GAE MAGNAFICI

STATE REPRESENTATIVE • 28th ASSEMBLY DISTRICT

Today, I am here before you to voice my strong support for Assembly Bill 154, the Advanced Practice Registered Nurse (APRN) Modernization Act. This bill is not just a legislative proposal; it's a beacon of hope for improving healthcare access and quality across Wisconsin, particularly in our underserved rural communities.

Wisconsin, like many states, is grappling with a significant healthcare provider shortage. The APRN Modernization Act offers a practical and forward-thinking solution to this crisis. By aligning with the National Consensus Model of Advanced Nurse Licensure, this bill paves the way for APRNs to contribute more effectively to our healthcare system.

This change will empower APRNs to practice to the full extent of their education and training, particularly in areas where physicians are scarce.

APRNs are highly educated and skilled professionals. To attain APRN status, a nurse must graduate with a master's degree or higher and complete ongoing continuing education. This bill does not diminish the standards for prescribing authority; it maintains the rigorous certification required under current law.

From my perspective as a healthcare professional and legislator, I see the APRN Modernization Act as a critical step towards a more efficient and accessible healthcare system. The act recognizes the valuable role APRNs play and removes unnecessary barriers, allowing them to serve Wisconsinites more effectively.

The experiences shared in previous testimonies, including from nurses who have worked closely with APRNs, underscore the professionalism and commitment of these practitioners. They are trained to operate within their scope and collaborate with physicians when necessary. By expanding the healthcare services that qualified nurses can provide, this bill also upholds patient safety through Board of Nursing oversight and accredited education requirements.

Many states, including our neighbors Minnesota and Illinois, have already adopted similar legislation, reaping the benefits of a more flexible and responsive healthcare workforce. Wisconsin has the opportunity to join this progressive movement, ensuring quality, affordable healthcare for our citizens.

In closing, I urge the committee to support Assembly Bill 154. This act is not just about reforming healthcare practice; it's about taking a decisive step towards ensuring that every Wisconsinite, regardless of where they live, has access to the quality healthcare they deserve.

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Wisconsin State Senate
24th Senate District

Serving Wood, Portage, Adams,
Waushara, Monroe, and Jackson

PATRICK TESTIN
STATE SENATOR

DATE: November 15, 2023

RE: **Testimony on 2023 Assembly Bill 154**

TO: The Assembly Committee on Health, Aging, and Long-Term Care

FROM: Senator Patrick Testin

Thanks to Chairman Moses and Committee Members for hearing this bill. Over one million Wisconsinites live in an area where health care professionals are in short supply, yet the State of Wisconsin continues to tie the hands of some of our most qualified health care professionals. That's the problem that we're aiming to fix with AB 154.

There are about 8,000 professionals who would qualify as Advanced Practice Registered Nurses (APRNs) providing vital care to patients across our state. These nurses may provide primary 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 all share some things in common; these nurses have earned advanced degrees, completed hundreds of hours of clinical training, and are well-qualified to provide excellent care. Current law, however, doesn't allow these professionals to practice to the full extent of their training.

AB 154 will empower these professionals to do the work they are trained to do.

During the pandemic, when we depended on these professionals more than ever, the State of Wisconsin rolled back the restrictions on advanced practice nurses. Take for instance, the story of Jessica in Racine. At the beginning of the pandemic, Jessica was working in a traditional Urgent Care setting. With many people afraid or unable to visit the hospital even for routine treatment, Jessica found a way to provide patients with service in their homes. Ronda, a long-term care provider from rural Northwestern Wisconsin has a similar story. For nearly a year and a half, she continued to deliver care at a time when physician visits stopped. Tina in Waupaca noted how the "handcuffs" on her practice were removed during the pandemic to enable her to meet the dramatically increased demand. Her reward for meeting the challenge? Having those handcuffs slapped back on.

These nurses stepped up, only to be told by some to take a step back. That's not right.

APRNs are a vital part of our health care workforce. We count on them to ensure access to quality health care – especially for rural populations and other traditionally underserved demographics. Sometimes it seems those who oppose our reforms would rather see patients go

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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.

Twenty-seven states, including our neighbors in Minnesota and Iowa, have already enacted changes to what we are proposing. These states run the gamut politically, from conservative Idaho to liberal Connecticut. Not one state that's allowed trained medical professionals to fully practice their scope has ever returned to a more restrictive model. That's because states see what numerous studies have found – that there is no evidence that advanced practice nurses provide inferior care.

Qualified professionals must be treated as such; that's why I'm asking you to join me, the Wisconsin Nurses Association, Americans for Prosperity, the Oneida Nation, Wisconsin Manufacturers and Commerce, Concordia University, and many more in supporting the APRN Modernization Act.

RACHAEL A. CABRAL-GUEVARA

STATE SENATOR • 19TH SENATE DISTRICT

Testimony before the Assembly Committee on Health, Aging and Long-Term Care

Senator Rachael Cabral-Guevara

November 15, 2023

Hello, Chairman Moses and members of the committee. Thank you for allowing me to testify on Senate Bill 145/Assembly Bill 154, an important bill that will bring Wisconsin up-to-date in providing high-quality, affordable healthcare for people across the state.

I am a Nurse Practitioner (NP) who owns 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 two other clinics establish themselves in rural Wisconsin.

Collaborative agreement requirements, which this bill largely removes, place a roadblock in front of NPs looking to open clinics in underserved areas. If my collaborative MD would die or decide they couldn't fulfill this role, then I would be forced shut down tomorrow. Having provided ten years of care to many families, this clinic is essential to their well-being, and in many cases their family budget.

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.

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 a Masters or Doctorate degree upon graduation and then yearly 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.

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Sen.Cabral-Guevara@legis.wisconsin.gov

RACHAEL A. CABRAL-GUEVARA

STATE SENATOR • 19TH SENATE DISTRICT

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.

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WNA
WISCONSIN NURSES ASSOCIATION

NURSE PRACTITIONER FORUM

TO: Representative Clint Moses, Chair and members of the Assembly Health, Aging and Long-Term Care Committee

FROM: Tina Bettin DNP, MSN, RN, FNP-BC, APNP, FAANP, President of the Wisconsin Nurses Association Nurse Practitioner Forum

DATE: November 15, 2023

RE: Support of AB 154 and SB 145 as amended, The APRN Modernization Act

I would like to thank you Chairperson Moses and members of the Assembly Health, Aging and Long-Term Care Committee for allowing me the opportunity to testify in support of the Advanced Practice Registered Nurse or APRN Modernization Bill Assembly Bill 154 and Senate Bill 145 that was amended and passed by the Senate. I also would like to thank Representative Gae Magnafici for her sponsorship of AB 154. It is truly appreciated.

My name is Tina Bettin. I am president of the Wisconsin Nurses Association Nurse Practitioner Forum which is a special interest group supported by WNA and I also serve as the state liaison for the American Academy of Nurse Practitioners.

I am a doctoral prepared Family Nurse Practitioner. I have been a nurse practitioner for over 35 years, with over 30 years of those years working in rural Wisconsin. The APRN Modernization Act is needed for the citizens of Wisconsin. Wisconsin is experiencing a healthcare workforce challenge. The latest data from the April 2021 Health Resources Services Administration (HRSA) reported that 70 of our 72 counties have shortages of primary care providers leaving patients with very little choice or access to care. Given the shortage of primary care providers in Wisconsin, it is imperative to allow Wisconsin patients full and direct access to the nearly 5000 nurse practitioners in Wisconsin. Their track record indicates safe and cost-effective care. We support AB 154 as it retires the unneeded and expensive physician collaborative agreements.

