☞ **09hr_SC-HHIPPTRR_sb0451_pt01**

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10

(session year)

Senate

(Assembly, Senate or Joint)

Committee on ... Health, Health Insurance, Privacy, Property Tax Relief, and Revenue (SC-HHIPPTRR)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  - (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  - (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (June 2012)

Senate

Record of Committee Proceedings

Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Senate Bill 451

Relating to: hospital staff privileges for and written agreements required for nurse-midwives and allowing nurse-midwives to elect to be covered under the injured patients and families compensation fund.

By Senators Robson and Vinehout; cosponsored by Representatives Roys, Smith, Young, Berceau, Pasch, Sinicki, Turner and Vruwink.

January 07, 2010 Referred to Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

February 17, 2010 **PUBLIC HEARING HELD**

Present: (7) Senators Erpenbach, Carpenter, Robson, Lassa, Lazich, Kanavas and Darling.

Absent: (0) None.

Appearances For

- Judy Robson — Sen.
- Kathryn Osborne — WI Chapter of the American College of Nurse Midwives
- Jackie Tillett, Milwaukee — Midwifery and Wellness Center
- Pat Osborne

Appearances Against

- Judith Warmuth — WI Hospital Association
- Mark Grapentine — WI Medical Society

Appearances for Information Only

- None.

Registrations For

- Britt Wanta — Open Arms Midwifery
- Ingrid Andersson — Community Midwives

Registrations Against

- Ryan Natzke — WI Academy of Family Physicians

Registrations for Information Only

- None.

March 30, 2010	**EXECUTIVE SESSION HELD**		
	Present:	(6)	Senators Erpenbach, Carpenter, Lassa, Lazich, Kanavas and Darling.
	Absent:	(1)	Senator Robson.
April 22, 2010	Failed to pass pursuant to Senate Joint Resolution 1.		

Kelly Becker
Committee Clerk

Record of Committee Proceedings

Joint survey committee on Tax Exemptions

Senate Bill 452

Vote Record
Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Date: 3/30/10
Moved by: unp. Seconded by: Lassa

AB____ SB 451 Clearinghouse Rule____
AJR____ SJR____ Appointment____
AR____ SR____ Other____

A/(S) Amdt 1
A/S Amdt ____ to A/S Amdt ____
A/S Sub Amdt ____
A/S Amdt ____ to A/S Sub Amdt ____
A/S Amdt ____ to A/S Amdt ____ to A/S Sub Amdt ____

Be recommended for:
☐ Passage ☑ Adoption ☐ Confirmation ☐ Concurrence ☐ Indefinite Postponement
☐ Introduction ☐ Rejection ☐ Tabling ☐ Nonconcurrence

Committee Member	Aye	No	Absent	Not Voting
Senator Jon Erpenbach, Chair	☑	☐	☐	☐
Senator Tim Carpenter	☑	☐	☐	☐
Senator Judith Robson	☐	☐	☐	☐
Senator Julie Lassa	☑	☐	☐	☐
Senator Mary Lazich	■	☑	☐	☐
Senator Ted Kanavas	☐	☑	☐	☐
Senator Alberta Darling	☐	☑	☐	☐

Totals: ____ ____ ____ ____

712-7489 Teresa

☐ Motion Carried ☐ Motion Failed

Vote Record

Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

Date: 3/30/10

Moved by: ______________ Seconded by: ______________

AB______________ SB 451 as amended Clearinghouse Rule______________

AJR______________ SJR______________ Appointment______________

AR______________ SR______________ Other______________

A/S Amdt ______________

A/S Amdt ______________ to A/S Amdt ______________

A/S Sub Amdt ______________

A/S Amdt ______________ to A/S Sub Amdt ______________

A/S Amdt ______________ to A/S Amdt ______________ to A/S Sub Amdt ______________

Be recommended for:

☐ Passage ☐ Adoption ☐ Confirmation ☐ Concurrence ☐ Indefinite Postponement

☐ Introduction ☐ Rejection ☐ Tabling ☐ Nonconcurrence

Committee Member	Aye	No	Absent	Not Voting
Senator Jon Erpenbach, Chair	☐	☐	☐	☐
Senator Tim Carpenter	☐	☐	☐	☐
Senator Judith Robson	☐	☐	☐	☐
Senator Julie Lassa	☐	☐	☐	☐
Senator Mary Lazich	☐	☐	☐	☐
Senator Ted Kanavas	☐	☐	☐	☐
Senator Alberta Darling	☐	☐	☐	☐
Totals:	____	____	____	____

☐ Motion Carried ☐ Motion Failed

FORWARD

Date: February 17, 2010

To: Chairman Erpenbach

Members of the Senate Committee on Health

From: Dr. Lisa Hanson

Re: **Public Hearing Comments on SB 451**

I am Dr. Lisa Hanson, a Certified Nurse-Midwife. I am an Associate Professor at Marquette University, and teach in the Nurse-Midwifery Program. I have also practiced as a CNM at the Aurora Sinai Midwifery and Wellness Center, in Milwaukee for the past 23 years.

I would like speak in strong support of SB 451 as an educator who prepares Nurse-Midwifery Graduates to meet the needs of Wisconsin's families. SB 451 will improve access to the care of Wisconsin's Nurse-Midwives. More specifically, SB 451 will help correct the maldistribution of health care providers in Wisconsin. SB 451 will allow CNMs to establish practices in more settings to meet the need of Wisconsin's urban and rural underserved. For example, last year 4 Marquette midwifery school graduates left Wisconsin to find employment in other states. These Masters' prepared CNMs could have helped care for Wisconsin's families by starting new practices in their home communities.

While, SB 451 removes the requirement that certified nurse-midwives (CNMs) must practice under a written collaborative agreement with a physician, Nurse-Midwives will continue to work collaboratively with physician colleagues. Collaborative models of care are associated with improved outcomes.

