistent with APRN education, training, and experience, would have clear consumer benefits, particularly in rural and poorer areas." Wisconsin needs to move forward at this time to provide the citizens with the healthcare options they deserve and break the glass ceiling that is negatively impacting healthcare.

Please remove my hand cuffs and let me care for patients. Let Wisconsin open up for the business of caring for our citizens.

Tina Bettin DNP, MSN, RN, FNP-BC, APNP, FAANP

Tina Bettin DNP, MSN, RN, FNP-BC, APNP, FAANP

July 28, 2021

Senator Patrick Testin
Chair Senate Health Committee
Room 8 South
State Capitol
Madison, WI 53707

RE: Support of SB 394/AB 396 - advanced practice registered nurses

Dear Chairperson Testin and members of the Senate Health Committee:

My name is Diane Schadewald. I live in the Village of Whitefish Bay and I practice as a nurse practitioner (NP). I've been certified and have worked as a NP for the past 28 years. I thank you for holding a hearing on the two Companion Bills SB 394/AB 396 and I am writing in support of this legislation.

The APRN Modernization Act is needed to not only provide definition of the advanced practice registered nurse (APRN) roles in the state of Wisconsin, but also to remove barriers to patient access to APRN services. This Act includes provisions that will allow APRNs to practice to the top of their education and training. Allowing APRNs to practice without current barriers will increase patient access to safe, effective, and quality health care services APRNs have been proven to provide in numerous studies over the past several years[1].

Removing barriers to APRN practice is especially important for rural areas of the state in which there often is lack of access to health care services[2]. APRNs from rural areas are more likely to return to their rural roots to practice upon graduation[2]. Also, removing barriers to the practice of APRNs has been included as an important initiative in both the 2010 Future of Nursing Report of the National Academy of Science, Engineering, and Medicine (NASEM [formerly the Institute of Medicine] as well as in the 2020 Future of Nursing Report just released by NASEM[3,4]. Twenty-three states have removed barriers to APRN practice without any evidence of a decrease in the quality of care received by patients cared for by NPs in those states[5,6].

Thank you again Chairperson Testin and Committee members for providing me the opportunity to provide my thoughts. I respectfully ask that you support this legislation and vote it out of Committee in the near future. Please let me know if you have any questions.

Sincerely,

Diane Schadewald, DNP, MSN, RN, APNP, WHNP-BC, FNP-BC

6261 N Bay Ridge Avenue
Whitefish Bay, WI 53217

(414) 967-8705

[1-6]References cited are available upon request.

MARQUETTE
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College of Nursing
Office of the Dean
Clark Hall, 243
PO Box 1881
Milwaukee, WI 53201-1881
414-288-3812

TO: **Chairman Testin and Members of the Senate Committee on Health and Chairman Sanfelippo and Members of the Assembly Committee on Health**

FROM: **Janet Wessel Krejci, PhD, RN, NEA-BC, Dean and Professor of the Marquette University College of Nursing**

DATE: **July 27, 2021**

RE: **Support for Senate Bill 394 and Assembly Bill 396 Relating to advanced practice registered nurses, extending the time limit for emergency rule procedures, providing an exemption from emergency rule procedures, and granting rule-making authority.**

Please accept my written comments as my previous commitments will not allow me to testify before the Senate Committee on Health on July 28th regarding Senate Bill 394 nor the Assembly Committee on Health on July 29th regarding Assembly Bill 396. As Dean of the Marquette University College of Nursing, I would like to thank Senator Testin and Representative Cabral-Guevara for authoring SB 394 and AB 396 relating to advanced practice registered nurses, extending the time limit for emergency rule procedures, providing an exemption from emergency rule procedures, and granting rule-making authority.

Background on Marquette University College of Nursing
Marquette University's baccalaureate degree in nursing, master's degree in nursing, doctor of nursing practice, and post-graduate APRN certificate programs at Marquette University College of Nursing are accredited by the Commission on Collegiate Nursing Education (CCNE). In addition, the College of Nursing is approved by the Wisconsin State Board of Nursing. Marquette's Nurse-Midwifery Program is accredited by the Accreditation Commission for Midwifery Education. Marquette's Nurse Anesthesia Educational Program is accredited by the Council on Accreditation of Nurse Anesthesia Education Programs.