As a Family Practice Nurse Practitioner, I have been providing high-quality health care to the nearly 2000 patients that I care for in rural Waupaca County. Every day I spend time with my patients to diagnosis health conditions/diseases, manage their care and treatments, prescribe medications, and refer to specialists when needed. My employer tracks and reports quality metrics monthly within our health care system. Consistently, my quality metrics are one of the highest within the entire health system. Annually, you will find that I am one of the top three quality performers within my 13-member call group, and the group is usually first or second in quality metrics within my health care system. I am not an anomaly as you will find similar quality outcome data among the majority of nurse practitioners delivering care in Wisconsin and NPs practicing throughout the US.

AB 154 recognizes that the educational preparation and national board certification identifies our ability to conduct advanced physical assessment, diagnose, plan for treatment, and prescribe. However, current law prohibits advanced practice nurses from practicing to the top of license 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 care for Wisconsinites.

Our educational preparation is not the same as physicians, but one has not been proven to be superior to another. Nurse practitioner and APRN education is competency based and builds on previous nursing educational elements that were taught based on national nursing program accreditation. It is the advanced nursing educational programs that admit students utilizing nationally identified criteria needed to be a safe, and quality provider.

This model of licensure is not new. It's the model in 27 other states, 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.

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."

For over three years during the COVID public health emergency, nurse practitioners and other APRNs practiced under full practice authority in the State of Wisconsin under Governor Evers' emergency orders. During this time of significant health care need and burden, the nurse practitioners and APRNs were asked to step up, which occurred, and the sky did not fall, but now we are being asked to again step back into a subservient role.

Nurse practitioners and APRNs can have a significant positive impact on substance abuse issues in Wisconsin. At the Federal level on December 29, 2022, Congress passed into law the Consolidated Appropriations Act of 2023, allowing medication assisted therapies such as Suboxone/buprenorphine to be prescribed by all providers with a DEA license for controlled substances. Prior to this Federal change, Wisconsin citizens did not have the full access to this life saving treatment because to prescribe this life-saving medication in Wisconsin, APRNs needed to have a collaborative agreement with a physician who prescribed the Suboxone/buprenorphine. Wisconsin has one of the lowest number of physicians that prescribe Suboxone/buprenorphine which has been a barrier for NPs to provide Medication Assisted Therapy.

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 authority for advanced practice nurses. Wisconsin was one of the leaders in the nation allowing advanced practice nurses to prescribe. 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 when the Wisconsin Board of Nursing at the time were challenged about their opinion related to APN practice. This unfortunately opened the door for medical societies to convince the legislature that APNs needed written collaboration agreements with physicians to prescribe even though this does not appear in state statute.

Multiple federal agencies have issued reports and recommendations that APRNs should have the ability to practice to the full scope of their education and training. One agency that has weighed in many times to many state legislators is the Federal Trade Commission (FTC). The FTCs 2014 report, "Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses," and the 2018 publication "Reforming Americas Healthcare System Through Choice and Competition." Provided convincing evidence and remarks about the impact of providing barriers to consumer choice and competition for independent advanced practice nursing.

In closing, I ask that you support the 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, 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 vote AB 154 out of Committee as soon as possible, with the amendment to SB 145 that was passed by the Senate. Thank you for allowing me to testify today.

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

Wisconsin Nurses Association
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2023 APRN Modernization Act

Registered Nurses in Wisconsin are currently prevented from delivering the highest quality care. 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)*. When passed, Wisconsin will join the 27 other states that have enacted APRN legislation.

Benefits of APRN

- Allows nurses to practice at the top of the scope
- Helps address healthcare staffing shortages
- Provides patients greater access in all healthcare settings
- Helps contain rising healthcare costs

2023 APRN History

October , 2023
Passed the Senate with amendment adopted

March 8, 2022
- Passed the Senate with amendment adopted

January 25, 2022
- Heard and passed on the Senate floor

December 6, 2021
- Executive Hearing in the Senate Committee on Health

July 28, 2021
- Hearing in the Senate Committee on Health

April 14-15, 2022
- Sent to the Governor's desk, Governor vetoed

February 17, 2022
- Heard on the Assembly floor, amendment added

January 12, 2022
- Executive Hearing in the Assembly Committee on Health

July 29, 2021
- Hearing in the Assembly Committee on Health

May 18, 2021
- Cosponsorship Memo sent out

*The first APRN bill was drafted in 2015

APRN Legislation Summary

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
- Eliminates mandate of written collaborative agreement once experience requirements are met

PRESCRIBING

- Allows national board certified advanced practice nurses to continue to prescribe
- Maintains current educational and training requirements for prescribers
- Grandfathers current and non-prescribers Provides malpractice coverage under the Injured Patient & Family Compensation Fund.

Prepared by The Welch Group, 2023

WNA
WISCONSIN NURSES ASSOCIATION

WNA
WISCONSIN NURSES ASSOCIATION

November 15, 2023

Representative Clint Moses
Chair, Assembly Committee on Health, Aging and Long-Term Care
Room 12 West
State Capitol
Madison, WI 53708

RE: Wisconsin Nurses Association Support of AB 154 – Advanced Practice Registered Nurses

Dear Chairperson Moses and Members of the Assembly Committee on Health, Aging, and Long-Term Care

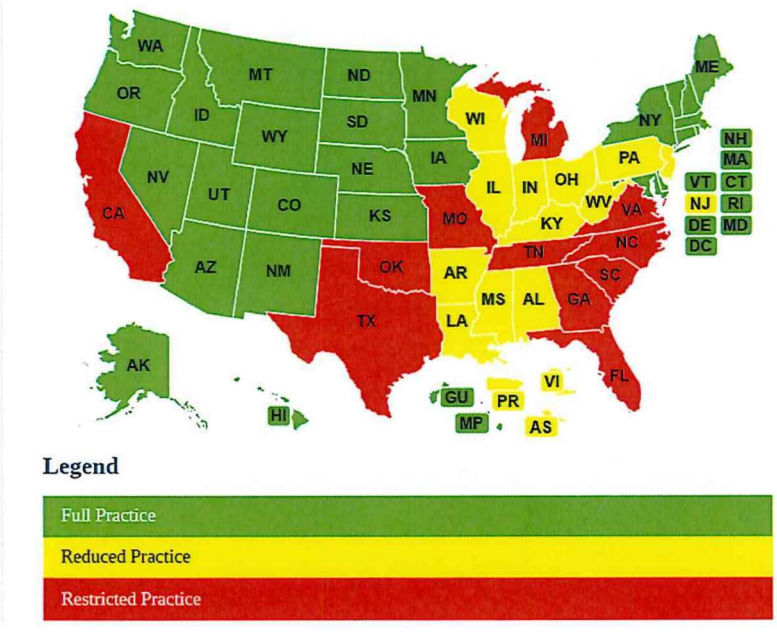
On behalf of the members of the Wisconsin Nurses Association I want to thank you for holding this hearing. My name is Gina Dennik-Champion, I am a RN and the Executive Director of the Wisconsin Nurses Association. I am here today to testify in support of AB 154 and the companion bill SB 145 that was adopted by the Senate with the amendment. Thank you, Chairperson Moses, for holding this public hearing. I would like to share our appreciation to Representative Gae Magnafici and to Senator Patrick Testin for being the Sponsors of these very important and timely pieces of legislation. I say timely because Wisconsin is at the intersection where the supply of physicians needed is not keeping up with the demand. This is why APRNs can support these care demands.

