

Myths and Truths: Senate Bill 2

Myth: If Senate Bill 2 passes APRNs are going to 'hang out a shingle' and patients won't understand they aren't seeing a doctor.

Truth: Senate Bill 2 **does not allow** APRNs to have Professional Limited Liability Companies (PLLC) or a Professional Services Corporation (PCS).

Myth: Senate Bill 2 will compromise patient safety because APRNs will perform procedures they aren't trained for and endanger patients.

Truth: Again, Senate Bill 2 states 'within the parameters of his or her education, training or national certification' 9 times in the bill. APRNs are currently regulated by the Board of Nursing, and will continue to be as they still hold an RN license. In addition there is an APRN taskforce created that will serve as the disciplinary subcommittee for the board of nursing to specific APRN scope issues. Any complaints would be addressed by the subcommittee and the department of licensing and regulatory affairs **as it is with all health professions licensed in Michigan.**

18 other states and Washington DC allow for APRNs to practice to the fullest extent of their education, training and national certification - including prescriptive authority, and have **maintained patient safety while improving access to healthcare.**

Myth: APRNs should practice under the delegation of doctors because doctors carry liability insurance and APRNs don't.

Truth: Every APRN currently carries his or her own malpractice insurance regardless of the business structure he or she practices in. They will continue to carry insurance with the passage of Senate Bill 2.

Myth: APRNs won't collaborate with a physician if SB 2 is passed.

Truth: APRNs will continue to work in clinical settings with other healthcare professionals—Senate Bill 2 even requires this with the mentorship agreement for prescribing. This legislation doesn't preclude an employer or a payer (insurer) from requiring a collaborative agreement with a physician. For example, CMS and most private insurers (BCBS, etc.) currently require a collaborative agreement for APRNs to be reimbursed for the healthcare services they perform. The passage of SB 2 wouldn't change that. This will continue to be a decision between a provider and a payer.

Myths and Truths: Senate Bill 2

Myth: Senate Bill 2 expands the scope of practice for APRNs.

Truth: Senate Bill 2 defines the scope of practice for an APRN based on their training, education and national certification. Currently the public health code allows an APRN to do whatever a physician delegates to them – this is a broader and more expansive scope than Senate Bill 2 allows.

Myth: Senate Bill 2 will destroy the team model of patient care.

Truth: Senate Bill 2 **REQUIRES** communication through consultation and referrals. Page 19 - Sec. 17202 (c) consult with other health professionals, as appropriate, or refer a patient to other health professionals if the patient's care is outside his or her education, training, or national certification. Nothing in Senate Bill 2 prevents a team model of care; it **allows the patient to choose** the primary care provider that is best for him/her.

Myth: Senate Bill 2 allows nurses to be doctors because it uses the word 'diagnose.'

Truth: APRNs are highly trained and educated health professionals with either a Masters or Doctorate degree in nursing. As such, there are medical needs they are trained to care for within the practice of nursing within their specialized field and population foci. The bill states "within the parameters of his or her education, training or national certification" 9 times – **it could not be any clearer that APRNs are not trying to do anything they aren't trained to do.**

Myth: APRNs are going to over prescribe because they can.

Truth: All APRNs must complete graduate level pharmacology, pathophysiology and physical assessment courses as well as clinical requirements to ever prescribe controlled substances-all within their specialized program and population foci. Any APRN without 2 years of experience working under the delegation of a physician **MUST have a mentorship agreement with an independent prescriber** (a physician or an APRN with 5 years of experience and licensed to prescribe) for two years in order to prescribe controlled substances.

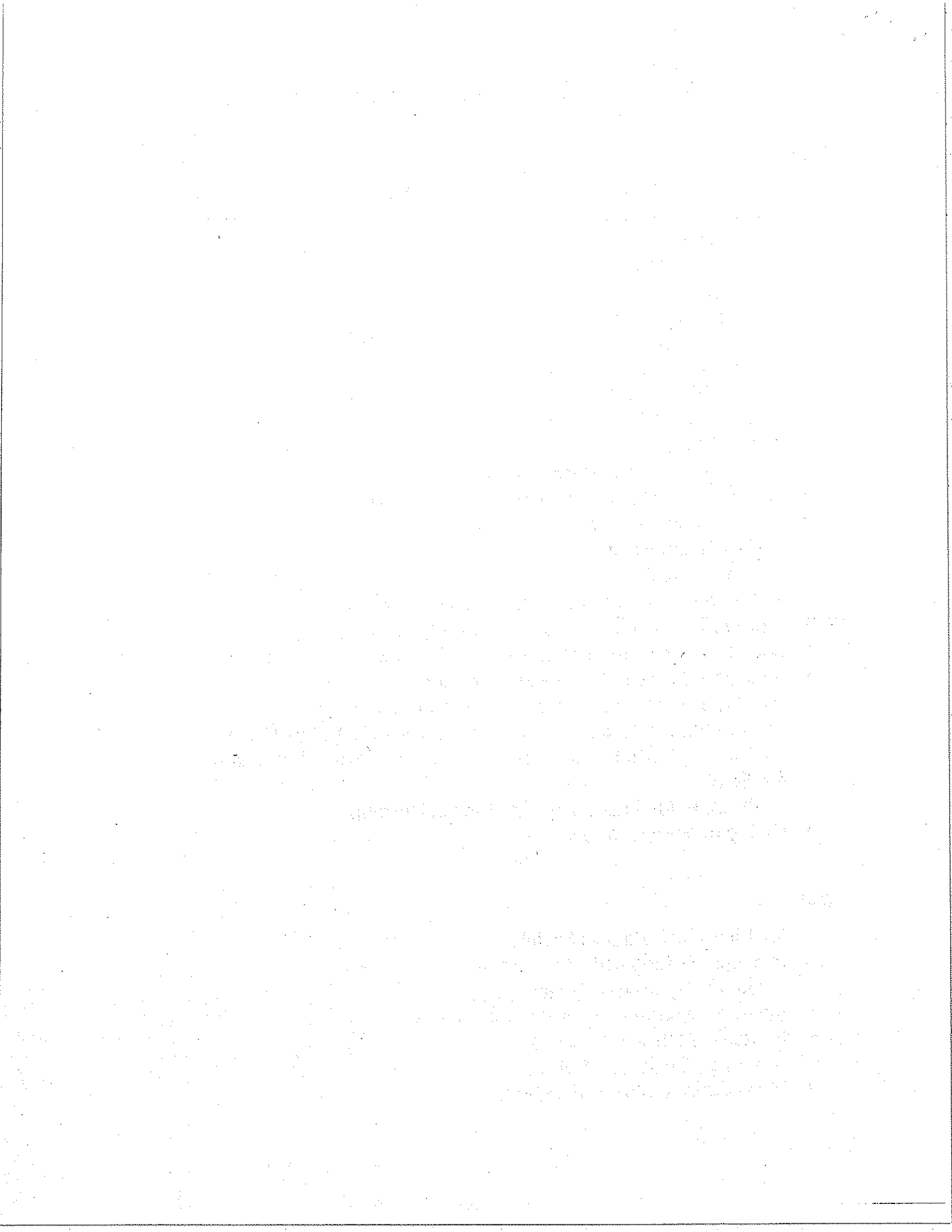
Support For and Opposition to Senate Bill 2

Support:

- Economic Alliance for Michigan, EAM (previously opposed, changed to support due to language in the S-1 version reported from RRR Committee)
- Michigan Workforce Development
- Michigan Primary Care Association
- Michigan Association of Health Plans
- Dr. Daniel McMurtrie, Department Chair of Obstetrics and Gynecology at St. Joseph Mercy Hospital
- Shawn Ulreich, Chief Nursing Executive and Vice President of Clinical Operations at Spectrum Health
- Hope Network
- Michigan Disability Rights Coalition
- School Community Health Alliance of Michigan
- Michigan Pharmacists Association
- MidMichigan Health
- Spectrum Health
- American Association of Retired Persons, AARP
- Coalition of Michigan Organizations of Nursing
- Michigan Association of Colleges of Nursing
- Michigan Council of Nurse Practitioners
- Michigan- American College of Nurse Midwives
- Gerontological Advanced Practice Nurses Association, GAPNA
- MI Chapter National Association of Pediatric Nurse Practitioners, NAPNAP
- Coalition of Michigan Organizations of Nursing
- Michigan Nurses Association

Opposed:

- Michigan Radiological Society
- Michigan Osteopathic Association
- Michigan Psychiatric Society
- Michigan Academy of Family Physicians
- Michigan Orthopedic Society
- American Congress of OBGYN
- Michigan State Medical Society



Snapshot of Advanced Practice Nursing Education

Individuals who have a Bachelor of Science in Nursing (B.S.N.) degree from a nationally professionally accredited program (clinical courses are taken throughout the BSN program) AND who are licensed Registered Nurses (RNs) may apply for admission into graduate nursing education programs in Michigan. State of Michigan licensure is required before individuals can start advanced clinical course work in a graduate nursing program.

Once you have met the requirements above you may either enter a Master's of Science in Nursing program, a post-master's program OR a Doctor of Nursing Practice program.

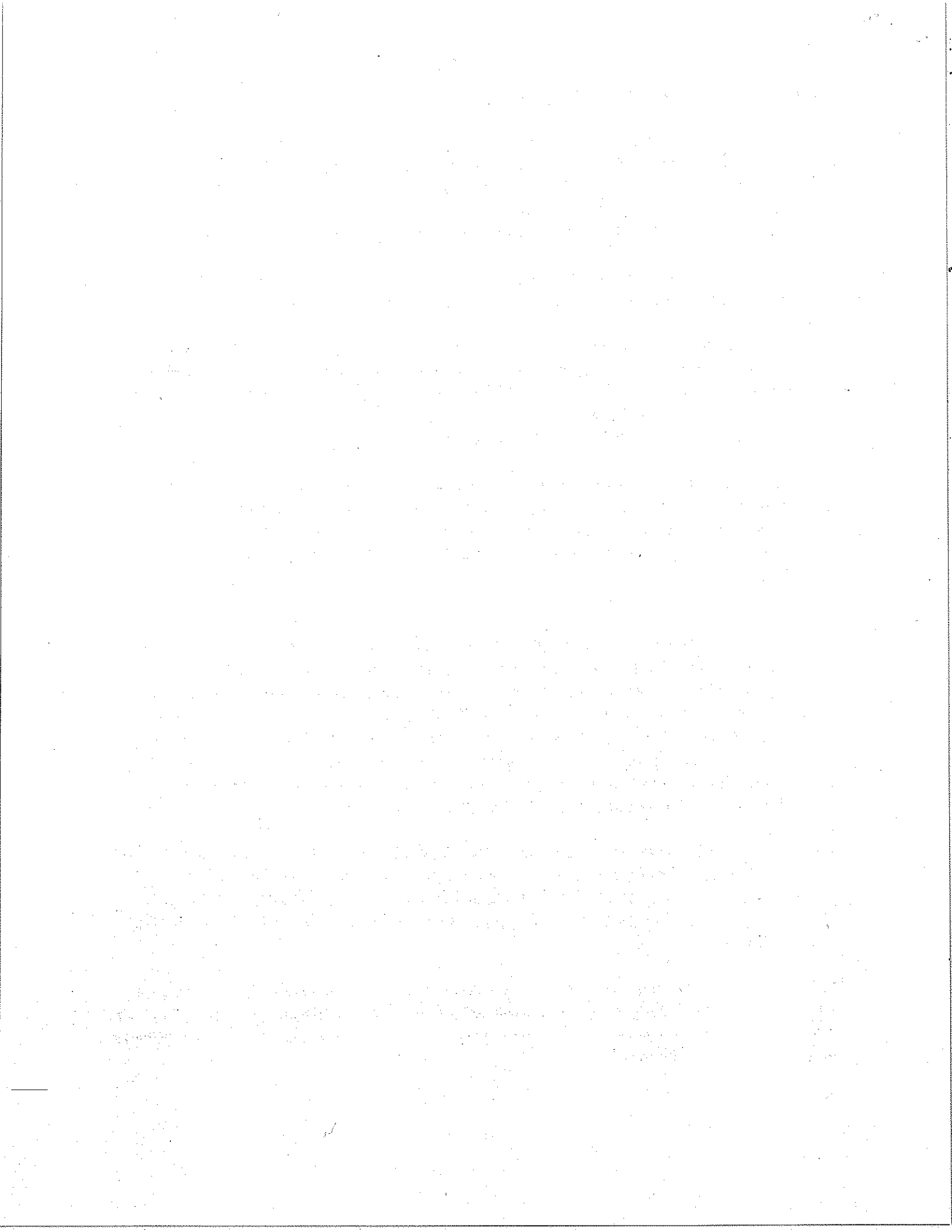
- The Master of Science in Nursing (M.S.N.) program is designed to prepare nurses for advanced nursing practice either as Nurse Practitioners (NP), Certified Nurse Midwives (CNM), or as Certified Nurse Specialists (CNS) in the care of culturally diverse individuals, families, groups, and communities within a variety of healthcare settings. Example of didactic and clinical courses to complete program: 47 credits.

Examples of specialties/concentration include: Adult Acute & Critical Care Nursing, Adult Primary Care Nursing, Gerontological Nursing, Women's Health Nursing, Nurse-Midwifery, Pediatric Primary Care Nursing, Pediatric Acute and Critical Care Nursing, Family Nursing, Neonatal Nursing, Community Health Nursing and Psychiatric Mental Health Nursing

- The Doctor of Nursing Practice (DNP) program is designed to prepare the nurse at the doctoral level of nursing science and prepares clinically focused advanced practice registered nurses who are capable of translating knowledge into the clinical setting that contributes to the positive development of individuals, families, communities, society and the discipline of nursing. Registered nurses can enter the DNP program as a post-BSN student or as a student who has attained a master's of science in nursing (MSN) degree. Example of didactic and clinical courses to complete program: Example of didactic and clinical courses to complete program: up to 87 credits.