More information regarding Marquette University College of Nursing's Master's, Post-Master's Certificate, Doctor of Nursing Practice (DNP), and Doctor of Philosophy in Nursing (PhD) programs can be found here: Nursing Graduate programs // Graduate School // Marquette University.

In many of these programs, there is a waiting list, primarily because of the limitations in placements in clinical settings. We are graduating our first Nurse Anesthesia DNP students this August. The demand is great for these and other Advanced Practice Nurses.

Support for Senate Bill 394 and Assembly Bill 396
Marquette University College of Nursing is supportive of SB 394 and AB 396 the Advanced Practice Registered Nurses (APRN) Modernization Act.

These companion bills provide criteria for licensure in Wisconsin, including:

- Graduated from an accredited APRN education program.
- Graduated with a Master's Degree (or Post-Master's certificate) or higher in one of the four roles.
- Obtained National Board Certification that is approved by the Board of Nursing.
- Provided evidence of having medical malpractice insurance coverage.

Under the proposed APRN Modernization legislation:

- Provides a separate license for APRN.
- Includes the practice role (CNM, CRNA, CNS, NP).
- Provides title protection for APRN, CNM, CRNA, CNS and NP.
- Allows all APRNs currently practicing in a recognized role to receive an APRN license.
- Replaces APNP with APRN across 50 other state statutes.
  - o Codifies the opt-out of federal CRNA supervision requirement that has been in existence since 2005.
- Repeals §441.15 – Nurse Midwife Practice Act.
- Repeals §441.16 – Prescription Privileges for Advanced Practice Nurse.

Thank you for the opportunity to outline key areas of Senate Bill 394 and Assembly Bill 396 and express the support of Marquette University College of Nursing as we continue to find ways to address the health care patient-centered needs of Wisconsin residents while meeting excellence in educational standards.

If you wish to discuss the Advanced Practice Registered Nurses Modernization Act further, I would be happy to make myself available. Please contact Mary Czech-Mrochinski in Marquette's Office of Public Affairs at mary.czech@marquette.edu or at (414) 288-3969 to arrange for a discussion.

Sincerely,

Janet W. Krejci, PhD, RN, NEA-BC
Dean and Professor

July 28, 2021

Senator Patrick Testin
Chair Senate Health Committee
Room 8 South, State Capitol
Madison, WI 53707

Re: Support of Senate Bill 394-Advanced Practice Registered Nurses

Dear Chairperson Testin and Senate Health Committee Members,

Thank you for holding a hearing on the two Companion Bills SB 394/AB 396. As a Nurse Practitioner in Green Bay, I support this legislation.

I have been a Nurse Practitioner for over 16 years and Registered Nurse for over 31 years, proudly providing care for thousands of patients during this time. Throughout my career as a Registered Nurse, I was inspired by experiences with Advanced Practice Nurses to pursue further education to be a Nurse Practitioner. I witnessed unique care of patients using a holistic and educational approach, with quality and patient satisfaction confirmed by numerous research studies. The inefficient delivery of care created by the need for collaborative relationships with physicians is unfortunate and unnecessary. Nurses are accustomed to working as a team and naturally collaborate responsibly, as the bill outlines. Competition between providers and redundancy in practice at present also reduce access to health care, especially important with current health care provider shortages. I would like to be able to practice at the top of my license, which in turn supports top of licensure practice for my physician colleagues.