Wisconsin's population is aging and with that requiring more care, Wisconsin also has populations with significant health disparities that are also requiring more care. The workforce predictions from Wisconsin Hospital Association, and the Department of Workforce Development/Wisconsin Center for Nursing surveys indicate that the demand for heath health care providers including advanced practice nurses now and will only worsen in the 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 preventive, primary, and acute care services to their patients including ordering tests and prescribing medications. APRNs diagnosis and treat illnesses, manage chronic disease, and coordinate care all within the lens of a professional nurse. They are part of interprofessional and multisector teams. According to the 2022

registered nurse workforce survey report, Wisconsin had a 32 percent increase in APRNs from 2018, resulting in almost 8,000 practitioners providing care throughout our state today.

AB 154 creates a separate license for those registered nurses who meet the criteria to practice as an Advanced Practice Registered Nurse (APRN). Separate license is not a new concept. There are 27 states and the District of Columbia that have adopted a nationally recognized regulatory model that includes separate licensure and the ability to practice without mandatory physician collaboration.

Wisconsin's advanced practice registered nurses would like Wisconsin to be the 28th state to benefit from allowing APRNs full practice authority. Allowing this will open the door for greater numbers of patients to have access to care in areas where limited services exist. AB 154 will accomplish this by removing the requirement for physician collaboration agreements. As you can see in the map below there are 27 states that are "green". These are the states that are supporting APRN full practice authority. As you can see Wisconsin is a "reduced practice" which is yellow in color because of the mandated physician collaboration agreement. As APRNs look at this map you can see the multiple opportunities for relocating to other states to practice more independently. In addition, these green states accept and respect the educational preparation of these practitioners and the quality they bring to health care. Wisconsin is at risk of losing our APRNs because of the increase in the number of states allowing independent practice. This is not the time to continue to restrict practice.



Through the creation of separate licensure for APRN practice, AB 154 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 in the following ways:

- Provides formal licensure for advanced practice registered nurses (APRN), recognizing the four different practice roles,
  - Certified Nurse Midwife,
  - Certified Registered Nurse Anesthetist,
  - Clinical Nurse 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 and coverage of medical malpractice and liability insurance coverage.
- Adds independently practicing APRNs to be covered under the Office of the Commissioner of Insurance Injured Patient and Family Compensation Fund.
- 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 which is important as telehealth care and services begin to occur beyond the borders.
- 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 included how this regulation creates scope of practice restrictions by giving one group of health care professionals the ability to restrict access to the market by another. This results in denying health care consumers the benefits of greater competition and access to care. Such a reduction of competition may lead to several anticompetitive effects, therefore perpetuating the lack of Wisconsinites having increased access to care.

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.

The shortage of physicians in our population dense and rural communities prior to, during, and post COVID-19 public health emergency has resulted in long wait times for individuals to access quality care in the most appropriate cost-effective setting. The potential for allowing full practice authority will support APRNs to practice in areas where care demands are high. 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. Over the past year, in the spirit of cooperation, we have met dozens of times with the State Medical Society and other physician groups. As an organization we have moved a great deal on this bill since we first introduced it. We have worked with the Governor's office ever since his veto to address his concerns and as witnessed by him including a version of the bill in the budget - we believe our efforts have been taken in good faith. We continue to work with the bill authors, this committee, our physician colleagues, and the Governor's office to get to a place where we can pass and get the bill signed. But more importantly is meeting the health needs of Wisconsinites. It is for these reasons that the members of WNA request support for AB154 and SB 145, which passed the Senate with an amendment that sets up the conditions for APRNs to practice independently without physician collaboration after three years. We ask the committee to please pass AB 154 out of committee as soon as possible.

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

Sincerely,

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

WACEP
Wisconsin Chapter
American College of Emergency Physicians

TO: Assembly Committee on Health, Aging and Long Term Care

FROM: Kerry Ahrens, M.D., Board President, Wisconsin Chapter
American College of Emergency Physicians

DATE: November 15, 2023

RE: Testimony on SB 145, APRN Licensure and Independent Practice

Good Morning, Chairman Moses and committee members. My name is Kerry Ahrens. I'm an emergency physician and partner at Baycare Clinic in Green Bay, I am medical director of Oshkosh Fire and Gillett Area EMS, a UW Assistant Clinical professor and UW Medflight physician, and last but not least, I'm currently the board president of the Wisconsin Chapter of the American College of Emergency Physicians, WACEP.

Thank you for the opportunity to testify today on SB 145. In its current form, WACEP opposes this bill. But like many of you, we are optimistic that compromise can be reached that all healthcare providers can support and, most importantly, protects patient safety.

Like many of our physician colleagues and the WI Medical Society we support a compromise that requires four years of clinical experience for independent APRN practice, guardrails on specialized practice like chronic pain management, and safeguards against the misappropriation of physician specialty titles. My understanding is that there is a lot of support around these principles and we're hopeful compromise will be reached.

An issue that is extremely important to WACEP and patient care in the context of nursing independence is emergency department staffing. While I recognize it potentially brings new conflict to an already difficult APRN practice debate, it should not be ignored.

In his executive budget proposal, Governor Evers included a provision, intended to be part of these APRN discussions, that would statutorily require hospitals to *"have sufficient qualified personnel at all times to manage the number and severity of emergency department cases anticipated by the location" and* ***"at all times, have on-site at least one physician who, through education, training, and experience, specializes in emergency medicine."*** WACEP strongly supports this position.

What's more, in speaking with many nursing colleagues, we understand that the intention of SB 145 was not necessarily to provide for independent practice in a stand-alone, high-acuity setting as the emergency department.

It's not unreasonable to assume that if you or your constituents suffered a medical emergency and were ambulanced to the nearest hospital emergency department, there would at least be an emergency physician on staff. But you could be wrong, especially if you live in a rural part of the state. Unfortunately, it's a trend we are seeing nationally and has taken hold in some hospitals in Wisconsin - emergency departments without emergency physicians.

I think most people think that emergency departments can handle any individual mishap or medical emergency. However, rural emergency departments often have no secondary support from other specialties and minimal staffing. This sets up any provider, without proper training, for failure which can often result in poor outcomes for our patients. And please understand, this is not a knock on nurse practitioners, most physicians aren't trained or prepared to staff an emergency room either.

Emergency physicians are specifically trained to handle complex medical cases. We often have to provide immediate, life-saving treatment for a patient, regularly making split second medical decisions based on minimal, if any, medical information. This calls for unique policy guardrails around the type of clinicians who may practice independently in emergency departments because, as opposed to our other physician colleagues who manage complex medical cases, in our practice environment, there is often no time to consult specialists or references for immediate life-saving measures.

We are "resuscitationists" – when you are at your sickest, we are the physicians you want treating you. We are a specialty that provides 'womb to tomb' care. I can initiate care for any patient at any time and have been trained to recognize the "sick" from the "not sick".

If a patient can't breathe or is struggling to breathe, I can place an airway and set you up on a ventilator. I can effectively care for a mother who may be experiencing an unexpected early birth – and be able to care for her and her new child while awaiting help to arrive. If you are having a heart attack and go into cardiac arrest, we know how to resuscitate you back. If you are having a stroke, we recognize this, and initiate the needed treatment.

Most importantly, I recognize the limits of my training: if there is someone who requires a specialty beyond my own, I get the patient to them as fast as needed.

In many parts of Wisconsin, especially the northern third of the state, there may not be a hospital particularly close by. If that hospital's emergency department is not prepared to handle tough cases, there are no other alternatives. Often these departments do not have more than 1-2 nurses to assist the provider; and many do not have a respiratory therapist who will assist with placing an airway and providing ventilation. These providers who cover these

emergency departments need to have an excellent base of knowledge and patient management skills to provide effective care for those profoundly ill patients.