SB 451 will make language clear that hospitals may grant nurse-midwives the ability to independently admit, treat and discharge patients in the hospital setting. This will enhance opportunities for CNMs to develop practices in underserved areas. Admitting privileges also improve the quality and efficiency of the care provided by CNMs because lines of communication concerning patient services such as laboratory test results are clarified. For example, at a hospital like Aurora Sinai, there are 4 midwifery practices with over 30 different nurse-midwives providing care to approximately one third of the birthing families. Without admitting privileges the patient records and labs, get mixed with those of the consulting physician taking large amounts of extra time to clarify the responsible nurse-midwife.

SB 451 maintains current law coverage under the PCF for nurse-midwives who are employed by a covered entity and creates a mechanism for non-employee covered nurse-midwives to obtain their own fund coverage which will further facilitate CNMs eligibility for independent hospital admitting privileges.

It is for all of these reasons that I urge you to vote in favor of SB 451.

Respectfully,

Lisa Hanson, PhD, CNM, FACNM
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Senior Certified Nurse-Midwife
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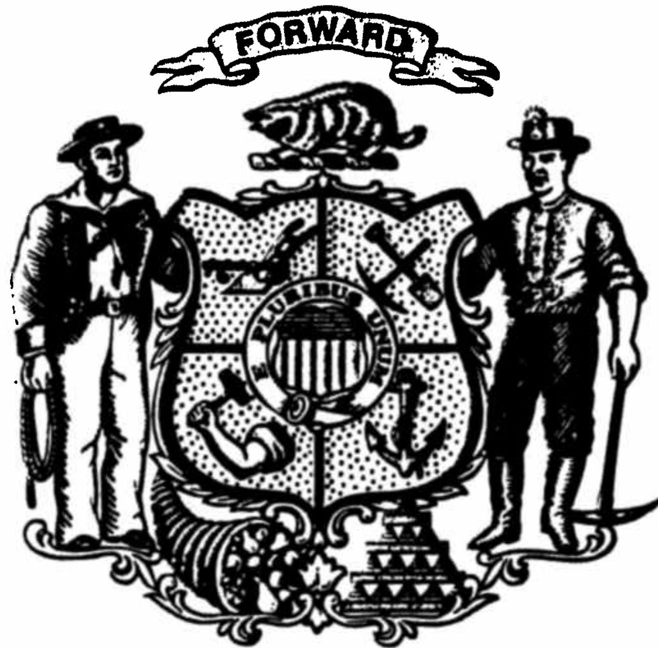
Milwaukee, WI


FORWARD
E PLURIBUS UNUM

Date: February 17, 2010
To: Chairman Erpenbach
Members of the Senate Committee on Health
From: Kathryn "Kate" Shisler Harrod, PhD, RN, CNM, APNP, FACNM
Re: Public Hearing Comments on SB 451

INTRODUCTION

Chairman Erpenbach, committee members, I would like to thank you for the opportunity to provide comments on Senate Bill 451. My name is Kate Harrod. I am licensed by the State of Wisconsin as a Registered Nurse, a Certified Nurse-Midwife and an Advanced Practice Nurse Prescriber. I completed my nurse-midwifery education and PhD from Rush University in Chicago, and am a Fellow of the American College of Nurse-Midwives. In addition, I am on the faculty of Marquette University teaching undergraduate Maternity Nursing and Midwifery, a practicing nurse-midwife in rural Elkhorn, Wisconsin, past chair of the local chapter of the American College of Nurse-Midwives, and member of the board of directors of the national organization of the American College of Nurse-Midwives. I am here today to tell you why it is important to remove the barriers this bill addresses, and to provide testimony in support of SB 451.

I would like to specifically discuss hospital staff privileges and the written agreements. I work for Aurora Health Care and have had admission privileges at Aurora Lakeland Medical Center for about nine years. I have worked there as a Certified Nurse-Midwife (CNM) for almost 12 years. I am the only CNM at Aurora Lakeland and have delivered many babies as an independent provider. In fact, each year only one or two other providers have delivered more babies then I have. Last year there were 807 births at Lakeland and I delivered 159 of the babies. This comes to about 20% of the babies born at the hospital. In addition to me, five obstetricians and three family practitioners also deliver babies at the hospital. In a time when the cesarean section rate is about 30%, my primary cesarean rate is about 3% and other operative delivery rates, meaning vacuum and forceps deliveries were about 2%. This means about 95% of the mothers I care for delivered vaginally with excellent outcomes.

ADMISSION PRIVILEGING

These statistics are outstanding. However, I have recently been told I will no longer have admission privileges at the hospital. Because of the wording of Wisconsin Administrative Code regarding hospital regulations, I will still be doing births, but all my patients will need to be admitted under a physician's name. This essentially makes the work I do invisible. It is difficult to access my patients and the medical data about them, if they all appear admitted under someone else's name. In addition, I am working hard, night and day, and not having admitting privileges allows someone else credit for the work I have done. Patients do not understand why my name is not on their admission wristbands. They do not understand why they have seen me for all their visits, the only provider they saw in the hospital and my name does not appear on anything they have

from the admission. Further, the physician's name appears on all the bottles of prescription medications my patients take home from the hospital, which causes confusion and diminishes patient safety.

WRITTEN AGREEMENTS

The second barrier I wanted to address is the written agreement. By the Standards of Nurse-Midwifery Practice, CNMs need to consult for any issue outside of our scope of practice. It is a standard of care to consult and we teach nurse-midwifery students these standards. Requiring a written agreement is not consistent with the American College of Nurse-Midwives (ACNM) Standards of Practice nor is it consistent with what is required of other midwives that are licensed in the state of Wisconsin. The American College of Obstetricians and Gynecologists (ACOG) and the ACNM in joint statement say the written agreement is no longer required. The written agreement has placed a significant barrier to many CNMs who would like to provide much needed health care to mothers and babies. In fact, while practices all across the state are refusing to accept Medicaid patients for care, 40% of the patients in our practice are insured by Medicaid, called the low payer provider. Because of the problems with Medicaid reimbursement more and more providers are limiting the numbers of these clients they will care for.