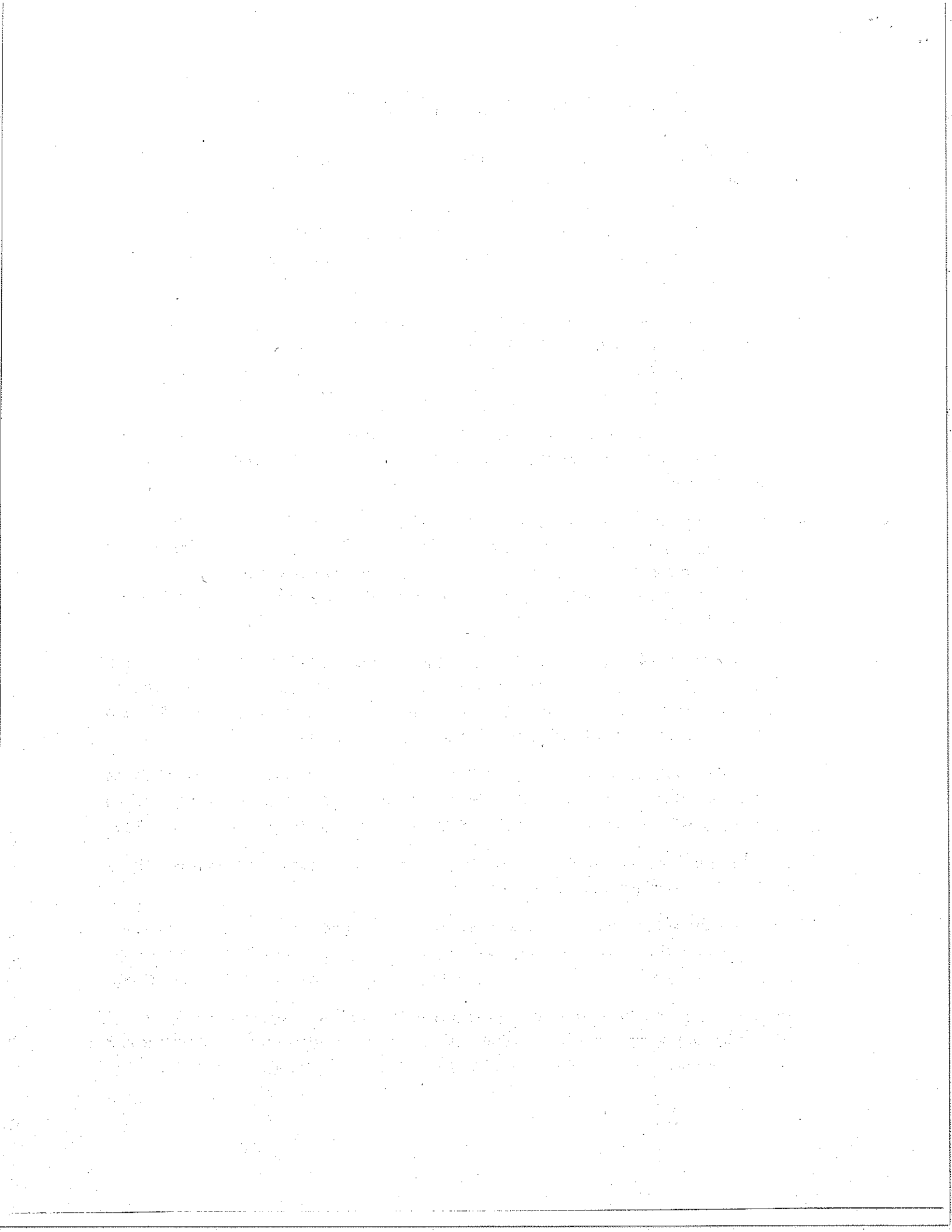
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*****Graduates from graduate degree programs must pass a national competency exam within their specialty in order to receive advanced practice registered nursing credentialing. The APRN curriculum is designed to prepare graduates to qualify for national certification in their anticipated area of population-focused practice.