I would like to share some tough cases that I, or my partners, have experienced recently that demonstrate the differences between providers in an emergency setting:

1. A 28 year old male was coming out of orthopedic hip surgery in our hospital. When he came out of anesthesia, he had obvious stroke symptoms. As is often the case, I am the only physician in the hospital who is comfortable evaluating and treating the initial stages of a stroke. The specialists are available to come into the hospital within the hour, but not immediately, when minutes matter. I was contacted, immediately recognized he was having a stroke upon my examination. I had the team mix up alteplase – a drug used to treat early stroke; but is known to cause bleeding as a complication. This drug would treat his stroke but could cause him to bleed from his recent surgical site. I discussed briefly with the surgeon and we gave the drug. The patient had immediate improvement in his stroke and luckily no issues with his surgical incision.
2. We recently had a transfer patient from a more rural ED. That patient was having what we call 'runs of V-tach' – a very unstable heart rhythm that could cause the patient to go into cardiac arrest, become unresponsive and potentially could die if intervention is not provided. After seeing an NP in the rural ED, this patient was recommended to drive to Green Bay in his own car to be seen in our ED. No call was placed to our facility or our EP cardiology team that the patient was coming. Both the absence of ambulance transport and the lack of communication to our ED reflect the lack of regulatory and medical knowledge at the initial ED.
3. About 6 months ago, I had a patient with history of diabetes come in feeling nauseous and dizzy. She reported that she had finally gotten into an endocrinology clinic and saw a nurse practitioner. This provider gave the patient the usual diabetes advice and then recommended she drink an 'ounce of water per pound of body weight' each day for optimal results. This patient weighed 189 lbs. Drinking anymore than 100 oz per day can result in water toxicity, meaning dangerously low sodium we call hyponatremia. The patient stated she "kept up for about 2 weeks", but couldn't for the last few days because she did not feel well. This patient wound up having a sodium level of 118 – normal levels are 135-145. Had her level dropped 1-2 points further this could have resulted in life-threatening seizures. This patient had to spend 2 nights in the ICU because an NP 'didn't know what she didn't know'. This NP caused unintentional harm to a patient and causing increased cost to our healthcare system.
4. Traumas. We have some very bad traumas especially in the north. Just this Sunday morning we had 5 casualties involved in a 2 car crash – many with severe injuries. Often time these patients are flighted to the necessary trauma hospitals. However, we live in Wisconsin – when the weather is often bad and where we can't fly a patient OR we are

in such a rural area that a helicopter may take 40+ minutes to arrive. In these cases, EMS crews bundle and transport the patient to the nearest critical access hospital to help with initiating care. As many of you know, many rural areas do not have paramedics in close range; thus many trauma patients are transported by advanced EMTs who cannot legally place an airway or give life saving drugs as a paramedic could. They will transport a patient to the nearest hospital to initiate care. Motor vehicle crashes and farm traumas often have severe multisystem injuries that need prioritization of care. If you or your family member were to enter a hospital where there was no physician providing coverage, your mortality rate soars. Simply put, anyone with limited clinical training would struggle with 'where to start'. The bloody airway? The dropping blood pressure? Should/when should blood be given? Often these patients need to be intubated, but their airways are bloody/messy, full of vomit. I learned how to handle those airways only in residency, not just doing intubations in a well-lit operating room or on a cadaver.

Sometimes a patient may have severe chest trauma and require a chest tube to be placed in a rapid manner before their oxygen and blood pressure drop to a point too far to bring them back. On these patients we perform a bedside ultrasound to look for life-threatening bleeding in the abdomen and stabilize as needed. We are one of the few specialties' who learn this bedside skill which is invaluable in a rural setting with minimal resources.

What if this patient's MVC trauma was caused by a heart attack? This is a learned skill in residency – you have to determine if there is any other medical emergency that preceded the crash. If yes, now we treat both. When the trauma patient arrives, it is the job of an ED physician to stabilize these patients. Only when they are stable can we consider transporting to a higher level of care – otherwise they often perish during transport.

Again, I don't share these stories to condemn nurse practitioners or any other particular provider. But I am trying to make clear that emergency physicians are unique, with a particular set of skills that are not taught outside of our emergency medicine residency and are honed with thousands of hours of clinical experience. Substituting other healthcare providers creates bad situations that inevitably result in bad outcomes.

We hear a lot about access in the context of APRN independence. But quality of care, especially in an emergency department can be a matter of life and death. Our rural residents don't deserve a lower chance of survival than others in a car crash or a medical emergency.

We've heard the argument that the requirement of a single emergency physician on staff at all times would put hospitals out of business in rural Wisconsin. First, does anyone really believe that? And second, is an emergency department without emergency physicians really even an emergency department? If you live almost anywhere in northern Wisconsin, if you live in parts of western Wisconsin, shouldn't the only hospital emergency room within thirty miles have an emergency physician on staff at all times? Our position is yes – absolutely. If we can't guarantee patients – your constituents – an emergency physician on staff at all times, then many Wisconsin residents are denied access to a true emergency department.

As a partner of a private practice group, a group that is part-owner of Aurora BayCare Hospital, I understand the challenges facing budgets. We staff our own emergency department and contract with other hospitals to staff their emergency departments, that's what we do. We understand that staffing our departments with physicians can be more expensive; however, we also understand that if an emergency physician is not present, those who suffer most are our patients. We have to strike a balance between physicians and nurses. If we were to staff an emergency department without an appropriate number of physicians, then we know we'd be compromising patient care and the ability to save lives, so we do not. A Wisconsin hospital, no matter where it's located, should not be able to make that bad choice. And yet some are doing so. Patients that seek emergency care in Oconto Falls, Chilton, Baron, and Cumberland have, at times, not had access to a physician at all. That is exactly why we seek clear requirements in Wisconsin law on emergency department staffing.

We hope the legislature, and specifically this committee, will look closely at this issue and work towards ensuring that our state's residents get the consistent care they deserve for any medical emergency – anywhere, any time.

Thank you very much for your time today and I'm happy to answer any of your questions.

WISCONSIN ACADEMY of FAMILY PHYSICIANS

Wisconsin Society of Anesthesiologists
Physician Led Care

Wisconsin Medical Society

Wisconsin Radiological Society

WACEP
Wisconsin Chapter
American College of Emergency Physicians

WISCONSIN ACADEMY OF OPHTHALMOLOGY

Wisconsin Chapter
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

TO: Assembly Committee on Health, Aging and Long-Term Care
Representative Clint Moses, Chair

FROM: 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 Medical Society, Wisconsin Psychiatric Association, Wisconsin Radiological Society, Wisconsin Society of Anesthesiologists

DATE: November 15, 2023

RE: **Request to Amend** 2023 Assembly Bill 154/Senate Bill 145

The above organizations representing Wisconsin physicians from numerous medical specialties request that the Assembly Committee on Health, Aging and Long-Term Care **amend** current legislation related to Advanced Practice Registered Nurses (APRNs). Amending the bill in three areas would better ensure a safer and more deliberate approach in a move away from physician-led, team-based care in Wisconsin. They are also likely necessary if the bill is to be signed into law.

Our physician groups have worked in good faith for multiple legislative sessions to reach a compromise on this proposal. Last session's effort, 2021 Senate Bill 394, was vetoed after physician concerns were not addressed. If the goal for this session is to see the bill enacted, we believe the following amendment areas are critical:

- Requiring four (4) years of real-world, team-based care experience before an APRN can advance to practice independently. Current law does not allow for independent practice.
- Including "Truth in Advertising" title protection language to help patients better understand who is providing their care.
- Ensuring that a physician specializing in pain medicine collaborates with independent APRN clinics (those not connected to a hospital or health system) so that complex pain medicine for patients can be provided more safely.