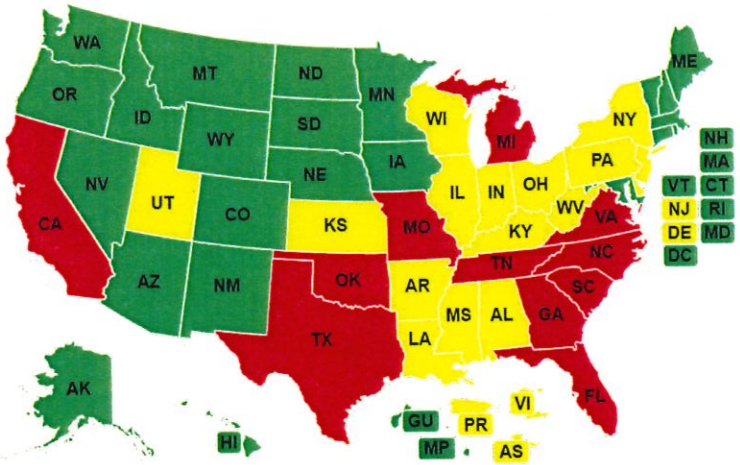
Thank you Chairperson Testin and Senate Committee members for this opportunity to share my thoughts. I respectfully request your support of this legislation and vote it out of Committee in the near future.

Sincerely,

Jackie Wirkus, DNP

Jackie Wirkus, DNP
817 Ash Street
Green Bay, WI 54313
(920) 819-4410

2021 NURSE PRACTITIONER STATE PRACTICE ENVIRONMENT



Full Practice: State practice and licensure laws permit all NPs to evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine, and the National Council of State Boards of Nursing.

Reduced Practice: State practice and licensure laws reduce the ability of NPs to engage in at least one element of NP practice. State law requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care, or it limits the setting of one or more elements of NP practice.

Restricted Practice: State practice and licensure laws restrict the ability of NPs to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team management by another health provider in order for the NP to provide patient care.

See State Fact Sheets for more information.

AANP | American Association of NURSE PRACTITIONERS®

1/2021

AANP State Government Affairs
1400 Crystal Drive, Suite 540, Arlington, VA 22202
703-740-2529
statepolicy@aanp.org

July 28th, 2021

Senator Patrick Testin, Chair Senate Health Committee

Room 411 South, State Capitol, Madison, WI 53707

RE: Support of SB 394/AB 396- Advanced Practice Registered Nurse

Dear Chairperson Testin and members of the Senate Health Committee,

My name is Kristina Strupp. I live in Franklin WI and I practice as a Clinical Nurse Specialist (CNS). I thank you for holding a hearing on the two Companion Bills SB 394/AB 396 and I am speaking in support of this legislation.

I currently care for patients that have suffered from a pulmonary embolism (PE) in the post hospitalization clinic setting. I assist with their follow up care after hospitalization by monitoring for continued symptoms, complications and medication adherence. This importance service that I provide, allows me to prevent my patients from having a potentially life-threatening complication, prevent a recurrent blood clot and prevent a hospital readmission. The patients I see often do not have a primary care provider and would be lost to follow up after their hospitalization without this clinic option that I run.

I would like to be able to practice at the top of my license to increase access to care, efficiency, transparency, and reimbursement for my employer.

Thank you again Chairperson Testin and Committee Members for providing me the opportunity to provide my thoughts. I respectfully ask that you support this legislation and vote it out of Committee in the very near future.

Please let me know if you have any questions.

Sincerely,

Kristina Strupp

Kristina Strupp, MSN, APNP, AGCNS-BC

Clinical Nurse Specialist Prescriber

7609 S. Drake Lane, Franklin

(414) 467-4767

Terri L. Vandenhouten, MSN, FNP-BC, APNP Family Nurse Practitioner

Employer – Advocate Aurora Healthcare – Bay Settlement Clinic

4070 Equestrian Road

New Franken, WI 54229

920-866-6104

Home- 1756 County Road C

Brussels, WI 54204

920-493-5603

Hello – My name is Terri Vandenhouten. I am a family nurse practitioner, employed by Advocate Aurora Healthcare since March 11, 1996. I live in the southern part of Door County. My clinic is located in New Franken, Wisconsin – northeastern part of Brown County. My state senator is Andre Jacques and my state representative is Joel Kitchens. I thank both of those gentlemen for having signed on in support of this bill.

I have worked as a NP for the past 25 years in family practice clinics. I can not speak about the inpatient hospital environment but I can about the clinic environment. I am here today in support of the APRN Modernization Act SB 394 and its companion bill AB 396.