Another problem is that many physicians are afraid they will be responsible if they sign a written agreement or they may even want to limit the ability of CNMs to practice and refuse to sign a written agreement. For example, the CNMs working in Madison with out of hospital practices have been unable to find a doctor in Madison to sign their written agreements. Under current law, these CNMs would not be able to practice. In fact, these CNMs in Madison have had their written agreements signed by my physician partner in Elkhorn. If they have an emergency in Madison, Elkhorn is too far away. The patients are transported to one of the local hospitals and receive good care even though none of the doctors would sign the agreement. Finally one set of midwives, Licensed Midwives in Wisconsin, do not have the educational back ground CNMs have but are not required to have a written agreement.

IN CONCLUSION

I am asking you to help us to provide better care for women in need in Wisconsin by eliminating these barriers to Nurse-Midwifery Practice by supporting SB 451. Thank you for your thoughtful consideration of this testimony. For more information contact Kate Harrod at (262)279-3681 or at kate.harrod@aurora.org.

REFERENCES

http://www.theunnecesarean.com/blog/2009/3/18/c-section-rate-rises-2007-us-cesarean-rate-hit-318-percent.html

http://www.marchofdimes.com/pnhec/240_1031.asp

FORWARD
E PLURIBUS UNUM

Testimony on SB 451
Aszani Kunkler, CNM, MSN
February 17, 2010

Good morning Chairman Erpenbach and members of the Senate Health Committee. My name is Aszani Kunkler, and I am a nurse-midwife. I own, direct and practice midwifery at the Madison Birth Center. The Madison Birth Center is the Wisconsin's only Nationally Accredited free-standing birth center. I am also an elected Board member of the American Association of Birth Centers, a national and international leader in supporting the development and science of birth center care. Our birth center has been open since 2003 and we've served over 500 families for obstetric care. We've also served hundreds of other families who have taken our classes and participated in new mothers groups over the years. We specialize in natural childbirth, and care for only women with healthy, term pregnancies. Women who are at high risk or who become higher risk during the delivery process are referred into hospital care.

My story is an important one, because I have been directly affected by the barriers to practice under the current midwifery regulations.
In 2002, when I decided that I wanted to start the birth center, I went to every obstetric practice in the city of Madison and asked if they would sign my practice guidelines. I have been active in the obstetric community for 15 years as a doula, educator and labor and delivery nurse, and I am well-known to members of the obstetric community. Most OB groups are large, and although many in each group were supportive, the dissenters won the day and each group in turn said no. Keep in mind that under the current regulatory wording I would be practicing independently and maintaining my own medical malpractice coverage. The risk of liability to the group signing the collaborative agreement was nil, and I do not believe that it was a worry about liability that led all of these practices to turn down my request.

I ended up in Elkhorn, WI, an hour and a half away, before I found a physician who would hear my plan and agree to sign my practice guidelines. I want to thank Dr. Beatse, who has been a steadfast supporter of our care since we opened, for his willingness to say "yes" to me that day. As a result, the Madison Birth Center has saved the healthcare system in this area over 5 million dollars in avoided epidural & cesarean section costs. We've also contributed to the long-term wellness of our community through the very high numbers of our clients who initiate breastfeeding and continue nursing through the first year of their child's lives. As many of you know, breastfeeding has well-researched health advantages for people throughout their lifespan.

I know that some of you might be worried about the safety of independent midwifery care, and so I've also brought along our Cumulative Statistics since we opened in 2003. As you can see, we have an average of a 6% cesarean section rate, compared with a 31 % rate in the United States in 2007. The World Health Organization recommends that every country aim for a cesarean section rate between 10-15%. They also report that a C-section rate over 15% causes more harm than good. Using these recommendations, you

can see that at least half of the cesareans performed in the US are probably unnecessary and may be causing harm. Nurse-midwives are important providers of the kind of obstetric care that avoids the harmful practices so common in today's obstetric environment.

You may or may not know that the United States is tied for last among the developed countries for neonatal mortality. This often comes as a surprise, since our country spends more than any other on maternity care. When you take our very high cesarean section rates and compare them with our dismal neonatal outcomes, it is clear to see that we have lost our way.

An important difference between the countries with excellent outcomes and the United States is that over 80% of the women who deliver babies in those countries are under the care of midwives. Our country is exactly the opposite, over 90% of women, even low-risk women, are under the care of physicians, primarily obstetricians. I don't want to knock obstetricians, because they are very useful when we need them. But when you put healthy childbearing women in the hands of surgeons, it should be no surprise that the result is a high cesarean surgery rate.

Every study on birth center care has shown that healthy women with term pregnancies are as safe or safer in a birth center than they are in the hospital. Recently, Childbirth Connection, a non-profit group dedicated to improving the quality of maternity care in the US, convened a series of symposia with multiple maternity care stakeholders. You have before you the "Transforming Maternity Care Project" flow chart so that you can see the enormous amount of work that went into this project. This multi-disciplinary group has released a Blueprint for Action that outlines specific steps to take toward improving our maternity health care system. One of the specific recommendations is to expand access to free-standing birth centers. I would recommend that anyone seriously interested in how maternity care happens in this country take a look at this amazing document. It is available on-line at the Childbirth Connection website, or Kathryn can get you copies of the article printed in the journal Women's Health Issues.

The Madison Birth Center is already doing what health reformers are calling for, by supporting and educating clients about healthy lifestyle choices, giving primary care to women in an accessible and non-intimidating style and helping women avoid the pervasive high technology, high cost maternity culture that is today's norm. In these days of budget deficits and soaring medical costs, our approach to care demonstrates excellent maternity outcomes, deep savings and very satisfied customers.