Our conversations this session on the above amendment have, in our view, already garnered widespread bipartisan support. We believe a majority of legislative members on both sides of the aisle are prepared to move forward with this compromise language as outlined. Amending AB 154/SB 145 to include the above provisions is a sensible and reasonable middle ground that would provide a much less controversial glidepath, ultimately resulting in passage of a bipartisan bill. We therefore request that the committee fully support these improvements to the current bill as introduced. Thank you for your consideration.

Testimony Endorsing Full Scope-of-Practice Authority for Advanced Practice Registered Nurses

Public Hearing on Wisconsin Assembly Bill 154/Senate Bill 145
November 15, 2023

Jeffrey C. Bauer, Ph.D.
Medical Economist
Madison, Wisconsin
jeffreycbauer@gmail.com — www.jeffbauerwords.com

I have been a full-time PhD medical economist for 50 years, focused on reallocating scarce resources to improve efficiency and effectiveness of health care delivery. I spent 18 of these years as a professor of statistics and research at two medical schools, including the University of Wisconsin at Madison. I am author of over 225 publications in respected journals, including at least a dozen articles and three books about advanced practice nursing. My review article on comparisons of care provided by nurse practitioners and physicians has been designated as the most frequently cited reference on the subject.

Regarding the issue of scope-of-practice of advanced practitioners, I have surely been involved in it longer than anyone else in the room. I started my academic career as an assistant professor at the University of Colorado School of Medicine in 1973 with a specific assignment to expand the School's health services research. One of my first collaborators was Dr. Henry Silver, co-founder of the nurse practitioner movement (along with Dr. Loretta Ford, Dean of the School of Nursing). I created what was probably the first data base for studying outcomes of care provided by nurse practitioners, and I continued to do research in the area throughout my career. I gave a keynote speech on the topic at a national meeting in February of this year. In other words, I've got considerable and ongoing experience in this area.

If you would like lots of data and economic analysis on issues related to HB 154, I would be pleased to provide it. I also volunteer to help you evaluate any data provided by others. However, my purpose today is to summarize 50 years of work in a few comments that will hopefully shape your legislative action and lead to the Governor's signature on a bill. My fundamental point is that all the respectable scientific literature in this area shows that the quality of care provided by nurse practitioners within their defined scopes of practice is at least as good as the comparable care provided by physicians.

I have never found—and believe me, I've searched extensively for many years—any good quantitative research that suggests nurse practitioners do less well than physicians in care they are trained and licensed to provide. If anyone else provides testimony to the contrary, demand that they support their position with valid data and sound analysis from peer-reviewed publications. For example, a NBER working paper by Chan and Chen (featured in recent American Medical Association publications) should be disqualified from consideration because it completely fails to meet the most basic criteria of scientific inquiry.

Anecdotes are irrelevant; they prove nothing of value in the scientific realm of health care. But anecdotes are the normal foundation of testimony against full scope-of-practice legislation. I will, however, make an honest concession to physicians who cite errors committed by nurse practitioners. Advanced practice nurses do make mistakes—but so do physicians, I reasonably believe, in comparable measure. Physicians should focus their quality-based concerns on eliminating errors in medical practice.

Physicians *and* nurses need to do everything they can to improve the quality of care provided by peers within their own respective professions. In particular, both professions need to define and enforce appropriate clinical criteria for referring patients whose care needs are outside their areas of competency. And if physicians see supervision as a legislative and regulatory necessity, they need to get serious about defining good supervisory practices. In my experience, physician supervision of other health professionals is a meaningless concept. It is a hodgepodge of different approaches, applied with varying degrees of rigor and undefined outcomes. It can also be expensive. Sure, some physicians are very good mentors, but others supervise inconsistently or not at all. If competency is the desired outcome, which it should be, then require determinations of competency in all health professions according to the requirements of their distinct boards of professional practice.

Under current circumstances, physician supervision of advanced practice nurses is an unnecessary and unjustifiable barrier to entry into practice. It is a monopoly behavior. (My latest book, the 2020 edition of Not What the Doctor Ordered, provides extensive analysis of this issue and proposes alternative solutions.) There's absolutely no reason to prevent Wisconsin's residents *from full and open access to advanced practice nurses—a right already* available in a majority of states, with no scientific evidence that these other Americans have been harmed by expanded access to care.

AMERICAN COLLEGE
of NURSE-MIDWIVES

To: Members, Assembly Committee on Health, Aging, and Long-Term Care
From: American College of Nurse Midwives, Wisconsin Affiliate
RE: Support for Assembly Bill 154 and Senate Bill 145

The American College of Nurse Midwives (ACNM) – Wisconsin affiliate supports Senate Bill 145 and Assembly Bill 154. I am Dr. Lisa Hanson, Klein Professor of Women's Health Research at Marquette University, where I am Associate Director of the Midwifery Program. I practice at Aurora Sinai Midwifery and Wellness Center in Milwaukee, WI for 30 years. Recently, it was the setting of my NIH funded research. I serve as legislative liaison of ACNM WI Affiliate.

Certified Nurse Midwives (CNMs) attend 12% of the state's births, with over 95% of us working in hospitals along with physician colleagues, and other advanced practice nurses. Less than five percent of us provide care in homes and birth centers.

Here are a few key points for your consideration.

Workforce development and patient access of health care
Each year we lose Wisconsin residents who graduate as certified nurse midwives to other states with full practice authority. Many states and nations already know that better integration of nurse-midwives yields less preterm birth, fewer c-sections, more satisfied patients, more breastfeeding and more effective utilization of healthcare resources.

22 counties in the state of Wisconsin have no access to obstetric or gynecologic care.
WI state residents need better access to maternity care and health equity. Widespread midwifery care will have long-reaching effects on the health and wealth of our communities. The United States has the highest maternal mortality rate among developed countries. African American families experience three times the rate of pregnancy related illness and death compared to Whites. If that wasn't bad enough, we are facing a looming provider shortage, while obstacles like practice restrictions keep over half of all nurse-midwives from working to our full potential. Our physician colleagues, members of the American College of the American College of Obstetrics and Gynecology, look towards CNMs to meet the unmet healthcare needs of women and their families. When we practice to the full extent of our education and training it improves access to care in under-resourced areas. We avoid the overused and avoidable interventions which

increases maternal morbidity and mortality. We save taxpayers money.

Current day to day practice of certified nurse midwives will not change.
Core competencies and licensure guide our scope of practice. We currently collaborate with multiple disciplines as necessary to provide patient care. In every state that has adopted full practice authority, there are more nurse-midwives and healthier mothers and babies.

Under current law, there are difficulties with compliance when a collaborating physician is no longer available.

If a certified nurse midwife's current collaborative physician unexpectedly dies or moves, she/he is immediately out of compliance to practice.

We understand that the Senate version of this bill has been amended and are not opposed to the changes. We would expect a similar change to the assembly version but if the amendments in the assembly are different from the senate, we reserve the right to change our position on the legislation.

AANA
American Association of
NURSE ANESTHESIOLOGY

TO: Chairman Moses and Members of the Assembly Committee on Health, Aging and Long-Term Care
DATE: November 15, 2023
RE: Testimony in support of Assembly Bill 154/Senate Bill 145, APRN Modernization Act

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Good morning, Chair Moses, and members of the Assembly Committee on Health, Aging and Long-Term Care. Thank you for the opportunity to testify in support of Assembly Bill 154 (AB 154)/Senate Bill 145 (SB 145), the Advanced Practice Registered Nurse (APRN) Modernization Act.

My name is Jennifer Banek, and I am a Certified Registered Nurse Anesthetist and serve on the Board of Directors of the American Association of Nurse Anesthesiology. AANA was founded in 1931 and is the professional association representing more than 61,000 CRNAs and student registered nurse anesthetists nationwide. I come before you today to speak in support of the modernization of nursing laws in Wisconsin to allow CRNAs to continue to provide safe, high quality patient care without unnecessary barriers. The AANA respectfully requests that you pass AB 154/SB 145.