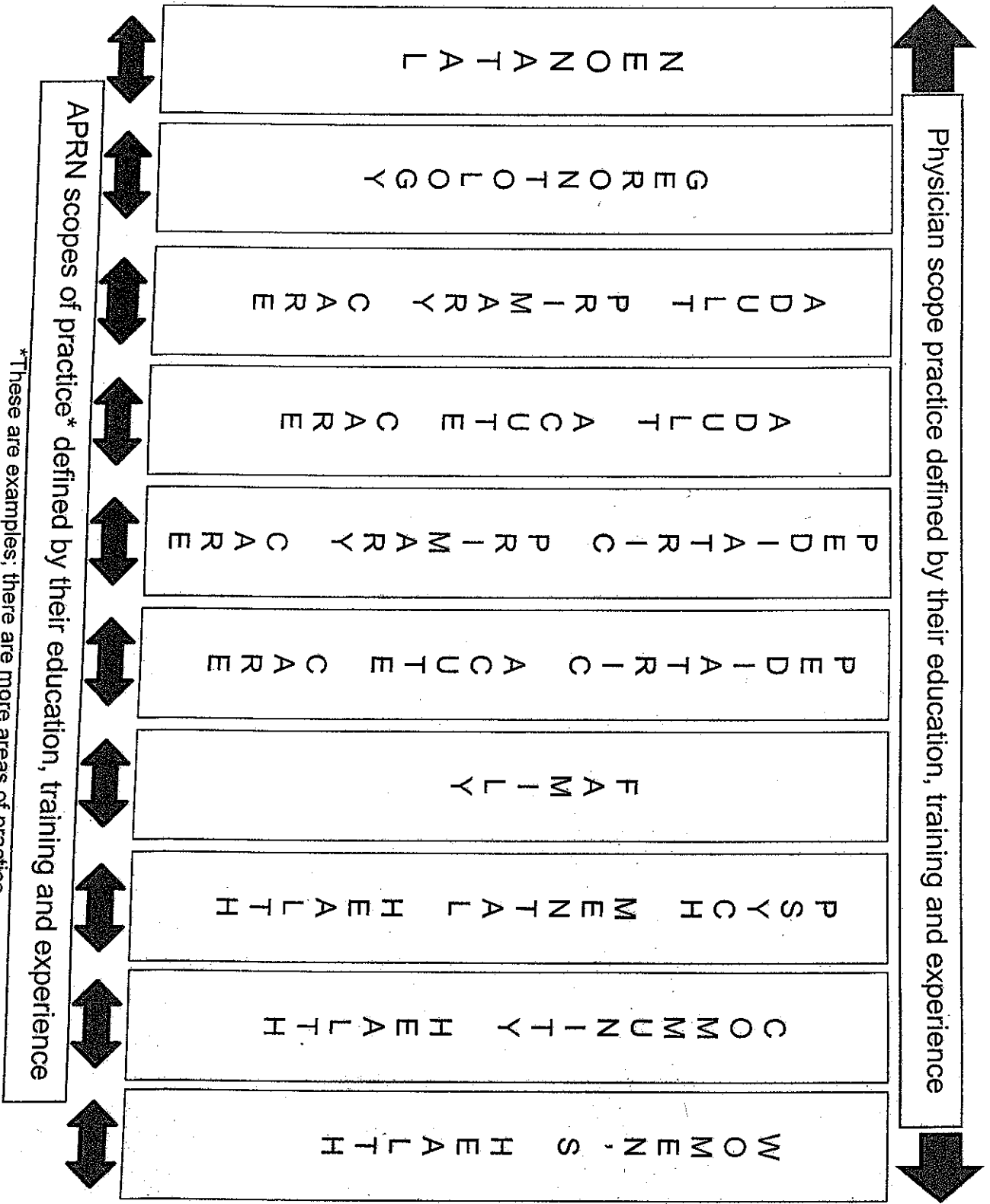


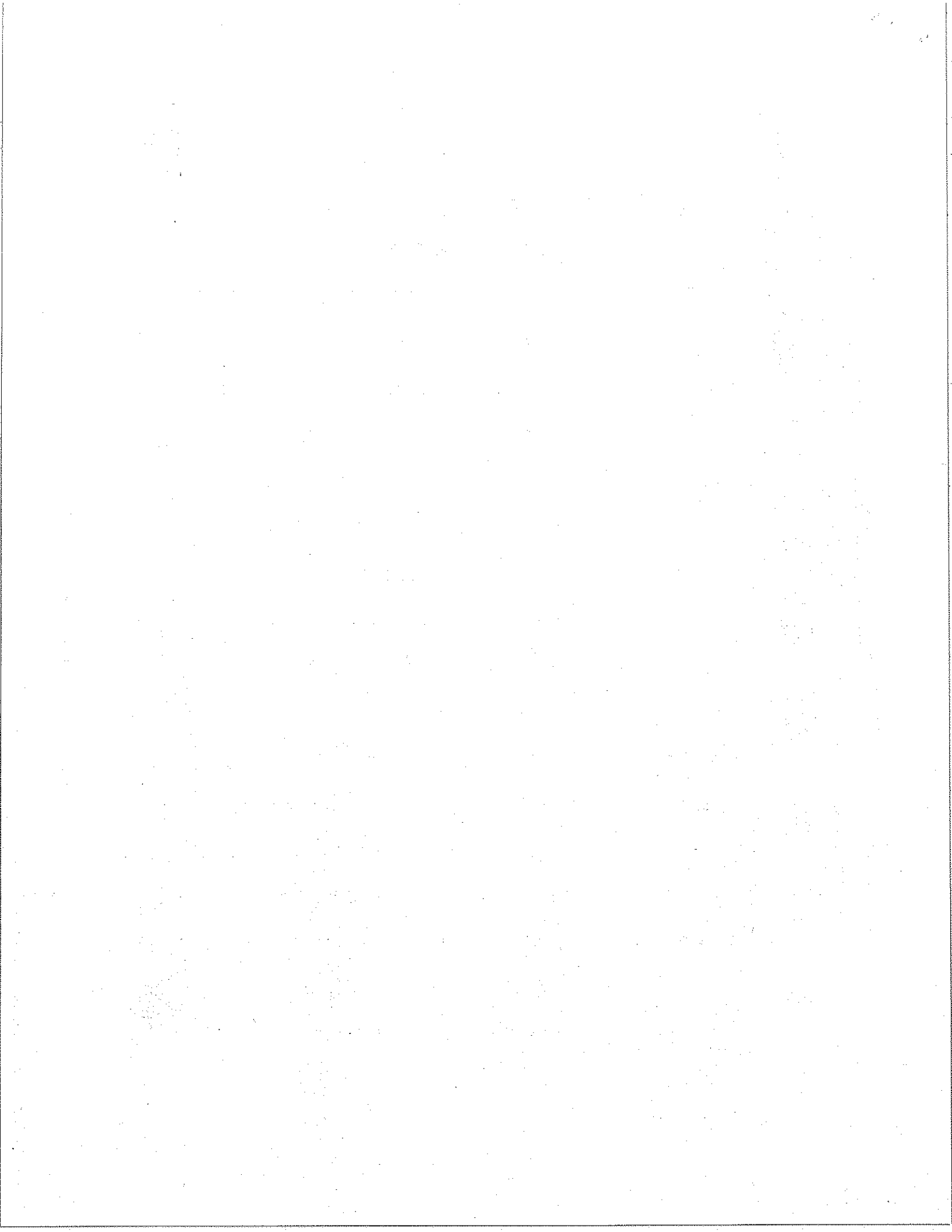
Senate Bill 2: THE FACTS

- Michigan's Public Health Code should be updated to reflect what is currently occurring in practice every day throughout the state. SB 2 defines in statute what activities are within each APRN's **narrow scope of practice based on their education training and national certification**. APRNs currently practice without a definition in the Public Health Code. This is often confusing for patients and other providers.
- In 18 states and DC where APRNs have a defined scope of practice based on their education, training and national certification, **patient outcomes are equal to or better than those of physicians**. (See attached study: "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians".)
- Licensure and full prescriptive authority for qualified APRNs allows for better tracking of patient outcomes, increases transparency of billing and clarifies accountability.
- APRNs support a Patient-Centered Team-Based Model of Care that integrates diverse health care providers, often from different disciplines, around the specific needs of the patient. Under this approach, the **lead health-care provider of the team is determined by the needs of the patient** at the point of care, not by the health-care provider.
- Physician's additional training has not been shown to result in a measurable difference from that of an APRN's in the quality of basic primary care services. (See attached study: "Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors".)
- There is no data to suggest that APRNs in states that impose greater restrictions on their practice provide safer and better care than those in less restrictive state or that the roll of physicians in less restrictive states has changed or deteriorated.
- APRNs tend to move from more restrictive to less restrictive states with a resulting **loss of access to care for patients**.
- For over 20 years, studies have shown that nurse practitioners do not increase liability claims or costs. APRNs carry their own independent liability insurance and have remarkably lower rates of malpractice claims and lower costs per claim.
- A recent estimate projects that **underutilization of NPs costs the nation nearly \$9 billion annually** due to practice restrictions in state laws and other denied access for consumers that are keeping the cost of basic healthcare inflated.



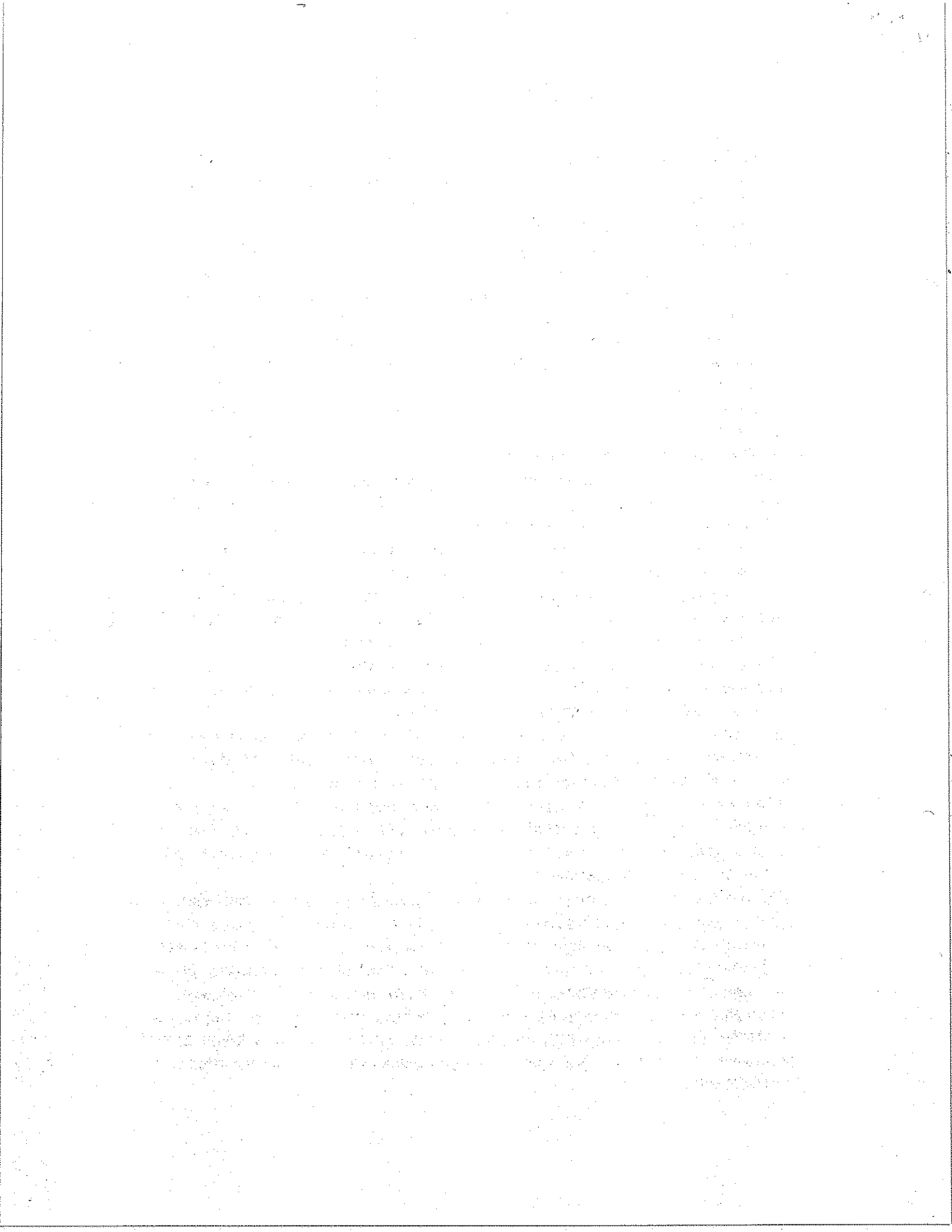
How APRNs scope of practice differs from Physicians