And so you have this decision before you- to remove the barriers to independent practice that have held nurse-midwifery back in this state. You've already removed these barriers for the Certified Professional Midwives in the state. But Nurse-Midwives are still constrained. Removing barriers to our practice will allow those of us who are entrepreneurial to offer innovative, safe and cost-effective care. The free market system will eventually demonstrate to large insurers and provider groups that women desire midwives to attend them. And the more women cared for by midwives, the lower the

cost of obstetric care and the better the outcomes. I am grateful that the Senate is considering this bill, and encourage you to support all midwives offering evidence-based maternity care.

Thank you for taking the time to hear me today.

Cost Comparison

	Madison Birth Center		Hospital
Admissions 2003-2009	504		504
x Epidural Rate	6.0%		80.0%
Epidurals	30		403
x Caesarean Rate	5.6%		25.0%
C-Sections	28		126
Standard Fees			
Facility Fee			
Normal Labor/Delivery	2,293		6,279
Normal Newborn	incl		2,312
Professional Services			
Physician - Global OB	4,402		4,470
Physician - Postpartum Home Visits	incl		n/a
Normal Vaginal Birth	6,695		13,061
Epidural Cost			1,084
Alternative Cost - Uncomplicated C-Section			
Hospital - C-Section without Complications			15,870
Hospital - Newborn			2,312
Physician - C-Section			5,551
			23,733
Total Costs			
Normal Births	3,374,280		6,582,744
Incremental cost - Epidurals			404,332
Incremental cost - C-Sections	477,064		1,344,672
	3,851,344		8,331,748
Never breast-fed in first year	0%		70%
Breastfeeding at six months	90%		30%
Breastfeeding at twelve months	70%		10%
Health Care Costs of Formula-Feeding in First Year (per child)	$ 400		$ 400
Total Costs of Formula-Feeding	-		141,120

Savings	Total
Normal Vaginal Births	3,208,464
Avoided Epidurals	404,332
Avoided C-Sections	1,344,672
	4,957,468
Savings from Successful Breastfeeding	141,120
Total Savings	5,098,588

NOTES

National average c-section rate is 31.1% (and climbing); MBC rate is 5%

Physician fee based on 75 percentile - local benchmarking (Source-Ingenix, 2008)

MBC fees reflect 2008 fee schedule

Epidural and uncomplicated c-section cost based on 2002 avg charge, Meriter (Source-DHHS)

Breastfeeding savings reported in "Health Care Costs of Formula-Feeding in the First Year of Life" (Pediatrics, Vol 103, No 4, April 1999)

MADISON BIRTH CENTER

Accreditation Statistics

	2003	2004	2005	2006	2007	2008	2009	Cumulative Total
Pre-Admit Referral	0	3	6	2	2	7	8	28
Intrapartum Referrals, Non-Emergency	4	8	6	3	5	9	11	46
Intrapartum Transfer, Emergency	0	0	0	0	2	1	1	4
Births in BC/Home Births	18	42	57	97	94	75	71	454
Intrapartum Admissions	22	50	63	100	101	85	83	504
C-Sections	2	5	2	3	4	6	6	28
Maternal Postpartum Transfer	0	0	0	0	1	1	1	3
Neonatal Transfer	0	2	2	1	4	5	2	16
Maternal Postpartum Hosp Admission from Home	0	0	0	0	1	0	0	1
Neonatal Hosp Admission from Home	0	1	1	1	1	2	0	6
Pre-Admit Intrapartum Referral Rate	0.0%	5.7%	8.7%	2.0%	1.9%	7.6%	8.70%	5.3%
Intrapartum Transfer Rate, Non-Emergency	18.2%	16.0%	9.5%	3.0%	5.0%	10.6%	13.0%	9.1%
Intrapartum Transfer Rate, Emergency	0.0%	0.0%	0.0%	0.0%	2.0%	1.2%	1.0%	0.8%
Births in Center/ at Home Rate	81.8%	84.0%	90.5%	97.0%	93.1%	88.2%	86.0%	90.1%
C-Section Rate	9.1%	10.0%	3.2%	3.0%	4.0%	7.1%	7.0%	5.6%
Maternal Postpartum Transfer Rate	0.0%	0.0%	0.0%	0.0%	1.0%	1.2%	1.2%	0.6%
Neonatal Postpartum Transfer Rate	0.0%	4.0%	3.2%	1.0%	4.0%	5.9%	2.4%	3.2%
Maternal Hosp Admission from Home Rate	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.2%
Neonatal Hosp Admission from Home Rate	0.0%	2.0%	1.6%	1.0%	1.0%	2.4%	0.0%	1.2%

FORWARD
E PLURIBUS UNUM

Date: February 17, 2010

To: Chairman Erpenbach
Members of the Senate Committee on Health

From: Kathryn Osborne on behalf of the Wisconsin Chapter of the American College of Nurse Midwives (ACNM) and the National Organization of the ACNM

Re: Public Hearing Comments on SB 451

INTRODUCTION

Chairman Erpenbach, committee members, thank you for the opportunity to provide comments on Senate Bill 451. My name is Kathryn Osborne. I am licensed by the State of Wisconsin as a Registered Nurse, a Certified Nurse-Midwife and an Advanced Practice Nurse Prescriber. I am on the faculty of the Frontier School of Midwifery and Family Nursing and am currently a full time doctoral student at Marquette University. I am the past chair of the local chapter of the American College of Nurse-Midwives, current chair of the legislative committee of the Wisconsin chapter of ACNM and member of the board of directors of the national organization of the American College of Nurse-Midwives. I am here today, on behalf of the Wisconsin Chapter of the American College of Nurse Midwives (ACNM), and the national organization of the ACNM to provide testimony in support of SB 451.

BACKGROUND

In the earliest forms of recorded history, from around the world, midwives were identified as the sole providers of labor and birth care. This trend continued in Colonial America and throughout the US until the early 19th century when upper class women in the US began seeking care from physicians who promised a safer, less painful childbirth experience (Levitt, 1983). By the turn of the 20th century, physicians were attending roughly half of the births in America, although almost exclusively in the homes of women. Most midwives at that time were either self taught or apprentice trained (Rooks, 1997).

