APRN Modernization Act: Supportive Amendments Offered by WHA

APRNs are important practitioners in hospital and health systems’ efforts to provide high-quality, efficient health care in team-based care models, and WHA supports efforts to modernize Wisconsin’s laws governing the practice of APRNs. WHA offers several amendments to SB 497 in support of that effort which are summarized below and which WHA offers specific statutory language to address (with additional rationale and explanation) in the attached document.

As discussed in greater detail below, WHA offers the following key suggested amendments to SB 497:

Licensure by APRN role - WHA proposes that each of the 4 recognized APRN roles should each have their own license utilizing the nationally recognized names for each of the roles. Under our proposal, an APRN is defined as a professional licensed in any of the four roles. We believe that our proposal is significantly simpler than the regulatory structure in the current draft of SB 497, and is easier for the public to understand. We believe that having licensure by role is consistent with the “National Consensus Model,” is consistent with how advanced practice nurses currently present themselves, and will allow Wisconsin to participate in the APRN Interstate Licensure Compact should it choose to do so.

Define scope of practice for each of the 4 APRN roles - Although CRNAs, CNMs, NPs, and CNSs are all APRNs, each of their scopes of practice are different. WHA proposes that each licensed role – CRNA, CNM, NP, and CNS – each have their own statutory scope of practice to help regulators, payers, hospitals, nurses, employers, and the public understand what a nurse’s scope of practice is and to help comply with obligations to ensure a nurse’s service is within his or her scope of practice. For comparison, Minnesota’s recent change to its APRN licensure statute specified scopes of practice specific to NPs, CNMs, and CNSs.

Make it explicitly clear that physician supervision not required - WHA proposes adding explicit statutory language consistent with current law that physician supervision is not required for an APRN to issue prescription orders for drugs, items and services.

Licensure Authority Does Not Preempt Employer, Health Plan, Hospital Policies - Employers, hospitals, health plans, and others that have a relationship with a licensed health care professional must be free to determine the scope of their relationship so long as the relationship is within the grant of practice authority conferred by the state to the licensee. WHA proposes adding language to SB 497 to make it clear to the reader that licensure is a grant of authority by the state, but that licensure authority does not preempt the authority of employers, health plans, hospitals, and others with a relationship with the nurse from setting their own policies with a nurse as a condition of their relationship.

Eliminate Special Barriers to Delegation to RNs – Team Based Care Reform - The provisions in current law prohibiting an APRN from delegating the issuance of a prescriptive order to any nurse have resulted in different standards for nurses in hospitals between physician orders and APRN orders. This current law has been carried over into SB 497. WHA has previously identified this as an unintended barrier to team-based care practice and proposes aligning APRN delegation authority with MD/DO delegation authority.

Other Team Based Care Reforms - Although SB 497 addresses the licensure of APRNs and their licensed scope of practice, it does not address various outdated limitations on APRN practice scattered throughout the statutes. WHA recommends that SB 497 also makes changes to several statutes outside of Chapter 441 that will permit an APRN to practice to the top of their licensed practice.

Malpractice Insurance - WHA proposes maintaining current law regarding medical liability and Injured Patients and Families Compensation Fund coverage for all APRNs. However, to provide more clarity, WHA proposes modifying SB 497
to more specifically enunciate the existing requirements in statute rather than leaving the requirements solely to rulemaking.

Certified Nurse-Midwife Collaboration — WHA proposes moving from a collaborative agreement requirement to a documented collaborative relationship requirement for certified nurse-midwives delivering babies solely in a hospital setting, and retaining collaboration and practice setting requirements for certified nurse-midwives in statute rather deferring to rulemaking. WHA also proposes explicit language making it clear that collaboration is not supervision.

CRNA Non-Supervised Anesthesia — Consistent with Wisconsin’s “opt out” declination to the federal government, and consistent with current Wisconsin rules governing CRNAs, WHA proposes explicitly providing in statute that a CRNA may administer anesthesia without physician supervision. This helps make clear that a CRNA working in a collaborative relationship with a physician is not working under the physician’s supervision.