Vote "Yes" for SB 2 Because...

- **Michigan has a significant primary care shortage**, with an expected physician shortage of 4,445 by the year 2020. In 2009, 67 of Michigan's 83 counties had either a partial or full county geographic or population group primary care shortage area (HPSA) designation by the federal government.
- **SB 2 will result in an increase in access to patient-centered health care for the residents of Michigan.** The 18 states that provide an APRN scope of practice reflective of their education, experience, and certification have more providers per population compared to the states that do not have a defined scope of practice in statute.
- **We need to provide a regulatory environment that encourages APRNs to stay and practice here in Michigan.** APRNs tend to move from more restrictive to less restrictive states. APRNs provide quality health care services and increase access to primary care in a wide variety of settings for populations not adequately served by physicians.
- **APRNs provide health care at a lower cost than comparable services by physicians and other qualified health professionals.** A three-year study of health clinics suggested that every dollar spent on APRNs saved several dollars that otherwise would have been spent for physician treatment.
- **Patient safety and efficiency is achieved through SB 2.** Licensure and full prescriptive authority for qualified APRNs allows for better tracking of outcomes, increases transparency of billing and clarifies accountability. SB 2 defines what activities are within each APRN's scope of practice based on their educational training and skill and requires consultation or referral of patients, when appropriate.
- **The quality of APRN care is evident.** Based on 40+ years of research, physician's additional training has not been shown to result in a measurable difference from that of APRNs in the quality of basic primary care services.
- Like other health care professionals, **APRNs need to be responsible for the disciplinary actions of other APRNs.** SB 2 will create an APRN taskforce which will consult with the Board of Nursing on the disciplinary actions of APRNs.
- **Money can be saved by reducing the direct and indirect costs of professional liability.** For over 20 years, studies have shown that nurse practitioners do not increase liability claims or cost. Nurse Practitioners have remarkably lower rates of malpractice claims and lower costs per claim.
- **We need to do all we can to help reduce hospitalization rates in Michigan.** Studies have shown that hospitalization rates were cut almost in half when nurse practitioners directly managed the primary care of nursing home residents. Clinical nurse specialists in hospital settings decreased medical costs, patient complication rates and stay length.
- **We need to encourage lower-cost treatments in health care in Michigan.** Studies comparing APRNs and physicians show that APRNs prescribe fewer drugs, order less expensive tests, and use lower costs treatments, at comparable or better quality than physicians. Patients seen at nurse managed clinics experience higher rates of generic medication fills.



*Advanced Practice Registered Nurses (APRNs)
Providing Cost Effective Patient-Centered Care
Savings in Real Dollars*

- Economic and clinical gains can be reached by allowing APRNs to provide quality and cost-effective health care services in a wide variety of settings. A number of empirical studies support the conclusion that greater utilization of Advanced Practice Registered Nurses can both improve patient outcomes and reduce overall health care costs. In addition, many areas are facing shortages of primary care physicians; APRNs can help alleviate these problems.
- For over 30-years, nurse practitioners have provided high-quality, cost-effective care. In 1981 the Office of Technology Assessment first demonstrated that nurse practitioners perform comparable medical care tasks at a lower total cost than physicians, and the same remains true today.
- The cost of health care could be reduced immediately by modernizing regulations and policies that reimburse higher cost health professionals (doctors) for the same services provided by nurse practitioners. APRNs typically get reimbursed at a lower rate for services. In 2009, the national average cost of a nurse practitioner visit was 20% less than a visit to a physician.
- The use of nurse practitioners can save money by reducing the direct and indirect costs of professional liability. For over 20 years, studies have shown that nurse practitioners do not increase liability claims or costs. Nurse Practitioners have remarkably lower rates of malpractice claims and lower costs per claim.
- A study in Tennessee found that costs at nurse managed clinics were 23% below the cost of care delivered by other primary care providers, inpatient hospitalization rates were 21% lower, lab utilization rate was 24% below other primary care providers, and prescription drug utilization is 42% below average.
- Studies have shown Clinical Nurse Specialists continue to decrease medical costs, patient complication rates and length of stay in hospital settings.
- A study has shown infants cared for by Neonatal Nurse Practitioners over medical residents averaged 2.4 fewer days in the hospital and between a cost-savings of \$3,491-\$18,240 per infant patient.
- A large corporation in North Carolina housed an on-site clinic run by nurse practitioners to provide employees with health care services. The annual cost savings for the employer was over \$1.3 million; yielding a benefit cost ratio of 15 to 1.

- Utilization of Nurse Practitioners to manage our aging population could net up to a \$166 billion in health care savings across the country.
- A recent estimate projects underutilization of Nurse Practitioner costs the nation nearly \$9 billion annually due to practice restrictions, outdated state laws and other denied access for consumers to health care.
- In 2009 researchers showed that nurse practitioners provide care of equivalent quality to physicians at a lower cost, while achieving high levels of patient satisfaction and providing more disease prevention counseling, health education, and health promotion activities than physicians.
- After insurance reform in Massachusetts, the state demonstrated that they could gain a cost savings of \$4.2 to \$8.4 billion over a 10-year period from increased use of nurse Practitioners.
- Treatment provided by nurse practitioners in retail clinics cost less than treatment in physician offices and urgent care centers with no apparent adverse effect on quality or delivery of care.
- A worksite clinic run by a single nurse practitioner resulted in direct medical care cost savings of nearly \$2.18 million over a two-year period, without including indirect savings related to lost productivity and absences.
- Clinics run by nurse practitioners create cost savings associated with reduced use of emergency rooms, urgent care centers, hospitals, and emergency medical services.
- In Texas, when Advanced Practice Registered Nurses are utilized within the systems of health care provision more efficiently, the economic benefits to the state are substantial. Estimates show the total current impact of enhanced efficiency includes \$16.1 billion in total expenditures and \$8.0 billion in output (gross product) each year as well as 97,205 permanent jobs in Texas. This economic activity also leads to additional tax receipts; which include \$483.9 million to the State and \$233.2 million to local government entities each year.
- A study conducted by Florida state government estimated that eliminating practice barriers and greater utilization of APRNs (and physician assistants) can generate potential cost savings of \$7 million to \$44 million annually for Medicaid, \$744,000 to \$2.2 million for state employee health insurance, and \$339 million across Florida's entire healthcare system.