I work full time seeing patients as their primary care provider ages 2 months and older to advanced geriatric. I have my own practice panel and am designated as their primary care provider of record. As a nurse practitioner I do wellness or preventative visits such as well child physicals, well women exams, complete physical exam, sports and camp physicals, pre-operative clearance physicals. I treat patients with a wide variety of chronic health conditions such as diabetes, hypertension, hyperlipidemia, chronic kidney disease, depression, anxiety, asthma, allergies, ADHD. I also see acute problem visits – such things as urinary tract infections, ear aches, back pain to name a few. I assign a diagnosis to a patient based on my history, physical exam, any test results – then develop a plan for treatment. I prescibe medications and any other treatment recommendations as needed. Patients are billed under my name and NPI number. I practiced alone as the only provider in my clinic for two years and I have shared clinic space with other providers both physicians and nurse practitioners since then. Typically I spend < one minute per month "collaborating" with my designated physician about a patient issue. Generally, I ask him to cosign or review EKG's per my personal comfort level. We talk about other clinic issues or family practice department issues or social issues as coworkers. We cover for each other when someone is out of the office.

Since 3-11-1996 I have seen an evolution in my system toward better understanding and utilization of Nurse Practitioners in clinics. I was on the first system wide leadership council of Advanced Practice Clinicians and served in that role for four years. APC's have become part of management committees and have a voice at the table. Just yesterday, July 26, 2021, it was announced we now have a "Chief Advanced Practice Officer for the Medical Group". I feel however there is still much to be done in my system and in our state. As of 6-22-2021 Advocate Aurora has 1,923 APC's plus 3609 physicians

The National Council of State Boards of Nursing, NCSBN, has recommended a Consensus Model to help states progress toward uniformity among all 50 states. Currently, Wisconsin is the only state in the United States that uses the terminology "APNP" advanced practice nurse prescriber. My employer encompasses clinics and hospitals throughout the eastern side of Wisconsin; Menominee, Michigan and Illinois. – we are all referred to by something different in our states. In Wisconsin we are called "APNP" or advance practice nurse prescribers; in Michigan "nurse specialists" and in Illinois APRN "advanced practice registered nurse". As a system Advocate Aurora has decided to refer to us as "APC" Advanced Practice Clinicians. When, now a Senior Vice President, Chief Medical Officer at Advocate Aurora – came to us from another state, he told me himself, he had no idea what a APNP was – it had to be explained to him. If this physician administrator didn't understand this terminology I know many less education people including patients do not fully understand who we are and what we can do. This bill would title us as advance practice registered nurses- which is something I believe 33 other states have already done. Under that APRN title then would be the four defined roles: nurse practitioners; certified nurse anesthetists, nurse midwives and clinical nurse specialists. A patient or health professional going from one state to another would have a familiar uniformity of title and qualifications.

Additionally, this bill sets to stipulate what constitutes an APRN by specifying our title and its definitions based on education – masters degree or higher from an accredited program in one of the four roles. It specifies the need for national certification and licensure. Currently Wisconsin APNP's are not licensed in the state – we are certified as APNP's. Our licensure is as a Registered Nurse which I have been since 1982. When we talk about practicing to fullest extent of our licensure – it brings me back to RN status. This bill very importantly changes APRN's to holding a licensure in the state of Wisconsin. There are already recommendations being made so we could do our RN and APRN licensure at the same renewal time – something we do not have now. I feel very strongly that it is important to change us from certification to licensure status. We want to work to the fullest extent of our licensure – as Advanced Practice Registered Nurses licensed in the state of Wisconsin.

Quality of care is essential. In our system we track Quality CMI and CRA Scores for each provider, each clinic, each region. I have enclosed a copy of my June 2021 Quality CMI and CRA scores. Highest you can score is 4.0. I was at a 4.0 past five months consistently and 3.9 month of January 2021. I was told in writing by my Quality Improvement Coordinator/ North Team that "you are my only 4.0 provider-congratulations on maintaining this level of quality related to your patient care". I do not share this to brag but to tell you Nurse Practitioners like me are providing high quality of health care to our patients. I am only one of those NP providers providing quality care in our state.