Nurse Practitioner Collaboration — WHA proposes retaining the current Wisconsin law requirement that an APRN have a collaborative relationship with a physician and that the relationship be documented by the nurse. We propose stating that requirement in statute rather than deferring to rulemaking. It is important to note that this is consistent with the Board of Nursing's 2015 rulemaking removing the requirement that a nurse have a written collaborative agreement with a physician and changing the requirement to the nurse must merely document the collaborative relationship. This documented collaborative relationship requirement set by the Board of Nursing in 2015 is the same requirement for federal Medicare reimbursement for services rendered by an NP. WHA also proposes explicit language making it clear that collaboration is not supervision.

Other amendments - WHA proposes other technical amendments relating to continuing education and RN sick notes.

WHA looks forward to working with all of the provider stakeholders and the legislative authors of SB 467 on this important bill. A more detailed summary of WHA's proposals and specific proposed amendment text is attached.
SB497 Proposed APRN Licensure Equation

RN License + APRN License + BOA Specialty Certification + CRNA, CNM, NP = BOA deems Authority to Prescribe = APRN Specialty with BOA registered Authority to Prescribe

WHA Proposed APRN Licensure Equation Consistent with National Consensus Model

RN License + CRNA, CNM, NP + Frequency of authority included in license = All Recognized as APRN in Wisconsin Statutes

RN License + CNS License + CNS requests BOA for Authority to Prescribe = All Recognized as APRN in Wisconsin Statutes
Licensure by APRN Role

APRNs are important practitioners in hospital and health systems’ efforts to provide high-quality, efficient health care in team-based care models. We support licensure as opposed to current “certification” recognition of nurses practicing in the 4 nationally recognized APRN roles.

WHA proposes that each of the 4 recognized APRN roles should each have their own license utilizing the nationally recognized names for each of the roles. Under our proposal, an APRN is defined as a person licensed in any of the four roles. We believe that our proposal is significantly simpler than the regulatory structure in the current draft of SB 497, and is easier for the public to understand.

We also believe that having licensure by role is consistent with the “National Consensus Model,” is consistent with how advanced practice nurses currently present themselves, and will allow Wisconsin to participate in the APRN interstate Licensure Compact should it choose to do so.

WHA proposal:

CRNA role: Licensed CRNA/Certified Registered Nurse Anesthetist**

CNM role: Licensed CNM/Certified Nurse-Midwife**

NP role: Licensed NP/Nurse Practitioner**

CNS role: Licensed CNS/Clinical Nurse Specialist PLUS Board granted prescriptive authority.

*The statutes are amended to utilize the term “APRN/Advance Practice Registered Nurse” to mean any of the above licensed roles.

**Different from SB 497, we propose that prescriptive authority automatically be a part of the scope of practice of a licensed CNRA, CNM, or NP.

Current law:

CRNA role: Certified APNP/Advanced Practice Nurse Prescriber

CNM role: Certified CNM/Certified Nurse Midwife

NP role: Certified APNP/Advanced Practice Nurse Prescriber

CNS role: Certified APNP/Advanced Practice Nurse Prescriber

SB 497:

CRNA role: Licensed APRN/Advanced Practice Registered Nurse PLUS Board of Nursing certification as CRNA/Certified Registered Nurse Anesthetist PLUS Board of Nursing special grant of authority to prescribe

CNM role: Licensed APRN/Advanced Practice Registered Nurse PLUS Board of Nursing certification as CNM/Certified Nurse Midwife PLUS Board of Nursing special grant of authority to prescribe

NP role: Licensed APRN/Advanced Practice Registered Nurse PLUS Board of Nursing certification as NP/Nurse Practitioner Certified Nurse Midwife PLUS Board of Nursing special grant of authority to prescribe

CNS role: Licensed APRN/Advanced Practice Registered Nurse PLUS Board of Nursing certification as CNS/Certified Nurse Specialist PLUS Board of Nursing special grant of authority to prescribe.
Defining Scope of Practice

Although CRNAs, CNMs, NPs, and CNSs are all APRNs, each of their scopes of practice are different. WHA proposes that each licensed role – CRNA, CNM, NP, and CNS – each have their own statutory scope of practice to help regulators, payers, hospitals, nurses, employers, and the public understand what a nurse’s scope of practice is and to help comply with obligations to ensure a nurse’s service is within his or her scope of practice. For comparison, Minnesota’s recent change to its APRN licensure statute specified scopes of practice specific to NPs, CNMs, and CNSs.