APRN Response to Physician Misleading Assertions on SB 2

Senate Bill 2 does not erase any meaningful legislative or regulatory distinction between physicians and nurses. Rather, it defines the scope of practice for Advanced Practice Registered Nurses (APRNs), who are currently undefined in Michigan's Public Health Code.

- Senate Bill 2 does nothing to impact the education and residency training required of physicians or impede on their defined scope of practice. APRNs agree that a physician's years of medical education and training are vital to the health care team and optimal patient care.
 - A family physician usually obtains a four-year bachelor's degree in any field, then goes on to medical school for four years, and must complete a three years of residency training. Students interested in obtaining their Advanced Practice Registered Nursing license must have a Bachelor's degree in Nursing (BSN), have passed the national licensure exam and hold an active registered nursing (R.N.) license to be considered for admittance into a nationally accredited graduate nursing program.
 - Once an applicant has met the requirements above, they may either enter a Master's of Science in Nursing program OR a Doctor of Nursing Practice program.
 - *The Master of Science in Nursing (M.S.N.) program* is designed to prepare nurses for advanced nursing practice either as Nurse Practitioners (NP), Certified Nurse Midwives (CNM), or as Certified Nurse Specialists (CNS) in the care of culturally diverse individuals, families, groups, and communities within a variety of healthcare settings. Example of didactic and clinical courses to complete program: 47 credits.
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- Graduates from either graduate degree program must pass a national competency exam within their specialty in order to receive advanced practice registered nursing credentialing.
- o Senate Bill 2 allows for APRNs to practice nursing to fullest extent of their education, training and certification. It does not allow for APRNs to practice independently.
 - o APRNs are educated, trained and nationally certified to diagnose, treat and manage patients. This includes ordering, performing, supervising and interpreting laboratory and imaging studies based on their specialty role. While in nursing school or while taking their national certification examination, students do not "call a doctor" to get advice. They are educated to practice nursing, autonomously.
 - o Senate Bill 2 requires consultation with other health professionals and referral if the patient's care is outside the parameters of the APRNs education, training and national certification.

Team Based Care: The Michigan Council of Nurse Practitioners (MICNP) supports the implementation of the Institute of Medicine's (IOM) concept of team based care. All members of a health care delivery team should practice to the fullest extent of their educational preparation in order to provide high quality care for patients at the appropriate time and in various settings to meet the patients' needs and desires.

- o The Institute of Medicine's (IOM) concept of team based care is; "... the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively, to the extent preferred by each patient.
- o The purpose of Team Based Care is to provide coordinated, high quality, and patient-centered care." (IOM - Best Practice Innovation Collaborative, 2012). Collaboration is defined as the communication, coordination and cooperative efforts of health care professionals around care delivery.
- o Team based care is a systems approach to care delivery and is not a regulatory construct.

- The team concepts of well communicated care, coordinated information sharing and cooperative partnerships among patients and various health care professionals have always been the foundation of nursing practice. It is the belief of MICNP that in systems utilizing coordinated care models, such as team based care, the following principles apply:
 - The patient is the center of the health care team.
 - Health care teams consist of patients and their health care providers.
 - The health care team does not belong to a single provider, system or health care discipline.
 - The health care team is dynamic, with the needs of the patient directing who best can lead the team at any given point of time.
 - Characteristics of the health care team include:
 - Patient identified and supported goals
 - Mutual trust among all participants
 - Effective communication
 - Measurable processes and outcomes in the provision of health care services

The physician organizations in Michigan are inaccurately representing the statutory changes that occurred in Texas and Virginia.

The Virginia Council of Nurse Practitioners (VCNA) has made an official statement regarding the misrepresentation by physician groups (including those in Michigan) regarding the recently passed legislation in Virginia that impacts APRNs. VCNA does not endorse similar legislation to be passed in other states. Background: Virginia was a very restrictive state for APRNs to practice- and HB 346, which passed in 2012, removed the word “supervision” and the requirement that physicians regularly practice in the same settings as Nurse Practitioners. The law allowed for a less restrictive consultative and collaborative approach. However, VCNP does NOT endorse physician-led teams.

In Texas, Nurse Practitioners must practice within 75 miles of their overseeing physician, preventing many NPs from settling in locations that are more rural. Further- prescriptive authority for NPs is limited to site-based authority, for medically underserved populations only. Each site has its own set of restrictions. Texas APRNs want a similar law to be passed, as SB 2 (MI). A recent report conducted in Texas shows that allowing APRNs to practice to the full extent of their education and certification would enhance efficiency, increasing state economic output by \$8 billion and create nearly 98,000 permanent jobs. The economic stimulus would spark additional yearly tax receipts of \$483.9 million in the state of Texas and \$233.2 million to local governments.

Responses to Actual Misleading Claims Made by Physician Organizations regarding SB 2

Misleading Claim: The language of Senate Bill 2 is an unwarranted expansion of scope of practice.

APRN Response: SB 2 does NOT expand APRN scope of practice.

Misleading Claim: Senate Bill 2 creates a scope of practice for APRNs that allows independent practice in nearly any setting. There is no language about specifying when and how an APRN should interact with a physician.

APRN Response: Language included in SB 2 (S-1, as reported out of committee) specifically states in each definition of their narrow scope of practice (Clinical Nurse Specialist, Certified Nurse Midwife, and Nurse Practitioner) that an APRN is limited to provide healthcare services that are ONLY within their education, training and national certification.

SB 2 requires consultation with other health professionals and referral if the patients care is outside the parameters of the APRNs education, training and national certification (pg.19). The legislation also limits prescriptive authority and diagnosing ONLY within their specialty role through their education, training and national certification.

SB 2 also requires new APRN graduates to complete a 2 year mentorship agreement with a physician or an independent prescriber in order to obtain their full-prescriptive authority license.

Misleading Claim: Senate Bill 2 would treat a nurse differently than a physician assistant (PA). PAs are highly trained professionals that have as much education as APRNs, but would be regulated in completely different fashion than APRNs. This inconsistency would further complicate the delivery of service to patients.

APRN Response: APRNs are highly trained health professionals; who are required to have a 4-year Bachelor of Science in Nursing degree, Registered Nurse (R.N.) license, and pass a national RN licensing exam PRIOR to being admitted into a graduate nursing program to pursue an advanced practice registered nursing degree (which takes an additional 2-4 years after their required undergraduate nursing bachelor's degree). All nurses practice NURSING.

Physician Assistants practice medicine (as defined under the Public Health Code). **Physician Assistants (PA's) DO NOT have similar or more education than APRNs.** It takes 24 months to become a physician assistant, once you have obtained a bachelor's degree in ANY field. Some Physician Assistants programs are Bachelors programs. The Public Health Code specifically states physician assistants are a sub-field of medicine and are directly supervised by physicians-APRNs are NOT.