I do realize I am part of a large system in our state and feel I am allowed to practice as a primary care provider. Not all health systems practice the same or utilize their nurse practitioners the same. I also know because of the collaboration requirement, it is difficult for NP's to find collaborating physicians or dentists to collaborate with especially in rural parts of the state.

I once had a conversation with Robin Voss at a gathering for Joel Kitchens in Sturgeon Bay, WI. I talked with him about this APRN Modernization Act. He asked me why I thought it may not go thru – which took me surprise and I responded "money". I am very aware that physicians from some health care organizations – not all – are compensated for "collaborating" or "supervising". Advocate Aurora has merged and grown together as a health system. We are currently under one medical group structure and as of very recently I was informed we are still paying physicians for collaboration or supervision of

advance practice clinicians. The first year an Advanced Practice Provider is in practice a physician is paid $18,000 per year to collaborate or to supervise. The second year for collaboration with an APC they are paid $15,000 a year. For the third year an APC is in practice and for all subsequent years a physician collaborator is paid $12,000 per year. Generally physicians collaborate with multiple APC's and are compensated for each one. I encourage you to check with Health Care Organizations – inquire if they pay physicians to collaborate or supervise.

I really believe APRN Modernization Act's biggest challenge is money – not patient safety or quality or any limitation of our ability to diagnose and treat patients. It is money paid to physicians to collaborate or supervise that they do not want to lose.

As our "baby boomer" generation is retiring, we are already facing a less than ideal number of health care providers across the spectrum in Wisconsin health care. Please untie the nurse practitioner's hands especially in our rural areas to utilize their skills and provide health care to our state's residents.

Please highly consider this bill, SB 394 and AB 396, and vote it out of committee in the near future.

Thank you,

Terri L Vandenhouten MSN, FNP-BC, APNP

920-493-5603

June 2021 Quality CMI and CRA scores for Terri Vandenhouten NP

Jeske, Kathy <Kathleen.Jeske@aah.org>

Thu 7/22/2021 3:26 PM

To: Vandenhouten, Terri <Terri.Vandenhouten@aah.org>; Van Wychen, Megan <Megan.VanWychen@aah.org>
Cc: Jeske, Kathy <Kathleen.Jeske@aah.org>

Hi Terri and Megan-

Hope you are both doing well!

These are your June 2021 scores with year to date trending as it is the end of the quarter.

You are doing an amazing job, keep it up!

I have a meet/greet scheduled with you on 8/6, Megan-I will send you that invite as well. Would like to meet you both. We continue to be a remote work team.

If you have immediate needs, please reach out-I am always available on Teams and happy to provide resources to assist with quality patient care.

Thanks
Kathy

North PSA Updates:

- Great Job maintaining a **3.7 CMI score** and still being the highest across all Markets!!!
- The Market maintained for **HTN** at **86%** - the goal is 89%. We know this continues to be a huge focus for the Market and the system, please keep up the great work on moving toward that 89%!!
- The Market saw a 2% dip in MWV from 83% to 81% for June. We know there has been many changes/updates around this measure and we just want to make sure that we maintain the focus through the end of the year!!
    - If there are any questions regarding outreach or any of the new process/tools, please reach out to me.

CMI Quality Data Trending Jan 2021-June 2021

AHC-GREEN BAY, EQSTRN LN	VANDENHOUTEN,	JAN 21	3.9		79	86	87	86	86	85	[illegible]	86	83	81	100	33	50	74	60	84	86	100	17	96	89	66	100	99				
AHC-GREEN BAY, EQSTRN LN	VANDENHOUTEN,	FEB 21	4.0	▲	80	86	87	87	86	85	89	87	84	82	100	50	50	75	60	84	86	0	17	96	90	69	100	99				
AHC-GREEN BAY, EQSTRN LN	VANDENHOUTEN,	MAR 21	4.0	=	81	84	86	87	86	85	85	87	84	82	100	50	50	73	60	84	81	0	20	96	92	72	100	99				
AHC-GREEN BAY, EQSTRN LN	VANDENHOUTEN,	APR 21	4.0	=	83	86	86	87	87	81	85	87	84	84	100	0	0	73	75	84	82	0	20	97	92	71	100	99				
AHC-GREEN BAY, EQSTRN LN	VANDENHOUTEN,	MAY 21	4.0	=	73	86	84	86	86	81	82	86	85	84	100	0	0	73	100	84	83	0	20	97	93	69	100	99				
AHC-GREEN BAY, EQSTRN LN	VANDENHOUTEN,	JUN 21	4.0	=	78	84	84	85	85	82	87	86	85	84	100	0	0	73	100	84	80	0	20	98	95	69	100	99				