We believe that having scopes of practice for each role is consistent with the “National Consensus Model” and as drafted will allow Wisconsin to participate in the APRN Interstate Licensure Compact should it choose to do so. In drafting WHA’s proposed general scope of practice language for each role, WHA pulled from NCSBN, AANA, AANP, NACNS materials, as well as the new Minnesota APRN statute and language provided in SB 497 regarding nurse midwife practice. Our intent was to craft language that was clear but broad enough to be applicable to modern and evolving practice.

WHA proposal:

CRNA License: A licensed Certified Registered Nurse Anesthetist may consistent with rules established by the board and his or her education, training, and experience provide anesthesia care, pain management care and care related to anesthesia and pain management for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illness or injury, in diverse settings, including, but not limited to, hospitals, ambulatory surgery centers, and outpatient clinics.

CNM License: A licensed certified nurse midwife may consistent with rules established by the board and his or her education, training, and experience practice in the management of women’s health care, pregnancy, childbirth, postpartum care for newborns, family planning, and gynecological services consistent with the standards of practice of the American College of Nurse-Midwives.

NP License: A licensed nurse practitioner may consistent with rules established by the board and his or her education, training, and experience practice in ambulatory, acute and long-term care settings as primary and specialty care providers who assess, diagnose, treat, and manage acute episodic and chronic illnesses.

CNS License: A licensed Clinical Nurse Specialist may consistent with rules established by the board and his or her education, training, and experience provide advanced nursing care, including the diagnosis and treatment of illness, and as provided by sub. (d), issue prescription orders.

Current law:

APNP (only applicable to prescribing advance practice nurses): No general scope of practice is specified in statute.

CNM: “Practice of nurse-midwifery” means the management of women’s health care, pregnancy, childbirth, postpartum care for newborns, family planning, and gynecological services consistent with the standards of practice of the American College of Nurse-Midwives and the education, training, and experience of the nurse-midwife.

SB 497:

All APRNs: Advanced practice registered nursing” means practicing in one of the 4 recognized roles based on advanced clinical knowledge and skills focusing on direct care of individuals, greater responsibility, autonomy, and accountability for the provision of care, health promotion and maintenance, management of patient conditions, and the use and prescription of pharmacological interventions.

CNM: “Practice of nurse-midwifery” means the management of women’s health care, pregnancy, childbirth, postpartum care for newborns, family planning, and gynecological services consistent with the standards of practice of the American College of Nurse-Midwives and the education, training, and experience of the nurse-midwife.
Licensure Authority Does Not Preempt Employer, Health Plan, Hospital Policies

Employers, hospitals, health plans, and others that have a relationship with a licensed health care professional must be free to determine the scope of their relationship so long as the relationship with within the grant of practice authority conferred by the state to the licensee.

WHA proposes adding language to SB 497 make it clear to the reader that that licensure is a grant of authority by the state, but that licensure authority does not preempt the authority of employers, health plans, hospitals, etc., from setting their own policies with a nurse as a condition of their relationship.

WHA proposal:

"The permissions provided in sub. (a) are permissions granted by the State of Wisconsin authorizing the licensed practice of a nurse practitioner. Nothing in this sub. (a) prohibits an employer, hospital, health plan, or other similar entity with a relationship with a licensed nurse practitioner from establishing additional or different practice requirements on a licensed nurse practitioner as a condition of their relationship."

Current law:

The statute is silent on this issue.

SB 497:

The bill is silent on this issue. However, a previous version of SB 497 contained a provision that would have created a claim of action against hospitals that would have effectively restricted hospitals' ability to limit an APRN's practice as a condition of medical staff privileges.

Eliminate Special Barriers to Delegation to RNs – Team Based Care Reform

The provisions in current law prohibiting an APRN from delegating the issuance of a prescriptive order to any nurse has resulted in different standards for nurses in hospitals between physician orders and APRN orders. This current law has been carried over into SB 497. WHA has previously identified this as an unintended barrier to team-based care practice.