Misleading Claim: Senate Bill 2 regulates nurses similar to a minority of states that completely eliminates the collaborative model of health care delivery from the statute.

APRN Response: 19 states and Washington DC allow for APRNs to practice to the fullest extent of their education, training and national certification, and allow for full prescriptive authority (similar to that of SB 2). Michigan ranks 46th worst state for restrictive practice for APRNs.

Misleading Claim: Senate Bill 2 shifts scope of practice of APRNs out of the control of the state legislature and defers future considerations to the national nurse organizations.

APRN Response: Just as physicians and other health professionals pass national competency exams upon completion of their degree in order to obtain licensure in their healthcare field, so do APRNs. Michigan Board of Nursing rules require that NPs and CNMs be graduates of an accredited graduate nursing program and be nationally certified by established accredited certifying bodies before they can obtain a specialty certification to practice as NPs or CNMs.

Regulation of APRNs in Michigan will continue to be under the Michigan Department of Licensing and Regulatory Affairs (Bureau of Health Professions) and the Michigan Board of Nursing.

Misleading Claim: Senate Bill 2 creates a category of “unlimited license for nurses. This designation has been rejected in every other profession except in medicine.
-Referral and consultation requirements are completely left to the discretion of the APRNs (p. 17, line 22).

APRN Response: This legislation does NOT allow APRNs to have an unlimited license. SB 2, S-1 version, limits each APRN ability to practice nursing to only what is within their education, training and national certification-. The S-1 version also includes language on referral and consultation (pg. 19).

Misleading Claim: Amendments were included that allegedly limits the services that an APRN could provide by requiring that the service must be “within his or her scope of practice”. This language is virtually meaningless in that their scope as defined in the bill is already broad enough to allow virtually any service that is currently provided by an MD or DO to be included, and the ultimate arbiter of what is within their scope of practices would be their licensing board as guided by their national certifying entity.

APRN Response: The suggested language added “within his or her scope of practice” was at the request of the Economic Alliance of Michigan (EAM). Scope of practice is defined not just by statute and regulation. It is also defined by education/training and certification. Therefore, NP, CNSs and CNMs could only practice in areas that they had formal accredited education/training and their competency verified through national certification. The Board of Nursing (BON) in Michigan continues to be one of the most active and diligent regulatory boards regarding the monitoring of nurses who have licensure and practice issues, including advanced practice nurses. The APRN coalition supports the work of the BON and the job they have done in maintaining the safety and well-being of the citizens of Michigan.

Misleading Claim: Certified Nurse Midwife -p. 14, “Comprehensive maternity care including prenatal care”, this language makes no meaningful distinction between services provided by an APRN as opposed to an OB/GYN. This could literally include any service a pregnant mom could need including unsupervised surgical services. Offering the full scope of surgical services are only excluded because the national certifying body does not allow them...yet.

APRN Response: There is no support for this allegation in the other states that have allowed full autonomous practice for midwives. Nurse-midwives are not advocating for an expansion of their scope of practice, but rather appropriate recognition of the types of services their education and training prepares them to provide. The scope of midwifery practice may be expanded beyond the core competencies to incorporate additional skills and procedures that improve care for women and their families. Primary health care, which is a component of midwifery care includes, but is not limited to, the provision of integrated, accessible health care services that address the majority of health care needs for women.

The scope of practice for certified nurse-midwives is delineated within several American College of Nurse-Midwives (ACNM) standards, including “Core Competencies for Basic Midwifery Practice” and “Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives.”

Briefly, the appropriate scope of practice for CNMs is defined by ACNM to include “primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis and treatment. They conduct physical examinations; prescribe medications including controlled substances and contraceptive methods; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests and order the use of medical devices. Midwifery care also includes health promotion, disease prevention, and individualized wellness education and counseling.”

Misleading Claim: p. 14, “Childbirth in diverse setting”, this language provides that a Nurse Midwife could practice outside of a facility and without a relationship with an OB/GYN to handle potential complications.

APRN Response: The phrase “childbirth in diverse settings” refers to care offered in ambulatory care clinics, private offices, community and public health systems, homes, hospitals and birth centers. The variation in practice sites reflects differing scopes of practice amongst midwives (some of whom may only provide gynecological care, for example). Numerous studies have confirmed the safety of midwifery care in all settings.

Regardless of the setting, scope of practice requires that CNMs practice within a setting that provides for consultation, collaborative management, or referral, as indicated by the health status of the client.

Misleading Claim: p. 14, “Newborn care”, language was included to specify that a nurse midwife could offer care to infants up to 28 days. While this is somewhat helpful, it does not

provide any specificity with respect to what services could be offered or when it would be required than an APRN refer the infant to a pediatrician.

APRN Response: According to the “Core Competencies for Basic Midwifery Practice,” routine newborn management centers on applying midwifery knowledge and training to newborns, such as effects of maternal/fetal risk factors on the newborn; bonding and attachment theory; evaluation of the newborn: initial gestational age assessment and initial and ongoing physical and behavioral assessment; methods to facilitate adaptation to extrauterine life: (i) stabilization at birth, (ii) resuscitation, and (iii) emergency management; primary health screening, health promotion and assessment of growth and development up to 28 days of life; facilitation of the initiation, establishment, and continuation of lactation; management strategies to facilitate integration of the newborn into the family; and indications of deviation from normal, recognizing which infants should be referred to their pediatric care provider for further evaluation and care.

Misleading Claim: p. 14, “GYN reproductive health”, this is an extremely broad definition that could include very complex fertility treatments such as in vitro fertilization and other services. Language is not limiting in any way.

APRN Response: According to the “Core Competencies for Basic Midwifery Practice,” routine gynecologic care offered by CNMs includes common screening and diagnostic tests; parameters for differential diagnosis of common uro-gynecologic problems; management strategies and therapeutics for gynecologic health, implementation of contraceptive methods, and common uro-gynecologic problems; management strategies and therapeutics for sexually transmitted infections that includes indicated partner evaluation, treatment, or referral; counseling for sexual behaviors that promote health and prevent disease; and counseling, clinical interventions and/or referral for unplanned or undesired pregnancies, sexual concerns, and infertility.

CNMs who seek additional training and education may provide an expanded scope of care. The Standards for the Practice of Midwifery require that the midwife first identifies the need for a new procedure taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel; ensures that there are no institutional, state, or federal statutes, regulations, or bylaws that would constrain the midwife from incorporation of the procedure into practice; demonstrates knowledge and competency, including: a) Knowledge of risks, benefits, and client selection criteria. b) Process for acquisition of required skills. c) Identification and management of complications. d) Process to evaluate outcomes and maintain competency; identifies a mechanism for obtaining medical consultation, collaboration, and referral related to this procedure; and maintains documentation of the process used to achieve the necessary knowledge, skills and ongoing competency of the expanded or new procedures.

Misleading Claim: p. 14, “Treatment of male partners for STI and reproductive health”, this could mean something as simple as providing antibiotics for an STI or could be as invasive as a vasectomy or a vasectomy reversal.

APRN Response: Midwifery practice includes the treatment and/or referral of male sexual partners for sexually transmitted diseases. Midwives do not care for men, but rather can treat male STIs in the context of treating a female partner who has tested positive for an infection.