For North Market-we have seen dip in blood pressure control and advance directives-this is a focus of the North Market now. Keep up your great work!

Number to next grade report:-you are my only 4.0 provider-congratulations on maintaining this level of quality related to your patient care!

VANDENHOUTEN, TERRI | JUNE 2021 Impact Score: 4.0 | Prev Month Impact Score: 4.0

VANDENHOUTEN, TERRI - AHC-GREEN BAY, EQSTRN LN

Practice Report	Measure Desc	Num	Den	Tot	Goal %	Goal (A)	Appro x # for A	Appro x # for B	Appro x # for C	Prev Month Num	Prev Month Den	Prev Month Pct	Prev Month Goal	Prev Month Appro x # for A	Prev Month Appro x # for B	Prev Month Appro x # for C
ADVANCED DIRECTIVES - 65	% pts 65+ with an Advance Directive	138	178	78	A (4)	>= 59				139	178	78	A (4)			
BREAST CA SCREENING	% Women screened ages 50-74	291	309	94	A (4)	>= 84				293	309	95	A (4)			
CERVICAL CA SCREENING	% Women screened ages 21-64	354	377	94	A (4)	>= 85				353	375	94	A (4)			
COLORECTAL CA SCREENING	% Patients screened ages 50-75	362	424	85	A (4)	>= 84				362	424	85	A (4)			
DEPR SCREEN W/ F/U PLAN	% screened age 12+; f/u plan if positive	449	473	95	A (4)	>= 88				465	485	96	A (4)			
DIABETES >= 2 A1c Tests	% with 2 A1c's in last 12 months	72	78	92	A (4)	>= 82				73	80	91	A (4)			
DIABETES A1c	% with A1C < 8.0	68	78	87	A (4)	>= 75				70	80	88	A (4)			
DIABETES URINE MICROALBUMIN	% with kidney tx monitor or treat	77	78	99	A (4)	>= 97				78	80	98	A (4)			
DIABETES STATIN	% on a Statin (40-75 or has IVD)	69	73	95	A (4)	>= 90				70	74	95	A (4)			
HYPERTENSION	% with BP in adequate control (<140/90)	277	294	94	A (4)	>= 89				276	293	94	A (4)			
IMM - ADOLESCENT	Adolescent series rate	1	1	100	n/a	>= 92				3	3	100	n/a			
IMM - CHILDHOOD	Primary series rate	0	1	0	n/a	>= 81				0	1	0	n/a			
IMM - 2 FLU VACCINES BY AGE 2	% Vaccine Received - 2 by age 2	0	1	0	n/a	>= 74				0	1	0	n/a			
IMM - FLU RECEIVED (2020-21)	% Vaccine Received >= 6 months	470	642	73	A (4)	>= 65				471	643	73	A (4)			
IMM - HPV	% completed HPV vaccine series by 13	1	1	100	n/a	>= 50				3	3	100	n/a			
IMM - ADULT PNEUMONIA	% 65 years+ with >= 1 PN vaccine	168	178	94	A (4)	>= 93				168	178	94	A (4)			
MEDICARE WELLNESS VISIT	% pts w/wellness visit in past 12 mths	185	206	90	A (4)	>= 70				193	207	93	A (4)			
WELL-CHILD VISITS	% pts with >= 6 WCE by 15 mo.	0	0	0	n/a	>= 78				0	0	0	n/a			
ASQ SCREENING *	% patients screened in 12 months prece	1	5	20	n/a	n/a				1	5	20	n/a			
BMI SCREEN WITH F/U PLAN *	% screened; f/u plan if < 18.5 or >=25	723	741	98	n/a	n/a				722	744	97	n/a			
DIABETES BP *	% with BP < 140/90	74	78	95	n/a	n/a				74	80	93	n/a			
DIABETES EYE EXAM *	% with dilated eye exam	54	78	69	n/a	n/a				55	80	69	n/a			
HTN AFRICAN-AMERICAN *	% with BP in adequate control	2	2	100	n/a	n/a				2	2	100	n/a			
IMM - FLU OFFERED (2020-21) *	% Vaccine Offered age >= 6 months	636	642	99	n/a	n/a				637	643	99	n/a			
IMM - FLU RECEIVED 6 Mos - 18 Yrs	% Vaccine Received - 6 months - 18 yrs	22	33	67	n/a	n/a				22	33	67	n/a			
IMM - FLU RECEIVED (2020-21) - All	% Vaccine received >= 6 months (All Po	586	864	68	n/a	n/a				580	858	68	n/a			
MCHAT-R SCREENING *	% patients, 30 months of age, screened	0	3	0	n/a	n/a				0	3	0	n/a			
POTENTIALLY AVOIDABLE ED VISIT	Rate per 1,000- Potentially Avoidable ED	5		59	n/a	n/a				5		59.9	n/a			
TOBACCO CESSATION - ASK *	% asked status in last 12 mnths	729	729	100	n/a	n/a				734	734	100	n/a			
TOBACCO CESSATION - ASSESS *	% w/ cessation advice in last 12 mnths	66	67	99	n/a	n/a				67	70	96	n/a			