Nurse-midwives first appeared in the US in 1925, when Mary Breckinridge opened the Frontier Nursing Service (FNS) in the heart of Appalachia, in an attempt to improve the deplorable maternal-child health outcomes that existed in the area. Since there were no nurse-midwives in the US at that time, Breckenridge recruited British trained midwives who were educated in the science of nursing and the art of midwifery to staff the Frontier Nursing Service. Meticulous record keeping by the nurse-midwives allowed FNS to document their success; success that was astounding. Leslie County, Kentucky went from having some of the poorest maternal-child outcomes in the country, to having outcomes that were far better than most of the nation. In fact, over 80 years ago, after Louis Dublin of the Metropolitan Life Insurance Company completed a study of the first 1,000 births attended by FNS nurse-midwives, he wrote this: "The study shows conclusively that the type of service rendered by the Frontier nurses safeguards the life of mother and babe. If such services were available to women of the country generally, there would be a savings of 10,000 mothers' lives a year in the United States. There would be 30,000 less stillbirths and 30,000 more children alive at the end of the first month of life".

Dublin's words were not heard loudly or clearly enough to overcome the organized campaign waged by physicians to take control of childbirth in America. By 1955, 95% of American women were giving birth in the hospital under the care of a physician (Rooks, 1997). In contrast, most births continue to this day to be attended by midwives in Europe and other developed nations. It should also be noted that the maternal-child health outcomes in countries where midwives continue to provide most of the care for pregnant women far surpass the outcomes in the US. In fact, maternal-child outcomes in the US are worse than any other developed nation (Skala & Corry, 2008). Globally, the US ranked 27th for maternal-child outcomes in 2008 (Save The Children, 2008).

Present Day - Wisconsin

In 2008 there were 72,002 births in WI (WI Department of Health Services, 2009). Of that total, certified nurse-midwives attended 5,416, or 7.5% of all births in this state. Almost all births (70,696 births or 98%), whether attended by a midwife or a physician, occurred in the hospital.

Nurse-midwives practice throughout the state, in rural, urban and suburban communities. Presently, almost all of the roughly 120 nurse-midwives practicing in Wisconsin are providing care in the hospital setting---and every single one of them does so in an employee capacity. However, there are no nurse-midwives employed in Beloit, Kenosha or Racine; communities in this state with some of the worst maternal-child health outcomes in the US.

Nurse-midwives have been licensed to practice in this state since the 1970s – roughly 40 years. In Wisconsin, nurse-midwives are master's prepared, nationally certified, advanced practice nurses who are tri-licensed by the Department of Regulation and Licensing as registered nurses, nurse-midwives and advanced practice nurse prescribers. As a condition of licensure, nurse-midwives are required to carry malpractice insurance in the amount of $1 million/$3 million.

Current licensure provides that nurse-midwives may independently practice as primary care providers within their scope of practice, yet they do not have independent access to the market place. In Wisconsin, these independently licensed providers of labor and birth care, are required to enter into a written agreement with a physician in order to practice and in most instances are dependent upon their physician colleagues to admit their patients to hospitals. Each of these requirements presents barriers to practice and limit the number of primary care providers for the women of this state. The purpose of this bill is to remove these unnecessary barriers.

COMMENTS ON SB 451

I. Admitting Privileges

SB 451 clarifies that hospitals may grant nurse-midwives the ability to independently admit, treat and discharge their patients in the hospital setting. Current law is unclear as to whether a hospital may grant a nurse-midwife independent admitting privileges. That lack of clarity has resulted in disparate interpretations throughout the state. While some hospitals have already granted nurse-midwives admitting privileges, others have rejected application for privileges based on their legal counsel's interpretation of current law. SB 451 provides that a hospital may grant independent hospital privileges to a nurse-midwife.

II. Written Agreement

SB 451 deletes the requirement that nurse-midwives must practice under a written agreement with a physician, consistent with updated national practice standards. The "written agreement" requirement in current law (2001 WI Act 52) was based on the then-current joint practice relations agreement between the American College of Nurse-Midwives (ACNM) and the American College of Obstetrics and Gynecology (ACOG). Since then, the joint agreement between those two national standard setting professional organizations has been changed to remove the "written agreement" standard. Aside from consistent national standards, the deletion of the requirement removes the potential for one provider group to essentially veto the practice opportunities of another provider group. Nurse-midwives routinely collaborate with a number of health care providers in keeping with their professional practice standards, not just the physician with whom they have a written agreement, and would continue to collaborate with multiple providers as a routine matter of sound practice. The *Standards for the Practice of Midwifery* mandate that nurse-midwives practice in collaboration with members of the health care team. Those standards are incorporated in Wisconsin law by reference under Section 441.15 (1) (b), which SB 451 does not propose to modify.

Elimination of a written agreement requirement has little or no correlation with patient safety. The state of Maryland recently removed their requirement for a written agreement with a physician as a requirement for nurse-midwifery licensure. In pursuit of that action, the nurse-midwives in Maryland compiled key maternal-child outcome statistics in states

that impose a requirement for a written agreement, and compared them to the same outcome statistics for states without a requirement for a written agreement. In preparation for this hearing, I looked at the same statistics for WI and our neighboring states. As can be seen in the table included with this testimony, the outcomes for states without a written agreement requirement are better on every single measure than the outcomes in states with a requirement for a written agreement. If the presence of a written agreement improved patient safety, it seems to me the reverse would be true and the outcomes would be better in states with a written agreement requirement. Let me reassure you, this bill does not diminish patient safety in Wisconsin. It simply eliminates the ability of one group of professionals to control access to the market place and the ability to practice, of another group of professionals.

III. Patients Compensation Fund

SB 451 maintains current law coverage under the injured patients and families compensation fund (Fund) for nurse-midwives who are employed by a covered entity and creates a mechanism for self employed nurse-midwives to obtain Fund coverage. Currently, nurse-midwives who are employed by an entity covered under the Fund have Fund coverage. Because the employee coverage under current law is linked to the "written agreement" provision, which is being deleted, the bill modifies the statute to maintain employee coverage for nurse-midwives.