As a team-based care reform, WHA proposes aligning authority of an advance practice registered nurse to delegate orders to be consistent with the delegation authority of a physician. WHA's proposed change mimics MED 10.02(1) and MED 10.03(1)(l). As a result, an RN – and employers of RNs – will no longer need to keep track of different delegation laws between MDs/DOs and APRNs.

WHA proposal compared to current law and SB 497:

(9) DELEGATION. An advanced practice nurse who is certified to issue prescription orders may not delegate the act of issuing a prescription order to any nurse who is not certified to issue prescription orders medical tasks and orders to another clinically trained health care worker if the advance practice nurse is competent to perform the delegated task or order and has reasonable evidence that the clinically trained health care worker is minimally competent to perform the task or issue the order under the circumstances.

(10) RULES. The Board shall promulgate rules necessary to administer this section, including rules for all of the following:

(e) Specifying the conditions to be met for registered nurses to do the following:

1. Administer a drug prescribed by an advanced practice registered nurse.
2. Administer a drug at the direction of an advanced practice registered nurse.
Malpractice Insurance

It is important that APRNs have malpractice liability insurance. Under current law, CNMs/certified nurse-midwives and APNs/advanced practice nurse prescribers are required to have malpractice liability insurance. Additionally, APNs that are CRNAs/certified registered nurse anesthetists are required to have their own individual coverage under the Injured Patients and Families Compensation Fund (the “Fund”). Under current law, all advanced practice nurses—whether prescribers or not—and CNMs are covered by the Fund as employees of Fund-covered hospitals, clinics, etc., pursuant to s. 655.005(2)(a) and INS 17.28(3h), so long as the CNM or APRN is:

- Practicing within the scope of the nurses’ license,
- Subject to a quality assurance program, peer review process, or other similar program or process that is implemented for and designed to ensure the provision of competent and quality patient care, and
- That program or process also includes participation by a physician or a nurse anesthetist.

WHA proposes maintaining current law regarding medical liability and Fund coverage for all APRNs. However, to provide more clarity, WHA proposes modifying SB 497 to more specifically enunciate the existing requirements in statute rather than leaving the requirements solely to rulemaking.

Continuing Education

WHA proposes amending AB568’s provisions regarding special continuing education for the prescription of controlled substances to be limited to apply only to APRNs with prescriptive authority. Requiring prescriptive education to non-prescribers does not appear to make sense.

WHA also proposes amending AB568’s provisions regarding special continuing education for the prescription of controlled substances to track the approach taken by the medical examining board. When the MEB adopted a similar special 2 credits for prescriptive drug best practices, they did not make that a permanent requirement. The MEB felt that having a permanent continuing education requirement for best practices in controlled substances would not make sense if over time general awareness regarding prescription best practices no longer merits a specific requirement for specific CE. We believe that the MEB has taken the better approach and that in the long term, the Board of Nursing should have flexibility in determining specific continuing education requirements for nurses.

Sick Notes – Team Based Care

Under current law at s. 118.15 (3) (a), an RN may write a school sick note while acting under the delegation of a physician. It appears that SB 497 inadvertently removes the ability of an RN that is not an APRN to write such a sick note. WHA recommends an amendment to SB 497 to clearly maintain the ability of RNs to write sick notes as a delegated act.

Other Team Based Care Reforms Elsewhere in the Statutes

Although SB 497 addresses the licensure of APRNs and their licensed scope of practice, it does not address various outdated limitations on APRN practice scattered throughout the statutes. WHA recommends that SB 497 also address the following reforms that will enable an APRN to practice to the top of their license (WHA can provide draft language):

- Permit APRNs to activate a power of attorney (s. 244.09(3)) and do-not-resuscitate orders (s. 154.19).
- Like physicians, chiropractors, dentists, physician assistants, and podiatrists, exclude APRNs from the applicability of the radiographer certification requirement in s. 462.02(2).
- Provide clarity that APRNs may admit a patient to a residential care facility and perform other historically “physician” duties under the long-term care facility regulations in chapter 50.
- Permit an APRN to complete a medical certification of death under s. 69.18.
- Permit APRN-Psych practitioners to complete competency examinations under ch. 50, 51, and 55.
Issues Specific to Certified Nurse-Midwives

Many Wisconsin hospitals—large and small—utilize certified nurse-midwives to help provide high-quality, efficient obstetrical services to women. However, obstetrical practice is one of the higher risk medical specialties. Further, when birth complications occur in a non-hospital setting, such cases often arrive at hospital emergency departments. Thus, hospitals have a particular interest in ensuring that nurse-midwifery services are high quality and collaborative.