CRA data April-June 2021

Below is your April-June Risk Adjusted Scores and *Monthly Tip*

2021 Clinical Risk Adjustment Targets - All Target Columns are in the darker blue

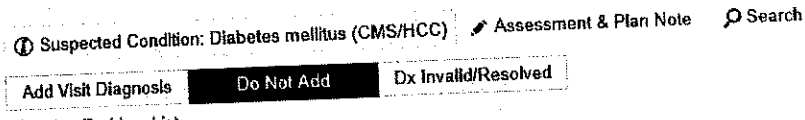
- **1-Recapture (Refresh) Rate ≥75%** The recapture rate correlates with your usage of the Clinical Risk Adjustment BPAs.
  0. **2-Score Gap <0.200** This correlates with your usage of the CRA BPA and your recapture rate. The higher the recapture, the lower the score gap.
- **3-Suspected Condition Gap of ≤ 10%** Conditions that have not been captured as a visit diagnosis but are suspected that the patient has based on clinical evidence (lab, med, test results) from internal record or external sources.
- **4-Average Current RAF YTD Score ≥ 1.09 and/or match your Average Potential Score** CMS Reported Normalized Medicare Patient Severity Score is 1.09

				2				4			1	3
Current PCP	Average of Potential RAF Score (Avg RAF Score of All HCCs)	Sum of Total # of HCCs	Sum of HCCs that still need to be addressed		# of patients with HCCs that still need to be addressed	Sum of Suspected Conditions that need to be addressed	# of Pts with Suspected Conditions that need to be addressed		# of CRA Patients Seen this Year	Month		
VANDENHOUTEN, TERRI L [25575]	0.943	152	26	0.100	16	11	11	0.843	83	2021Q2M4	83%	
VANDENHOUTEN, TERRI L [25575]	0.949	183	26	0.084	18	8	8	0.864	99	2021Q2M5	86%	8%
VANDENHOUTEN, TERRI L [25575]	0.937	186	25	0.079	18	8	8	0.859	102	2021Q2M6	87%	8%

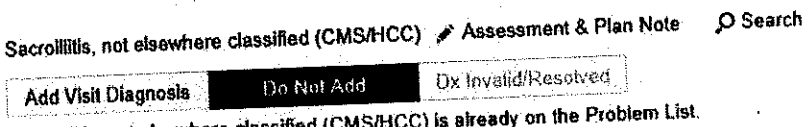
You are at goal in your CRA work! Great job!!
Continue to address HCCs flagging or *suspected HCCs* in the BPA or CRA tab at every appointment.
You have 25 HCCs and 8 suspected conditions to address before year-end as of the June 2021 data

Monthly Tip: In order to remove diagnoses that are no longer valid.