The bill also requires a hospital to condition the granting of privileges based on the demonstration of Fund coverage by the applicant nurse-midwife. A nurse-midwife who is not employed by a covered entity would not be able to obtain fund coverage under current law. Accordingly, the bill recognizes nurse-midwives as a class of voluntary participants in the fund so that a nurse-midwife, who is not employed by a covered entity, could apply for and purchase their own Fund coverage.

CLOSING REMARKS

In closing, let me suggest that removing barriers to nurse-midwifery practice in Wisconsin, and removing barriers to advanced practice nursing in general, is a health care reform proposition that speaks directly to the dual goal of affordable, quality health care. Nurse-midwives have repeatedly demonstrated the high quality of the care they provide. More specifically, there is a large body of evidence demonstrating improved outcomes for underserved and vulnerable populations when they are cared for by nurse-midwives (Raisler & Kennedy, 2004). Further, there is substantial evidence that nurse-midwifery care is cost effective, value added care. I have enclosed a summary of the cost-effectiveness of nurse-midwifery care.

Thank you for your thoughtful consideration of this testimony. For more information contact Kathryn Osborne at 608-241-5094, e-mail at kosborne@midwives.org or Patrick Osborne at 608-258-9506, e-mail at osborne@hamilton-consulting.com

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Maternal-Infant Outcomes

States With Requirements for a Written Agreement vs. States Without the Requirement

North-Atlantic States

	NH	CT	ME	RI	Average for states without agreements	NY	MJ	MD	PA	VT	Average for states with agreements	National Average
Written Agreement Required	No	No	No	No		Yes	Yes	Yes	Yes	Yes		
% of women receiving care in the first trimester	91.5	88.3	87.9	89.6	89.325	81.6	80.3	84.1	84.6	88.9	83.9	83.7
Maternal Mortality	NA	5.3	6.3	4.3	5.3	12	6.9	9.1	6.4	9.1	8.7	7.7
Infant Mortality	5.2	6.2	5.3	6.3	5.75	6.2	6.4	8	7.2	5.3	6.62	6.5
Low Birth Weight	6.3	8.2	6.7	7.1	7.075	8.3	8	9.1	8.4	6.7	8.1	8.2
% of Births attended by nurse-midwives	17.9	9.2	13.9	13.4	13.6	11.1	6.3	8.5	8.8	18.6	10.66	8

Midwestern States

	MN	MI	IA	Average for states without agreements	WI	IL	Average for states with agreements	National Average
Written Agreement Required	No	No	No		Yes	Yes		
% of women receiving care in the first trimester	86.5	86.1	88.9	87.17	84.9	85.4	85.15	83.7
Maternal Mortality	3.7	13.6	7.0	8.1	7.2	9.1	8.15	7.7
Infant Mortality	4.9	8.1	5.4	6.13	6.4	7.5	6.95	6.5
Low Birth Weight	6.4	8.4	6.7	7.17	7.0	8.4	7.7	8.2
% of births attended by nurse-midwives	8.4	7.4	5.1	6.97	6.5	4.6	5.55	8

Source: National Women's Law Center. (2010). National Report Card on Women's Health. Retrieved from: http://hrc.nwlc.org/Default.aspx

QuickInfo

AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

Cost Effectiveness

"Obstetrical care in the United States is burdened by soaring costs and a paradoxical inability to bring rates of infant mortality in line with those of other developed countries. A look at the costs and outcomes of obstetrical care demonstrates that a greater reliance on the use of certified nurse-midwives (CNMs) could help solve these problems. Midwifery has a good track record with regard to quality of care, it represents a good value for health care dollars, and it rates high in client satisfaction."
(Gabay and Wolfe, 1997, p. 112)

Health care payors have been interested in nurse-midwifery care because of evidence that it is cost-effective, or value-added, care. The lower costs associated with nurse-midwifery care are due to:

- lower rates of technological intervention
- shorter lengths of stay in hospitals
- lower payroll costs for staff model HMOs

Costs are lower in spite of, and partly because of, value-added care, including:

- longer office visits allowing for more client education
- continuous care during labor
- comprehensive postpartum follow-up

Costs are lowered even further when a birth center is used rather than a hospital. Preliminary data from a prospective cohort study that evaluated the Birth Place Model of care (CNMs in a birth center in collaboration with obstetricians) compared with traditional perinatal care (obstetricians in a hospital) (Jackson, 1998) found that "the midwife/birth center collaborative model cost the payor 21% or $1,122 per birth less ($4,432 vs. $5,464) for pregnancy related services."

Planned home births can eliminate hospital costs entirely. In one study the average uncomplicated vaginal birth cost 68% less in a home than in a hospital, and birth initiated in the home resulted in lower rates of intrapartum/neonatal mortality and cesarean delivery (Anderson & Anderson, 1999).

The cost-effectiveness of midwifery care was further documented in a National Center for Health Statistics study of over 3 million births (MacDorman & Singh 1998). After controlling for social and medical risk factors, this study found that births attended by Certified Nurse-Midwives demonstrated

- a 19% lower rate of infant mortality
- a 33% lower rate of neonatal (first month of life) mortality
- a 31% lower rate of low birth-weight newborns

The authors of the study attributed these outcomes to the continuity of care and client education that are hallmarks of midwifery care. The cost-effectiveness of such hallmarks was also supported by Turnbull & Holmes, et al. (1996). When comparing outcomes of low-risk women receiving midwifery-only care to those receiving Scotland's standard "shared care" (alternating between OBs and midwives), they found that although the midwives used less technology, outcomes of midwifery-only care were as good or better, with a higher rate of patient satisfaction.