Under current statute and rule, all certified nurse-midwives must meet the following three criteria:

- Must practice in a collaborative relationship with a physician that is a OB/GYN or family practice physician with obstetrics training (some nurses have mistakenly said that collaboration with an OB/GYN specialist is required; it is not)
- The certified nurse midwife must have a written agreement with the collaborating physician.
- The practice occurs in a health care facility approved by the board by rule.

SB 497 removes this language from the statute, but does not invalidate the existing rule requirements at N4. Thus, without additional action by the Board of Nursing, the above three criteria would remain valid law should SB 497 be enacted.

WHA proposes retaining collaboration and practice setting requirements in the statute given the high-risk status of obstetrical care. However, for certified nurse mid-wives delivering babies solely in a hospital setting, WHA does propose changing the standard from requiring a collaborative agreement to requiring that the nurse document the collaborative relationship. For these nurses, this would be in alignment with the N8 standard applicable to APNPs which pursuant to a rule change in 2016 only requires documented collaboration rather than a collaborative agreement.

WHA proposal:
Maintain in statute the following requirements:

- All CNMs must practice in a collaborative relationship with a physician that is a OB/GYN or family practice physician with obstetrics training
- If the CNM only delivers babies in a hospital setting, the CNM must document the collaborative relationship. If the CNM delivers babies outside of a hospital setting, the CNM must have a written collaborative agreement with the collaborating physician.
- The practice occurs in a health care facility approved by the board by rule.
- A licensed certified nurse midwife is authorized to issue prescription orders for drugs, items, and services consistent with his or her scope of practice without physician supervision.

Current law:
The following requirements are both in statute and in rule:

- All CNMs must practice in a collaborative relationship with a physician that is a OB/GYN or family practice physician with obstetrics training
- The certified nurse midwife must have a written agreement with the collaborating physician.
- The practice occurs in a health care facility approved by the board by rule.

SB 497:
The bill removes all statutory provisions regarding collaboration and practice location. But by being silent and not explicitly removing Board authority to specify collaboration and practice location, the following Board of Nursing rules would be retained unless the Board chooses to remove the requirements:

- Must practice in a collaborative relationship with a physician that is a OB/GYN or family practice physician with obstetrics training (some nurses have mistakenly said that collaboration with an OB/GYN specialist is required; it is not)
- The certified nurse midwife must have a written agreement with the collaborating physician.
- The practice occurs in a health care facility approved by the board by rule.
**Issues Specific to CNRAs**

CRNAs are utilized in hospitals and other health care settings to provide high-quality, efficient pain management care in rural and urban communities throughout Wisconsin. CRNAs are also subject to different CMS Medicare payment requirements. In particular, in 2001 a federal rule was published allowing states to “opt out” of the CMS federal requirement that CRNAs be supervised by a physician as it relates to reimbursement for facilities.

For a state to “opt out,” the state’s governor must send a letter of attestation to CMS stating that:
- The state’s governor has consulted with the state’s boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state; and
- That it is in the best interests of the state’s citizens to opt-out of the current federal physician supervision requirement; and
- That the opt-out is consistent with state law.

In 2005, Wisconsin became the 14th state to “opt out.” According to WIANA, in 2007, a Wisconsin administrative law judge determined:
- The administration of anesthesia is, under Wisconsin law, both part of the practice of medicine and is also within the practice of professional nursing.
- CRNAs who are certified as Advanced Practice Nurse Prescribers (APNPs) may lawfully administer anesthesia without physician supervision. As is the case for all APNPs, the CRNA must maintain and document a collaborative relationship with a physician.
- CRNAs who are not certified as APNPs may administer anesthesia only under the supervision of a physician.

Because of the importance of retaining Wisconsin’s status as an “opt out” state, WHA proposes codifying Wisconsin’s existing CRNA practice requirements that recognizes collaborative practice as non-supervised practice.