- Click on the Dx: Invalid/Resolved



- If the Dx: Invalid/Resolved button is grayed out, it means the diagnosis is on the problem list. Go to your problem list and resolve or delete the diagnosis from the problem list.



Please reach out with any needs, here to help.

Thanks for the work you both do to keep our patients well!

Thanks
Kathy

AdvocateAuroraHealth

Kathy Jeske MBA RN BSN OCN
Quality Improvement Coordinator, Sr. RN
Quality Improvement-North Team
3189 Voyager Drive
Green Bay, WI 54311
WORKING REMOTELY AT THIS TIME
Use Microsoft Teams to Connect
Or email at kathleen.jeske@aah.org
Or Mobile Number 920-655-2574 (last option)

Advocate Health Care *Aurora Health Care*

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To: Senator Dale Kooyenga

From: Martha M. Libster, PhD, MSN, APRN-PMHCNS, APHN-BC

Date: July 27, 2021

Re: Senate Bill 394 APRN Modernization Act 2021

Thank you very much for meeting with me to discuss SB 394. Advanced practice psychiatric mental health nursing has been my profession for twenty-two years and the subject of my research and professional publications. I am licensed as an advanced practice psychiatric Clinical Nurse Specialist in Colorado, California, and Illinois where I also am a provider for a major PPO plan. I have lived in Wisconsin for nearly five years, own a home in Wauwatosa, work as a Director of Academic Partnership Design for the second largest behavioral health system in the country, direct an APRN graduate level program for Milwaukee School of Engineering School of Nursing, and maintain a private counseling and health coaching practice.

I support SB 394; but I have strong objections to a few specific clauses. The purpose of my follow-up email is to provide the Senate and Assembly health committees suggested language for amending the current bill that I believe, based on my experience in other states, will strengthen the bill. My objections are:

1. Strike the requirement that an APRN pass, pay for, and maintain national board certification (exam). I attended the National Council of State Boards of Nursing APRN roundtable for five years and they have never demonstrated significant evidence for a benefit of such certification to the safety of the public. Some states, such as California, have excluded this requirement deeming it unconstitutional for a state to delegate its responsibility for the safe practice of APRNs to a private business outside of the state that produces such tests. Employers can require "board certification" as a marketing strategy but there are many reasons why this language should not be in Wisconsin statute.
2. If board certification language must be retained, the bill should include grandfathering language to protect the rights of the hundreds of APRNs currently practicing in Wisconsin who do not hold national board certification for several good reasons. There is one clause of grandfathering language in the current bill that addresses those APRNs who have not "graduated from accredited programs," but there is no grandfathering clause specific to a national board certification requirement. As stated in #1, I recommend striking this requirement completely.
3. Strike the clause just added that gives regulatory authority to the Wisconsin BRN to oversee graduate education programs. Historically, graduate programs in nursing have not been regulated by a BRN, for good reasons. For example, while a BRN, completely comprised of RNs, seemingly has the capacity and expertise to oversee undergraduate programs for initial RN licensure, a BRN overseeing graduate programs in nursing would not represent the specialization within the 4 recognized roles, such as advanced psychiatric mental health nursing or geriatric care. Faculties of nursing are experts in their fields who are best positioned with clinical partners and accrediting bodies to establish and maintain minimum standards for advanced practice nursing.

I have attached a copy of SB 394 that identifies these clauses with an explanation for my objections and proposed amendments. In addition, I have included an example of inclusive grandfathering language from Colorado's statute.

Thank you for your consideration.

6650 W STATE ST SUITE D95 WAUWATOSA, WISCONSIN • 53213
WWW.GOLDENAPPLEHEALINGARTS.COM
WWW.DRMARTHALIBSTER.COM