Nurse anesthetists have been providing anesthesia care to patients in the United States for more than 150 years. Certified registered nurse anesthetists (CRNAs) provide anesthesia in collaboration with surgeons, anesthesiologists, dentists, podiatrists, and other qualified healthcare professionals. They practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities.

CRNAs are the primary providers of anesthesia care in rural America, enabling healthcare facilities in these medically underserved areas to offer obstetrical, surgical, and trauma stabilization services. In some states, CRNAs are the sole providers in nearly 100 percent of rural hospitals. In addition to delivering essential healthcare in thousands of medically underserved communities CRNAs are the main providers of anesthesia care for women in labor, with 50 percent of rural hospitals using a CRNA-only model for obstetric care[1], and for the men and women serving in the U.S. Armed Forces, especially on frontlines around the globe. CRNAs serve as the backbone of anesthesia care in rural and other medically underserved areas of the United States. A 2019 study indicates that CRNA delivery models predominate in rural areas: 61% in ASCs, 55% in small hospitals, and 35% large hospitals.[2]

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[1] Kozhimannil KB, Casey MM, Hung P, Han X, Prasad S, Moscovice IS. The Rural Obstetric Workforce in US Hospitals: Challenges and Opportunities: The Rural Obstetric Workforce in US Hospitals. J Rural Health.2015;31(4):365-372. doi:10.1111/jrh.12112

[2] Coomer N, Mills A, Beadles C, Gillen E, Chew R, Quraishi J. Anesthesia Staffing Models and Geographic Prevalence Post-Medicare CRNA/Physician Exemption Policy. Nurs Econ. 2019;37(2):86-91.

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A Nursing Economics' study[3] found that CRNAs are providing the majority of anesthesia care in U.S. counties with lower-income populations and populations that are more likely to be uninsured or unemployed. They are also more likely found in states with less-restrictive practice regulations where more rural counties exist[4]. Further, a CRNA acting as the sole anesthesia provider is the most cost-effective model of anesthesia delivery, according to a groundbreaking study which considered the different anesthesia delivery models in use in the United States today. The results show that CRNAs acting as the sole anesthesia provider cost 25 percent less than the second lowest cost model. The results of this study are particularly compelling for people living in rural and other areas of the United States where anesthesiologists often choose not to practice for economic reasons.[5]

In addition, the Federal Trade Commission has weighed in numerous times in support of removing restrictions on APRNs, including CRNAs, stating again in 2019 that "consistent with patient safety, however, we have urged regulators and legislators to consider the benefits that more competition from independent APRNs – including CRNAs – might provide – especially benefits to patients. If APRNs are better able to practice to the full extent of their education, training, and abilities, and if institutional health care providers are better able to deploy APRNs as needed, health care consumers – patients – are likely to benefit from improved access to health care, lower costs, and additional innovation."[6]

CRNAs safely administer more than 50 million anesthetics to patients each year in the United States. CRNAs are the primary providers of anesthesia care in rural America, and, as expert anesthesia professionals, deliver chronic pain management services in all types of facilities. CRNAs provide acute, chronic and non-surgical pain management services and are competent, effective providers of pain management care. CRNAs using pain management techniques is neither new nor unusual and has long been a part of CRNA practice. In 2012, Medicare published a final rule authorizing direct reimbursement of CRNAs for chronic pain management services. This action confirms the fact that the federal government recognizes CRNAs as qualified pain management providers.

There has been discussion about titles and who should be allowed to use a specific title. When I meet my patients, I introduce myself as Jennifer Banek, nurse anesthesiologist. Even though CRNAs have been practicing for more than 150 years, patients do not always immediately recognize the term CRNA. As healthcare becomes increasingly complex, it's important that patients are adequately informed of a healthcare professional's licensure and other pertinent credentials through appropriate mechanisms. Appropriate mechanisms vary based on care setting, and may include name badges, prominent posting of credentials in facilities, or identification during verbal introduction to the patient.

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[3] Liao CJ, Quraishi JA, Jordan LM (2015). Geographical imbalance of anesthesia providers and its impact on the uninsured and vulnerable populations. *Nursing Economic$*, 33(5):263-270.

[4] Quintana, J. "Answering today's need for high-quality anesthesia care at a lower cost," *Becker's Hospital Review,*, January 20, 2016, available at http://www.beckershospitalreview.com/hospital-physician-relationships/answering-today-s-need-for-high-quality-anesthesia-care-at-a-lower-cost.html.

[5] Hogan, P., Seifert, R., Moore, C., Simonson, B. "Cost Effectiveness Analysis of Anesthesia Providers." *Journal of Nursing Economic$.* May/June 2010. 28, No. 3. 159-169.

[6] https://www.ftc.gov/policy/advocacy/advocacy-filings/2019/12/ftc-comment-texas-medical-board-its-proposed-rule-19313-add

Transparency and public protection require that disclosure of licensure and other earned credentials to patients must apply to all healthcare professionals equally. Transparency and accountability in healthcare should help inform patients and the public, and promote patient safety and choice. It should not target some healthcare professionals for scrutiny, and exempt others from that same scrutiny, in order to provide certain providers with a competitive advantage in the market. Therefore, I request that you oppose any language that attempts to restrict a provider's ability to use an appropriate title when introducing themselves to patients.]

The healthcare landscape is demanding that APRNs, including CRNAs, work to the top of their license, education and training. Professionals whose services result in cost-effective, high-quality, safe outcomes are needed more than ever. CRNAs play a critical role in meeting that challenge by providing safe, quality anesthesia care at a cost that ensures access to anesthesia for millions of Americans.7 I urge you to support the APRN Modernization Act. Thank You.

[7] Quintana, J. "Answering today's need for high-quality anesthesia care at a lower cost," *Becker's Hospital Review,*, January 20, 2016, available at http://www.beckershospitalreview.com/hospital-physician-relationships/answering-today-s-need-for-high-quality-anesthesia-care-at-a-lower-cost.html.

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TO: Chairman Moses and Members of the Assembly Committee on Health, Aging and Long-Term Care
DATE: November 15, 2023
RE: Testimony in support of Assembly Bill 154/Senate Bill 145, APRN Modernization Act

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Good afternoon, Chairman Moses and members of the Assembly Committee on Health, Aging and Long-term Care. Thank you for the opportunity to testify on the Assembly Bill 154 (Senate Bill 145), the Advanced Practice Registered Nurse (APRN) Modernization Act.

My name is Jess Tomasiewicz. I am a Certified Registered Nurse Anesthetist (CRNA) and the President of the Wisconsin Association of Nurse Anesthetists (WIANA). WIANA represents over 1000 CRNAs in the state of Wisconsin close to over 90% of the total CRNAs in the state. CRNAs are a part of the advanced practice nurse prescribers in Wisconsin.

I respectfully request that you pass AB-154/SB 145, which officially describes and defines the role, responsibility and accountability of the Advanced Practice Registered Nurses (APRNs). An APRN is a registered nurse who has completed graduate-level education and obtained the clinical knowledge and skills required to provide direct patient care. CRNAs are one of the advanced practice nurse specialties' that will qualify as an APRN under the bill. By recognizing all practicing APRNs in statute, Wisconsin will help protect the citizens in this state 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.

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 providing anesthesia care during surgery in various settings. 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.

The APRN bill has been on a long journey to the current version of this bill. WIANA has worked to protect and maintain the great practice that we have in Wisconsin. We work everywhere in the state, with our rural locations being dependent on the anesthesia care that we

provide to the critical access hospitals. There are approximately 60 hospitals and surgery centers in the state that rely on CRNAs practicing to cover their anesthetic needs.