WHA also proposes incorporating the existing collaboration requirement in rule at N8, which includes a documented collaborative relationship with a physician but not a collaborative agreement with a physician.

**WHA proposal:**
- All licensed certified registered nurse anesthetists must practice in a collaborative relationship with a physician. The collaborative relationship is a process in which a licensed certified registered nurse anesthetist is working with a physician, in each other’s presence when necessary, to deliver health care services within the scope of the scope of his or her licensed practice. The licensed certified registered nurse anesthetist shall document this relationship.
- A licensed certified registered nurse anesthetist is authorized to issue prescription orders for drugs, items, and services consistent with his or her scope of practice without physician supervision.
- A licensed certified registered nurse anesthetist may lawfully administer anesthesia without physician supervision.

**Current law:**

The nurse licensure statute is silent regarding collaboration requirements for APNPs (Advanced Practice Nurse Prescribers), but pursuant to rulemaking authority, the Board of Nursing has established collaboration requirements which include a requirement that an APNP document the collaborative relationship. In 2016, N8 was changed by the Board of Nursing to require documentation of the collaborative relationship rather than a collaborative agreement.

**SB 497:**

As is the case with current law, the nurse licensure is silent regarding collaboration for CRNAs. The bill does not explicitly remove Board authority to specify collaboration and practice location, thus we presume the intent of the bill is to retain in rule the existing Board of Nursing rules requiring documented collaboration with a physician.

Unlike the WHA proposal, SB 497 is silent in regards to definitively stating that a CRNA may lawfully administer anesthesia without physician supervision.
Issues Specific to NPs

NPs/Nurse Practitioners are a key part of health systems’ primary care workforce and are increasingly an important part of health systems’ specialty workforce. NPs are also important members of the hospital team, including in emerging hospitalist roles.

Under current law, NPs gain their prescriptive authority by becoming certified as an APNP (Advanced Practice Nurse Prescriber) under requirements specified in rule. In order to reduce confusion in both current law and as proposed in SB 497, WHA proposes that all licensed NPs have prescriptive authority. WHA further proposes explicitly stating that prescriptive authority in the statute.

WHA also proposes incorporating the existing collaboration requirement in rule at N8, which includes a documented collaborative relationship with a physician but not a collaborative agreement with a physician. In addition, WHA proposes adding explicit statutory language consistent with current law that physician supervision is not required for an NP to issue prescription orders for drugs, items and services. It should also be noted that this language is consistent with the collaboration requirements stated in federal law necessary for an NP to receive payment from Medicare for services rendered.

WHA proposal:

• All licensed nurse practitioner must practice in a collaborative relationship with a physician. The collaborative relationship is a process in which a licensed nurse practitioner is working with a physician, in each other’s presence when necessary, to deliver health care services within the scope of the scope of his or her licensed practice. The licensed certified nurse practitioner shall document this relationship.
• A licensed nurse practitioner is authorized to issue prescription orders for drugs, items, and services consistent with his or her scope of practice without physician supervision.

Current law:

The nurse licensure statute is silent regarding collaboration requirements for APNPs (Advanced Practice Nurse Prescribers), but pursuant to rulemaking authority, the Board of Nursing has established collaboration requirements which include a requirement that an APNP document the collaborative relationship. In 2016, N8 was changed by the Board of Nursing to require documentation of the collaborative relationship rather than a collaborative agreement.

SB 497:

As is the case with current law, the nurse licensure is silent regarding collaboration for NPs. The bill does not explicitly remove Board authority to specify collaboration, thus we presume the intent of the bill is to retain in rule the existing Board of Nursing rules requiring documented collaboration with a physician.

Issues Specific to CNSs

The CNS/Certified Nurse Specialist role was the first recognized advanced practice role, established nearly 60 years ago. While there are fewer practicing CNS nurses, they most typically practice in a hospital setting.

It is WHA’s understanding that the education, training, and experience of a certified CNS does not always include prescriptive authority, and that many CNSs in Wisconsin have not sought prescriptive authority as an APNP under current law.

Thus consistent with the approach taken in SB 497, WHA is proposing that a CNS scope of practice not automatically include prescriptive authority, but that a CNS can receive special authority from the board to issue prescription orders which is delineated below at sub (d).