Senate Bill 394 SSA1 – APRN

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What the Bill Does

This sub would allow the full practice of APRNs in Wisconsin, joining 24 other states and DC in removing artificial and costly barriers to accessing health care.

The sub:

Codifies APRN scope of practice in statute.

Creates a simplified system for prescribing authority – clarifying, ***not expanding*** the list of who can prescribe.

Requires in statute, for the first time in state history, that APRNs must collaborate, consult and refer patients when a situation is beyond their scope of practice.

- Organizations wishing to require a written collaborative agreement of their nurse employees may do so
- Outside of those employer agreements, APRNs will not be required to obtain, and pay the "Nurse Tax" for, a written permission slip from a physician who does not know their patients, and who likely will never see their patients.

Requires the Board of Nursing to establish professional conduct standards, and prohibits the board from expanding APRN scope without legislative approval.

Eliminates the Nurse Tax, a hidden cost that contributes to higher healthcare costs.

To reiterate: Collaboration between APRNs and Physicians is ***required by law*** for the first time in state history under this legislation.

Why We Should Pass the Bill

We face a critical shortage of healthcare workers in the state, and rank in the top 12 of states suffering from lack of access to primary care. At the same time, we have placed artificial and in some cases ridiculous barriers in the way of Advance Practice Nurses – highly educated and trained health care professionals with a master's degree and hundreds if not thousands of clinical hours under their belts when they graduate.

Rural areas of the state stand to suffer most as the aging demographics of the state and nation are most acutely felt in rural geographies. Today in Wisconsin, nurse-midwives and CRNAs are critical to health care access in these areas.

This bill is the product of many sessions of work by multiple authors, and intense negotiation and compromise this session that brought WHA from opposition to support.

Fiscal Effect(s)

DSPS: can be absorbed in current agency budget.

Supporters

AARP

Amazon

American College of Nurse-Midwives

Americans For Prosperity

CWAG

Concordia Univeristy

Potawatomis

Health Tradition Health Plan

Marquette University

Oneida Nation

United Healthcare

WEA Insurance

WI Assisted Living Assn

WI Assn of Nurse Anesthetists

WI Assn of School Nurses

WMC

Wisconsin Nurses Assn

WPS Health Insurance

WHA and Gunderson Health for the Sub

Supporters' Message

We need to remove barriers that prevent access to healthcare. Requiring collaboration statutorily – something APRNs already do – provides certainty that highly educated medical professionals can help expand access.

We shouldn't be engaging in "fence-me in, fence-you-out" laws when lives are at stake.

APRNS provide high quality care, and in some areas of the state, they are critical to the provision of necessary health care.

APRNs actually educate physicians during their training in medical school. For example nurse midwives in Wisconsin may currently be forced to obtain a permission slip and pay the Nurse Tax to a physician whom she taught in his obstetrics rotation.

Opponents

Med Society

MCW

Academy of Family Physicians

WI Chapter of Academy of Pediatrics

WI Chapter of College of Emergency Physicians

WI Psychiatric Assn

WI Radiological Society

Academy of Ophthalmology

WI Society of Anesthesiologists

Oppostition Message/Possible Hostile Amendments

Please see the attached chart for the numerous claims opponents are making, and the advocates' responses.

Physician groups either attended, spoke or submitted testimony on the vaccination bills in hearings last week, but spent the time in the building trying to maintain the Nurse Tax and prevent statutorily required collaboration. Obviously, it is a top priority to kill this bill, given they are willing to ignore the pandemic and the importance of universal vaccination in order to do so.

Physician groups have falsely claimed they were not included in the negotiations – negotiations that resulted in compromise on a number of their issues.

Physician groups are working in the Asm on hostile amendments.

- One would prevent any nurses from using the suffix 'ologist.' Although that suffix is not particular to physicians, and means simply 'expert' (geologist, seismologist, meteorologist, sociologist) these groups think that patients are being hoodwinked by the nurse providing their anesthesia – that if they introduce themselves as a nurse-anesthesiologist instead of a nurse-anesthetist, the patient is tricked into thinking they are not a nurse…or something.
- One would require a specific number of hours of practice with written collaborating agreement (and the Nurse Tax) for APRNs, except nurse-midwives, in an apparent attempt to divide and conquer. As a note, of the 24 states with full scope for APRNs, most do not have such requirements, and those that do have more requirements, in all but two the collaboration may also be done with another APRN. None carve out nurse-midwives.

Committee/Assembly Votes

Health 3-2 party line.