I live and work in Northeastern Wisconsin at a rural hospital. With the rural hospital I work at, we are able to provide high quality, evidence-based anesthesia care to the community it is located in. These patients do not want to drive over an hour both ways to the larger hospital in the organization when they can receive their care in their backyard. We provide services for general surgery including gallbladder or colonoscopy surgeries, urology including robotic prostatectomies to kidney stones, orthopedics including total joints and fractures, Ear, nose and throat including tonsillectomies, obstetric and gynecological care including the labor epidural for the new mom, and emergency services.

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

Wisconsin Society of
Anesthesiologists
Physician Led Care

Rep. Clint Moses, Chairman, and Members of the
Assembly Committee on Health, Aging and Long-Term Care
Room 12 West - State Capitol
Madison, WI 53708

November 15, 2023

Dear Chairman Moses and Assembly Health Committee Members:

My name is Michael Bottcher, I am an Anesthesiologist at Gundersen Lutheran Medical Center in La Crosse. I am also the Board President of the Wisconsin Society of Anesthesiologists (WSA). Thank you for the opportunity to provide testimony today on SB 145 related to APRN licensure and independent practice.

The WSA opposes this legislation as drafted and as it passed the state senate. We do not oppose APRN licensing and we do not oppose advanced practice nurses, in fact, as anesthesiologists we work closely with nurse anesthetists every day in a team based model that provides the best possible care for patients. As it relates to *independent* practice of APRNs however, we strongly support a requirement of at least four years of clinical experience, strong guardrails on chronic pain practice that can be very dangerous to patients when a provider is not properly trained, and we support "truth in advertising" provisions to ensure physician titles are not misappropriated and patients are not misled.

I have been a salaried employee of a multi-specialty group for over 33 years. I personally provide care as well medically direct nurse anesthetists and anesthesiologist assistants. I support team-based care and support the education of nurse anesthetists as well as anesthesiologist assistants. However, I do not support the assertion that our training is equivalent and I believe strongly that patients deserve transparency about who is caring for them.

I have participated in the education of nurse anesthetist students for over 30 years. Nearly every year I am identified by them as one of the anesthesiologists they like to work with the most because I teach them so much – my point is that I support their education and their participation in patient care. What I do not support is the assertion that the training of a nurse anesthetist is equivalent to that of an anesthesiologist, it is not. Is there overlap? Of course, but it is not nearly equivalent. That's why four years of clinical experience should be a basic requirement for independent practice of any APRN.

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Independent practice for a nurse practitioner, clinical nurse specialist, or nurse midwife is very different from independent practice by a nurse anesthetist. When nurse anesthetists pursue completely independent practice without any physician involvement, it is in the form of Pain Medicine or Pain Management. Pain medicine was part of my residency training. As part of my practice, I provided therapeutic injections for years. I never counted, but I am sure that I performed well over a thousand injections. However, as pain medicine evolved and therapeutic interventions became more complicated I recognized that there were people much more qualified than me to provide this care - physicians who completed a year-long fellowship in pain medicine. Pain medicine cannot be learned by taking some online courses and attending a couple of cadaver workshops. That's why the guardrails that have been proposed by the Governor and others on chronic pain management are so important.

Finally, as an anesthesiologist, I can interpret a chest x-ray, a CT scan, or an MRI, but that does not make me a radiologist and I would never call myself one. I can perform a transesophageal echocardiogram and read an ECG but that does not make me a cardiologist. The desire for the anesthetists' groups (WIANA, AANA) to be able to call themselves "nurse anesthesiologist" is just an attempt to blur the significant differences and confuse the patient. The nurse anesthetists clearly appreciate the importance of being able to distinguish professional titles. Their own title protection is included in the bill before you. An APRN independence bill is simply incomplete without the inclusion of provisions that prevent the misappropriation of physician titles.

Thank you for your consideration and I strongly urge you to continue working towards compromise that is not only supported by doctors and nurses but maintains patient safety and Wisconsin's high standard of care.

Sincerely,

Michael Bottcher, M.D.,
Board President, Wisconsin Society of Anesthesiologists

2023 APRN Modernization Overview

Legislative Session 2021-23 Compromises	2023-2025 Legislation
Required a High Acuity Emergency Care Plan for Certified Nurse Midwives practicing outside of a hospital setting.	✓
Simplified the prescription authority of those with an APRN License.	✓
Clarified the employer's right to require collaboration between Physicians and APRNs.	✓
Put the Scope of practice definitions in the bill rather than only in the rules.	✓
Put in the statutes for the first time that all APRNs shall collaborate and refer with physicians and other health care providers in situations that are outside of an APRN's expertise.	✓
Removed the statutory opt-out for CRNAs .	✓
The bill placed into statute scope descriptions and abilities already in place in the Administrative Rules.	✓
Assured that the Board of Nursing cannot expand the scope of practice for APRNs beyond the statutory definitions in the bill.	✓

2023 SB 145
as amended

3 Years of Required Experience

Certified Registered Nurse Anesthetists (CRNAs) practicing outside of the hospital setting are required to have a written collaborative agreement with a physician.

Both

✓

APRNs in the Injured Patients and Families Compensation Fund

Governor's Budget

4 Years of Required Experience

Certified Registered Nurse Anesthetists (CRNAs) practicing outside of the hospital setting are required to have a written collaborative agreement with the physician AND that physician must have additional training in pain medicine.

WNA
WISCONSIN NURSES ASSOCIATION

Testimony for APRN Modernization Act of 2023 - AB 154

November 15, 2023

Dear Chairperson Moses and members of the Assembly Committee on Heath, Aging and Long-Term Care.

My name is Jean Roedl and I live in Frederic WI, I have practiced in Webster WI for the past 22 years. I have been a nurse for 39 years and Nurse Practitioner for 24 years. Thank you for holding a hearing on Assembly bill 154 and I am speaking in support of this legislation. I want to thank Representative Gae Magnafici for sponsoring AB 154.

I have been employed by the St Croix Chippewa Indians of Wisconsin for the past 9 years as a Family Nurse Practitioner and Director of the Medical Clinic the past four 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 Medication Assisted Treatment for opioid and alcohol use disorders. 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. During the COVID-19 Pandemic we operated under emergency rule and collaborative agreement was not needed until May 11, 2023. Our collaborative physician did become ill during the COVID-19 pandemic and our contact was only by phone if needed. We have not been able to fill our position open for a full-time physician since April of 2019. We hired a part time physician in September 2022, who is in his late 70's. Once again, we hope he can stay so we meet our requirement of having a collaborating MD. The St. Croix Chippewa Indians of Wisconsin declared a State of Emergency on May 8th, 2023 due to the increased overdoses and deaths. In the recent weeks we have lost 1-2 tribal members due to overdose and death. In the same week the Oneida tribe also declared a State of Emergency also due to increased overdoses. If we lose our collaborative physician we cannot continue with Medication Assisted Treatment for opioid and alcohol disorders. I ask you to help us to get rid of the barrier of collaborative practice with can

severely hinder healthcare in rural Wisconsin care and the Native American population. The St Croix Tribal Health clinic currently employs 2 full-time Nurse Practitioners and one part time physician.

I thank you for allowing me to share the importance of this legislation. Please vote to pass AB 154 with the amendment adopted in Senate Bill 145.