Multiple states have recognized the value of this aspect of midwifery training and have formalized the arrangement with expedited partner therapy statutes. These laws arose after the Centers for Disease Control (CDC) recommended that health care providers who treat patients for chlamydia and gonorrhea also provide treatment for the patient's partner, even if he or she has not been seen by the provider, in 2006. As of July 2013, 26 states allow health care practitioners to provide at least some STI treatment for the partner of a patient diagnosed with an STI without first examining the partner.

Misleading Claim: p. 14, "Diagnosis and treatment of common health problems", this could literally mean almost any condition and any intervention to treat.

APRN Response: Certified nurse-midwives are providers of primary care for women and newborns. The "Core Competencies for Basic Midwifery Practice" describe the fundamental knowledge, skills, and behaviors expected of a new practitioner, including the provision of primary health care for women from the premenarcheal through the postmenopausal phase.

Midwives are trained to independently manage infections, self-limited conditions, and mild and/or stable presentations of chronic conditions, utilizing consultation, collaboration, and/or referral to appropriate levels of health care services as indicated. Specifically, midwives may identify deviations in the following areas and refer clients to the appropriate healthcare provider for follow-up: Cardiovascular/hematologic; Dermatologic; Endocrine; Eye, ear, nose, and throat; Gastrointestinal; Mental health; Musculoskeletal; Neurologic; Respiratory; and Renal.

CNMs are often the initial contact for women seeking health care. They provide such care on a continuous and comprehensive basis by establishing a plan of management with the woman. Furthermore, midwives provide care in the context of cultural, socioeconomic, and psychological factors that may influence the health status of the woman.

CNMs are recognized as primary care providers under existing federal health care programs, including those that address primary care workforce expansion, reimbursement for services, and loan repayment programs.

Misleading Claim: p. 14, "...consultation or referral as indicated", this is left to the discretion of the APRN, and therefore is nearly meaningless in terms of being a statutory constraint.

APRN Response: The objective of statute is to protect the citizens of the state. Safe, quality health care can best be provided to women and their infants when policy makers develop laws and regulations that permit CNMs to provide independent midwifery care within their scope of practice while fostering consultation, collaborative management, or seamless referral and transfer of care when indicated, as previously noted.

Twenty-two states currently recognize CNMs as independent practitioners and have felt no need to include “statutory constraint” of their practice. Numerous studies have concluded that CNMs provide care that is equal to the care provided by physicians in all types of regulatory environments. Midwives are safe and efficacious providers who are trained to work within a collaborative system with physicians and other healthcare providers. It is important to note that their outcomes remain consistent across all regulatory frameworks, and there is no evidence to support the belief that supervision or similar statutory constraints protect patient populations.

Misleading Claim: Certified Nurse Practitioner p. 15, “Diagnosing, treating, and managing patients with acute and chronic illnesses”, diagnosing, treating, and managing would include nearly any intervention while acute and chronic illness would cover the full range of conditions a patient might have. This language is extremely broad and essentially erases any distinction between a doctor and a APRN from a statutory perspective.

APRN Response: Nurse Practitioners are educated, trained and nationally certified to diagnose, treat and manage patients. This includes ordering, performing, supervising and interpreting laboratory and imaging studies based on their specialty role. While in nursing school or while taking their national certification examination, students do not “call a doctor” to get advice. They are educated to practice nursing, autonomously. Research evidence (over 45* years worth) in the states that NPs and CNMs diagnose and treat common health problems that they have done so appropriately, with quality equal to that of physicians and with great patient satisfaction.

Misleading Claim: p. 15, “Ordering, performing, supervising, and interpreting laboratory and imaging studies”, this language is extremely broad and would allow APRNs to essentially practice as pathologists and radiologists without any limitations.

APRN Response: SB 2 limits APRNs by ONLY allowing them to practicing within the scope of their education, training and certification; hence this alone would preclude nurse practitioners from working as pathologist and/or radiologists.

Misleading Claim: p. 15, “Prescribing pharmacological... and scope of practice”-given the broad definitional parameters in the preceding portion, this language is not limiting in any way.

APRN Response: Nurse Practitioners education and training includes prescribing within their specialty role. The Michigan Pharmacists Association supports SB2.

Misleading Claim: Certified Nurse Specialists p. 16, “Responsible and accountable for diagnosis, intervention and treatment of health illness states”, this language again essentially provides the full range of possible care to patients without any distinction between the level of expertise of a physician or an APRN.

APRN Response: These responsibilities of Clinical Nurse Specialists are consistent with the wording in the national standards for CNS practice published by the National Association of Clinical Nurse Specialists (NACNS) and with the Consensus Model for APRN Practice which was accepted by all of the major national nursing associations. This excerpt of wording from p.16 of SB 2 is also clearly linked with language that refers to exercising these responsibilities

within “the parameters of his or her education, training and national certification” for the role. This refers to diagnosis, intervention and treatment of health illness states by CNSs practicing nursing from a focus of advanced preparation in nursing, not practicing medicine.

Misleading Claim: p. 16, “pharmacological and non-pharmacological disease management”, this language is extremely broad and is worded in such a way as to assure that no option is excluded.

APRN Response: Again, this excerpt is accompanied by language specifying that this is to be within CNSs “specialty and scope of practice”. This scope of practice is defined by educational preparation and national standards and certification for CNSs. It is not an expansion of scope into the practice of medicine. In most settings for CNS practice, the need for prescriptive authority is mainly non-pharmacologic for items such as wound care and dressing supplies of home care supplies and equipment.

Misleading Claim: p. 16, “Translates evidence into practice”, this language is extremely broad. The practice of medicine is predicated on specific and statistical evidence in formulating treatments and interventions. Therefore, this language could be interpreted as providing APRNs with the ability to perform any task that is supported by some sort of evidence. This could create an unlimited scope of practice for these three professionals.

APRN Response: One of the major areas of focus for all Clinical Nurse Specialists is the improvement of patient outcomes through advancing the science of nursing. Translating credible evidence from health care disciplines into improvements in the practice of nurses directly caring for patients is a key component of improving the safety, quality, and cost-effectiveness of nursing practice and health care across the spectrum of care settings. Clinical Nurse Specialists have extensive education and preparation in evaluating new evidence, piloting practice changes, evaluating patient outcomes, and facilitating effective change in health care systems.

Misleading Claim: Senate Bill 2 is based on national consensus statement contained in a document authored by many of the nursing groups at the national levels. While there may be justification for elements of this statement to be included in the Public Health Code, simply overlaying the broad terminology of this statement into Michigan Law is not conducive facilitating a team-based approach to health care. Furthermore, without some sort of counterbalance to the inclusion of this extremely broad language into the Public Health Code, the differences between the training of physicians and advanced practice nurses will no longer be reflected in law.

APRN Response: The Michigan Public Health Code allows for physician’s to have an unlimited scope of practice within a patient’s lifespan. SB 2 defines a narrow scope of practice for 3 APRN roles, within their specialty area, which is based on a population foci, and with oversight of the state Bureau of Health Professions and the State Board of Nursing. Examples of specialties of APRNs include: Adult Acute & Critical Care Nursing, Adult Primary Care Nursing, Gerontological Nursing, Women’s Health Nursing, Nurse-Midwifery, Pediatric Primary Care

Nursing, Pediatric Acute and Critical Care Nursing, Family Nursing, Neonatal Nursing, Community Health Nursing and Psychiatric Mental Health Nursing.