The following resource, available from the ACNM website at www.midwife.org, provide further description of the value-added care provided by Certified Nurse-Midwives and Certified Midwives:

- Nurse-Midwifery in 2008: Evidence-Based Practice (http://www.midwife.org/siteFiles/news/nurse_midwifery_in_2008.pdf)

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The ACNM "QuickInfo" series was developed by the Department of Professional Services to respond to common inquiries, summarizing ACNM resources regarding a particular topic, as well as listing selected literature and a variety of other resources. Your feedback is welcomed; contact Professional Services at (240) 485-1800 or info@acnm.org.

FORWARD
E PLURIBUS UNUM

Date: February 17, 2010

To: Chairman Erpenbach
Members of the Senate Committee on Health

From: Jackie Tillett, CNM, ND, FACNM

Re: Public Hearing Comments on SB 451

Good morning, my name is Jackie Tillett. I am the director of the Midwifery and Wellness Center located in Milwaukee at Aurora Sinai Medical Center, the only inner city hospital in Milwaukee. The MWC midwives deliver about 500 babies a year in Milwaukee, about 75% of those births are covered by Title 19. We have been providing care in Milwaukee for more than 22 years.

I am a member of the American College of Nurse-Midwives and previous Chair of the ACNM Quality Management Section. I have been a nurse midwife for 23 years. My doctoral degree is in Community Health Nursing and I have developed successful programs for inner city women for many years. The MWC patients have a lower infant mortality rate than comparable patients in the city of Milwaukee, longer pregnancies and higher birth weights. We have successfully integrated our model into traditional clinic care, community health centers, a supermarket based clinic, and a Milwaukee High School.

The midwives of the MWC work in collaboration with the physicians of Aurora Sinai Women's Health Center. We work from standards and risk assessment mutually agreed upon by the physicians and the midwives. We transfer about 20 women a year to medical care due to chronic problems or problems that have developed during pregnancy. We have a cesarean section rate of 8%--about 40 babies last year.

Because we do not have admitting privileges at ASMC, our patients are admitted to the service of our physician colleagues. Recognizing that we are licensed independent providers and capable providers of maternity and L& D care, the patients we follow are often not seen by a physician during their labor and hospital stay. The physicians we work with are comfortable with this care.

Because the patient has a name on her wrist band that is not the name of her provider, it becomes confusing for patients as to who the provider is. We are diligent about follow-up care, but occasionally patients and nurses have confusion about who is providing the care. This confusion can lead to mistakes and errors that would have been totally preventable. We are careful and confident in our care and we feel that we should be responsible for the care we provide. I think that admitting patients to providers who are not providing the primary care adds a layer of bureaucracy and opens physicians and hospitals to liability that should not be theirs.

Denying admitting privileges and admitting responsibilities to nurse midwives marginalizes the care we provide and makes us invisible to the system and to the patients we care for. We appear to be "physician extenders" when actually we provide a high level of care unique to midwifery.

Today's health care environment strives to provide high level care at efficient costs for everyone. A team approach has been demonstrated to be one of the best ways to provide this care. Allowing hospitals to determine what the best mix of providers for the population served augments the team approach and lifts restrictions on finding innovative ways to provide high quality maternity care.

I urge you to support SB 451.

FORWARD
E PLURIBUS UNUM

Date: February 17, 2010

To: Chairman Erpenbach
Members of the Senate Committee on Health

From: Mary Ellen West, Chair of the Wisconsin Chapter of the American College of Nurse Midwives (ACNM)

Re: Public Hearing Comments on SB 451

Chairman Erpenbach, members of the committee, I appreciate the privilege of speaking to you today in support of Senate Bill 451. My name is Mary Ellen West, and I have been a Certified Nurse-Midwife for 29 years. I am licensed by the State of Wisconsin as a Registered Nurse, Certified Nurse-Midwife and as an Advanced Practice Nurse Prescriber. I am on staff as a Certified Nurse-Midwife at Gundersen Lutheran Medical Center in La Crosse and serve as adjunct clinical faculty as preceptor for students from the Frontier School of Midwifery and Family Nursing, University of Minnesota and Vanderbilt University. Currently, I have the honor of serving as the chair of the Wisconsin chapter of the American College of Nurse-Midwives.

I am proud to report that nurse-midwives deliver almost half of the babies in La Crosse. This is considerably higher than the statewide average of 7.5%. We owe this accomplishment to some very forward-thinking physicians and pioneering nurse-midwives who introduced nurse-midwifery to the region in 1975. We are fortunate in La Crosse. Women have access to high-quality, affordable midwifery care at both medical institutions. This is not true over the entire state of Wisconsin.

In fact, there are several areas of the State where women have no access to nurse-midwifery care. Among them are Beloit, Kenosha and Racine, which are also the Wisconsin communities with embarrassingly high infant mortality rates.

If there's one thing that nurse-midwifery care has been irrefutably proven to do, it is to lower infant mortality rates among at risk populations. Throughout our history nurse-midwives have cared for women of poverty with evidence-based, high quality maternity care.

I am also proud of the progressive heritage of Wisconsin, my home state. In the area of access to nurse-midwifery care, I'm afraid that our state is a bit behind the times. Among our neighboring states, only Illinois requires nurse-midwives to have a written agreement to practice. This requirement is generally recognized as a barrier to practice and therefore limits access to the high quality, cost effective maternity care that nurse-midwives can provide to Wisconsin families. SB 451 would remove this barrier.

It's important to note that nurse-midwives would still be required to work in consultation and collaboration with physicians. This is required by our Practice Standards. We will continue to work in collaboration with physicians, whom we can consult if complications arise.

This legislation has no effect on the CPMs or professional midwives of today. They are not required to practice to the same standards as that of nurse-midwives.

In conclusion, I want to share with you that I am also proud to carry on a family heritage of midwifery that began with my great-grandmother who was a midwife more than a century ago in a rural community outside of Shawano, Wisconsin. Our preparation was very different. She never attended nursing school, and I have a Baccalaureate as well as a Masters degree in Nursing. But I think she would approve and be proud of my goal to make nurse-midwifery available to more families in Wisconsin, because after all, we want the same thing, for women to have satisfying and safe birth experiences. Healthy families are the outcome we seek and they are our future.