AB 154 Testimony Gina Bryan DNP, MS, APRN, FAAN, FNAP

709 Woodward Dr. Madison, WI 53704

November 15, 2023

Thank you for allowing me this time to speak. My name is Gina Bryan, and I am a Doctor of Nursing Practice and a psychiatric Advanced Practice Registered Nurse. I have practiced in Dane County at Journey Mental Health Center and currently at Tellurian Behavioral Health. and Rock County Mental Health providing psychiatric and addiction services to the people of WI for over 20 years. I also have the privilege of being a clinical professor at UW-Madison teaching nursing, pharmacy, and medical students for the past 11 years. I am here today to ask each of you to support AB 154

Over the years I have worked to better understand the needs of the people I serve. The people I serve have been generous with their time, patience, and teaching. They have taught me that people need access to quality healthcare to be able to live their lives. They have taught me that Healthcare is a human right not a service to be afforded too only some. I am committed to working to improve access to HIGH QUALITY healthcare for the people of WI. They do not need healthcare professionals in a turf battle. They need all of us to make decisions based on evidence and allow all trained, educated, and experienced healthcare providers to utilize our full scopes of practice. They need each of you to support AB 154.

APRNs are simply requesting to be able to practice to the full scope of our training, education, and experience. Not to make more money or to have prestige. Rather, we simply ask to be allowed to do the work we were educated and trained to do so that we can provide evidence-based care without unnecessary barriers. One of the units I cover is a 30-day residential dual diagnosis substance use and mental health facility. We serve people from all over the state and from many of the tribes in the state. People are provided treatment and then discharged to communities that have not one board certified psychiatric provider in the entire county. This is also true of people who are incarcerated. They get care in corrections and then when they are released, they have no access to care. A large JAMA study showed that in states with full practice authority for APRNs, the # of MAT providers increased significantly.

Professional nursing has always taught, and supported team based, interdisciplinary care. Every profession is welcome and there is room for all. APRNs are not trying to be physicians. WE are APRNs. We made a conscious choice to pursue our profession, not a second choice. APRNs have a scope of practice, we have a profession, and we are simply asking to be able to practice without barriers so we can best serve our patients, communities and state.

It is true, there is a shortage of healthcare providers, particularly in primary care, obstetric care and in psychiatry. Allowing APRNS a full scope of practice can and will help solve this problem. HOWEVER, APRNs should not be allowed to practice to the full scope of our education and training because we are a "less expensive" or because we simply "fill a gap". We need to be able to practice to our full scope because health outcome data shows we are not only safe, but high-quality providers and the people we serve have improved health outcomes.

As I already shared, I have the privilege of teaching at Wisconsin's largest public university, UW-Madison. I work with nursing pharmacy and medical students. I support all my students and advocate for each profession to practice to the highest level of their scope of practice. I will ask each of you to do today what I ask my students to do and what you should expect your healthcare providers to do, make decisions based on what you know. Use the evidence. Do not speculate and share misinformation. Go to the data. Look at health outcome data. Look at the states we neighbor, and across the country, which already have voted in full practice authority for APRNs. Health outcomes have improved in those states and access to care has improved in those states.

Let's not have any more APRNs leave WI to practice in states with full practice authority, some of those being our neighboring states like Minnesota and Iowa. Let's make Wisconsin a state where the very best providers want to stay and serve.

I have been a part of working on APRN full practice legislation for many years. My true concern is that all the arguments against AB 154 have not been evidence based. We have sat by as the states around us and nationally have adopted APRN full practice authority. Those states have had improved health outcomes and access to care with none of expressed concerns proving to be true. When I leave here today, I will return to the clinic I work at providing mental health and substance use disorder care. I will do so because it is my calling, and it is what I have been educated at an undergraduate, graduate, and doctoral level to do. Please remove the unnecessary barriers in place.

I ask you again to support AB 154. Thank you for your time.

November 15, 2023

Assembly Should Adopt the Senate's Amendments on Insurance Coverage
All APRNs Delivering Babies Should be Covered by the IPFCF

Assembly Should Adopt Senate Amendment Ensuring that Nurse Midwives are Covered by the IPFCF. Senators Testin and Hesselbein each offered language amending AB-154/SB-145 to make sure that all nurse midwives are covered by the Injured Patients and Families Compensation Fund (IPFCF).

Nurse Midwives' Risk Profile is Significantly Higher than other APRNs Who Are Covered by Pending APRN Legislation. Current fees charged to medical providers for Nurse Midwives, when they are employees, are already structured according to risk. Hospitals that employ Advanced Nurse Midwives are currently assessed an annual fee of $878 per employee. This fee, demonstrating the risk differential in childbirth compared to other health care services, is nearly seven times greater than the $133 fee charged to employers of other types of APRNs.[1]

Professionals Delivering Babies Should be Included in the Patient's Compensation Fund. Childbirth is inherently risky and worthy of Fund coverage. Since 1975, medical doctors and other medical professionals have been required to carry $1 million in medical negligence liability insurance and they must participate in what is now the Injured Patients and Families Compensation Fund (IPFCF). All Advanced Practice Registered Nurses (APRNs) and their patients should benefit from the stability and protection that this system provides. We are grateful that legislation proposed by both the Governor and lawmakers seeks to provide the same clarity and certainty for most future APRN license holders.

IPFCF's Financial Position is Solid with Over $1 Billion in Surplus.

Fund Surplus Alone is Greater than the Total of All Claims Paid Over Nearly 50 Years. Between 1975 and 2022, the Fund has paid only 691 claims totaling $951,865,333.45.[2]

- **70 Percent of Fund's Paid Claims Have been for Less than $1 Million.**[3]
- **88 Percent of the Fund's Cases Closed without Payment.**[4]
- **Medical Negligence Claims Continue 20+ Year Decline.**[5]

LAB Audit: The Fund's Financial Position Driven by "Declining Estimated Loss Liabilities" and "Positive Investment Income." Even though the Fund has not collected premiums from providers for three years, the investment income of the fund has been strong enough to allow the assessment holiday "occur without having a detrimental effect on the Fund's current net position." The Fund typically closes roughly 90 percent of its cases without making any payment to injured claimants and it has earned positive investment income in each of the past ten years.[6]

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[1] IPFCF Report of Annual Fund Fee and Medical Mediation Panel Fee Charges for Fiscal Year 2024, 3/17/2023.
[2] IPFCF FY 22 Annual Functional and Progress Report; Wisconsin Watch, 3/30/23.
[3] LAB Audit 22-6, Table 1, June 7, 2022.
[4] *Id.*
[5] Wisconsin Watch, 3/30/23; Milwaukee Journal Sentinel, 6/28/14.
[6] LAB Audit 22-6, June 7, 2022.

Other Amendments Will Improve Clarity and Consistency of Bill

Language in Section 163 (p. 52-53) of the bill should be amended to improve clarity and ensure patient protection. As introduced, the bill appears to use holdover language from the last legislative session. Proposed Wis. Stat. § 411.09(5) is inconsistent with other liability insurance requirements included within the bill. It reads:

> (5) MALPRACTICE LIABILITY INSURANCE. Except for a person whose employer has in effect malpractice liability insurance that provides coverage for the person in the amounts specified under s. 655.23 (4), no person may practice advanced practice registered nursing unless he or she at all times has in effect malpractice liability insurance coverage in the minimum amounts required by the rules of the board. An advanced practice registered nurse shall submit evidence of that coverage to the board when applying for an initial license under this section or a renewal of a license under this section. An advanced practice registered nurse shall also submit such evidence to the board upon request of the board.

We propose amending it to be consistent with the remaining language in the bill:

> (5) MALPRACTICE LIABILITY INSURANCE. No person may practice advanced practice registered nursing unless he or she at all times has in effect malpractice liability insurance coverage in the minimum amounts specified under s. 655.23 (4). An advanced practice registered nurse shall submit evidence of that coverage to the board when applying for an initial license under this section or a renewal of a license under this section. An advanced practice registered nurse shall also submit such evidence to the board upon request of the board.