Physician Arguments against SSA1 to SB394	Response
This will allow nurses to practice as doctors.	The bill codifies a scope of practice for APRNs, and ***for the first time in Wisconsin history,*** puts in statutes the requirement that APRNs collaborate with, and refer to, physicians and other health care providers when a case is outside their expertise.
Nurses do not have enough training to provide care without a written agreement with a physician	Physicians DO have more training. That's why the bill requires APRNs – IN STATUTE – to collaborate with and refer to physicians when they are beyond their expertise. APRNs complete their medical training in 7 years Physicians complete their training in 11
Patients will think nurses are doctors if the nurse does not have a written collaborative agreement.	The vast majority of patients are currently completely unaware that a physician (whom they have likely never seen, could not name, and do not have a relationship with) has signed a written collaborative agreement for which the APRN may be paying a large fee. It is difficult to understand how placing collaboration requirements in statute rather than in a letter will cause patients to believe their nurse is a physician.
"Patients deserve care only from professionals with the most education and training: Physicians"	This seems to be a shocking physician-led effort to entirely eliminate nurses as caregivers which would devastate the health care system in the state. Further, since according to Kaiser Family Foundation, Wisconsin ranks 12th in the US for unmet need for **primary** health care professionals, we should not be in a position to
APRNs won't step in to fill the primary care shortage in rural areas	In rural parts of the state ***right now***, without nurse-midwives and CRNAs patients would not have access to care they're receiving. Without CRNAs, some rural hospitals could no longer provide surgeries. They're ***already*** shouldering the burden in these areas.
Quality of care will diminish	See attachment. States ranking high on healthcare quality are vastly more likely to have full APRN practice. States ranking low on healthcare quality are vastly more likely NOT to have full APRN practice.
APRNs refer patients to specialists more often/too often and that offsets savings	The fact that APRNs make more referrals strongly suggests they DO send patients up the food-chain. This is contrary to previous arguments that APRNs don't want to involve doctors when the case is beyond their training/education. With medical error being the third leading cause of death in the US (see below) it is worth considering that referrals might help save

	lives as well as decrease the cost of care by properly diagnosing and treating patients earlier in the disease process.
APRNs order more biopsies and diagnostic imaging than doctors and again this increases costs	According to Johns Hopkins researchers: Medical error is the third leading cause of death in the US. Misdiagnosis plays a role in up to 160K causes of serious harm to patients every year, on top of up to 80K deaths. Most misdiagnoses were attributed to clinical judgement failures, one suggested solution was quicker referrals (see above). One-third of misdiagnoses leading to death or permanent disability are related to cancer. It seems likely that NOT ordering biopsies results in increased costs due to advanced stage at diagnosis, as well as poorer outcomes.
The legislature will not be able to change licensure and scope laws in the future	The bill makes no changes to legislative authority.
Nobody listened to physicians or worked with them	SSA1 to SB394 is responsive to a number of physician concerns: - Requires collaboration with physicians, in statute, for the first time in state history - The sub removed the CRNA opt-out language - The bill puts in statute the APRN scope description, prohibits the BoN from expanding the scope without legislative approval, and clarifies (not changes) which nurses can and cannot prescribe.
Everyone is going to die	True enough. With or without the bill. However with access to more primary health care providers, we may help push that expiration date off for most folks.

SCOPE LAWS IN THE UNITED STATES

There are three levels of practice for APRNs in the US:

Full – 24 states plus DC

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

- Of these states, 14 have no further requirements in hours or time to practice.
- Of the remaining 10, 8 require some timeline/hours with a regulated collaborating agreement with another APRN or a physician.
- Of the two remaining, one requires collaboration specifically with a physician only for prescribing schedule II drugs, and the remaining one requires a collaborative agreement with a physician.

Reduced – 15 states, including Wisconsin

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

Restricted – 11 states

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

HEALTHCARE QUALITY WITH FULL SCOPE OF PRACTICE

Using three respected healthcare quality rankings of US states, the following page shows the states that rank in the top and bottom 10 for quality, along with their scope of practice status.

Sources: Commonwealth Fund, AHRQ, US News.

The vast majority of states with high quality rankings have full APRN practice. The vast majority of states with low quality rankings do not have full APRN practice.

APRN SCOPE DRIVING QUALITY?

States making the TOP 10 in any of these three rankings:

	State	Full	Reduced	Restricted	CW Rank	AHRQ Top or Bottom 10	USNR Rank
2	HAWAII	x			1		1
3	MASSACHUSETTS	x			2	Top	
4	MINNESOTA	x			3	Top	
5	IOWA	x			4	Top	
6	CONNECTICUT	x			5		
7	COLORADO	x			6		5
8	VERMONT	x			7	Top	
9	WASHINGTON	x			8		
10	ALASKA	x					2
11	ARIZONA	x					4
12	MARYLAND	x					7
13	OREGON	x					8
14	MAINE	x				Top	9
15	DELAWARE	x				Top	
16	NEW HAMPSHIRE	x				Top	
17	NORTH DAKOTA	x				Top	
18	RHODE ISLAND	x				Top	
19	UTAH		x		9		3
20	NEW YORK		x		10		
21	WISCONSIN		x		12	Top	10
22	CALIFORNIA			x		Bottom	6

States making the BOTTOM 10 in any of these three rankings:

	A	B	C	D	E	F	G
1	State	Full	Reduced	Restricted	CW Rank	AHRQ Top or Bottom 10	USNR Rank
2	OKLAHOMA			x	49	Bottom	45
3	MISSOURI			x	47		
4	GEORGIA			x	45	Bottom	41
5	TENNESSEE			x	44	Bottom	
6	TEXAS			x	42	Bottom	
7	MICHIGAN			x			42
8	CALIFORNIA			x		Bottom	6
9	FLORIDA			x		Bottom	
10	MISSISSIPPI		x		50		49
11	WEST VIRGINIA		x		46		43
12	LOUISIANA		x		43	Bottom	47
13	ARKANSAS		x		41	Bottom	50
14	KANSAS		x				48
15	KENTUCKY		x				46
16	NEVADA	x			48	Bottom	
17	MONTANA	x					44
18	NEW MEXICO	x				Bottom	

**No ranking means the state ranked in neither the top nor bottom 10 for quality.*