Thank you for your consideration of this important legislation.

For information, contact: meswest@gmail.com or mewest@gundluth.org

FORWARD
E PLURIBUS UNUM

WISCONSIN HOSPITAL ASSOCIATION, INC.

To: Chair Erpenbach and Members of the Senate Committee on Health and Health Insurance, Privacy, Property Tax Relief and Revenue

From: Judith Warmuth, PhD, RN. Vice President, Workforce, Wisconsin Hospital Association

Date: February 17, 2010

Re: Testimony in Opposition to SB 451 Certified Nurse Midwives

My name is Judy Warmuth; I am the Vice President for Workforce at the Wisconsin Hospital Association and a Registered Nurse with many years of experience. I am here today to testify in opposition to SB 451.

This bill offers three changes to the current practice of Midwifery in Wisconsin. The first allows Certified Nurse Midwives (CNW) to have admitting privileges in hospitals. We understand that the bill is permissive, and that hospitals and their medical staffs may determine on an individual basis if CNMs will be allowed to admit patients. Admitting privileges for all occupational groups are permissive in Wisconsin hospitals. We do not see this changing based on the bill.

The second change deletes the requirement of a written collaborative physician agreement for CNM practice. WHA believes that an original purpose of the agreement was to assure that patients cared for by CNMs had a physician willing to assume needed care outside the scope of CNM practice. The agreements used today by some CNMs do not reflect this assurance. This is already a concern to hospitals that fear that no physician will be available to assume care for complex patients and patients with unexpected complications. Rather than delete the requirement, WHA would prefer a strengthening of the expectations of the agreement to assure that a local physician supports and backs up the CNM practice. We do not believe the bill takes this need in the correct direction, but also recognize that current practice may not be changed by the bill.

Third and most important from the hospital perspective, this bill allows CNMs to determine if they wish to participate in the Injured Patients and Families Compensation Fund (The Fund). WHA is supportive and in agreement that CNMs should participate in the Fund, however, we believe strongly that their participation should be mandatory. It is important to note that Wisconsin's patient compensation fund works because it is a mandatory fund. A mandatory fund avoids issues like adverse selection. But most importantly, patients who seek care from CNMs deserve access to the Fund in the case of an untoward outcome. All patients of all CNMs deserve this access, not just some, or a few, ALL. Current fund members are required to participate-as a protection of patients. WHA does not see CNMs as different from CRNAs, physicians or others that currently participate in the Fund by contributing and receiving coverage.

This final change is the major reason that WHA is strongly opposed to SB 451. Participating in malpractice coverage and Fund protection should be a requirement of Certified Nurse Midwives.

Thank you.

FORWARD
E PLURIBUS UNUM

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief and Revenue
Senator Jon Erpenbach, Chair

FROM: Mark Grapentine, JD – Senior Vice President, Government Relations

DATE: February 17, 2010

RE: Testimony **opposing** Senate Bill 451 – Nurse Midwives

On behalf of nearly 12,500 members statewide, the Wisconsin Medical Society thanks you for this opportunity to share our opposition to Senate Bill 451, which alters nurse midwives-related statutes in a variety of areas. The Society's main concerns are in two of those areas: 1) elimination of the requirement that nurse midwives have a written collaborative agreement with a physician who has postgraduate training in obstetrics, and 2) allowing nurse-midwives to voluntarily opt in to the Injured Patients and Families Compensation Fund.

Current Law Requiring Collaboration is a Safeguard for Difficult Cases
Senate Bill 451 would remove the statutory requirement that a nurse-midwife maintain a relationship with a physician who also has postgraduate training in obstetrics. This requirement is clearly for the benefit of the mother and newborn facing unexpected complications, ensuring availability of expert medical care in high-risk situations.

Nurse-midwives already have a significant amount of independence when providing care to patients. The collaborative relationship is reasonable and benefits patients. Under SB 451, the collaboration requirements are removed and if a nurse-midwife discovers that a patient has a complication jeopardizing the health or life of the mother or newborn, the nurse-midwife may consult with any "qualified health care professional," which does not have to be a physician. Removing the requirement of collaborating with a physician who is specifically educated and trained to deal with such complications is unduly risky to patients.

We believe the collaborative requirement should be retained – there is no reason to remove the requirement, which was implemented to provide nurse-midwives with the ability to practice independently while providing safety measures in the event the patient has complications that place the mother and/or child at risk.

Optional Participation in the IPFCF
The state's physicians – and members of the Wisconsin Medical Society in particular, have a heightened awareness of any suggested changes to the innovative Injured Patients and Families Compensation Fund. Since its creation in 1975, the Fund has been a national success story, helping Wisconsin maintain its relatively stable medical liability climate. Part of that success can be attributed to the requirement that participation in the Fund for physicians, hospitals and nurse anesthetists is mandatory.

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While some nurse-midwives currently obtain umbrella liability insurance coverage as an employee of a covered entity, the bill would allow any nurse-midwife to opt into the Fund. This voluntary participation would be a dramatic change in current Fund operations, where opt-in is only allowed for specific situations – usually only for physicians or nurse anesthetists practicing medicine for a small number of hours in the state.

Mandatory participation is beneficial not only in better distributing overall risk among a specific profession's participants, but it also ensures greater stability for the Fund itself. This provides a resource for an injured patient to find a stable source of economic recovery. Allowing this unique ability to voluntarily participate thwarts both benefits that only mandatory participation currently provides.

We believe that if the legislature determines it is prudent to allow independent nurse-midwives to participate in the Fund, the requirement should be that such participation be mandatory. Additionally, the additional liability risk associated with the addition of nurse-midwives should be apportioned accordingly among nurse-midwives.

Thank you again for this opportunity to provide the Society's position on SB 451. If you have any questions regarding this or any other health care issue, please feel free to contact the Society at any time.