This document is the response to the request by the Chair of the Health and Human Service Policy Committee to identify areas of disagreement with the questionnaire submitted by the Minnesota Advanced Practice Registered Nurse Coalition on HF 435. This is submitted on behalf of the Minnesota Medical Association, Minnesota Academy of Family Physicians, Minnesota Society of Anesthesiologists, Minnesota Chapter of the American College of Emergency Room Physicians, Minnesota Chapter of the American Society of Interventional Pain Physicians, and Minnesota Psychiatric Society.

Below are the selected responses from the APRN Coalition where there is disagreement and our response following theirs in red.

LEGISLATIVE QUESTIONNAIRE FOR NEW OR EXPANDED REGULATION OF HEALTH OCCUPATIONS
Submitted to the Minnesota Legislature
by the Minnesota Advanced Practice Registered Nurse (APRN) in collaboration with the Minnesota Board of Nursing
January 29, 2014

HF435: A bill for an act relating to health; improving access to health care delivered by advanced practice registered nurses

Responses to Legislative Questionnaire Items #1-9
1. How is this profession's scope of practice in the area of proposed change currently defined and what failings or shortcomings are being addressed by the proposed changes to the profession's scope?

This bill refers to scope of practice of the four categories of advanced practice registered nurses (APRNs): certified clinical nurse specialist (CNS), certified nurse midwife (CNM), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA).
No expansion of APRN scope. **The bill does not expand the scope of practice of what each APRN role may perform and allows APRNs to practice to the full extent of their education and training.** All four categories of APRNs are currently authorized to practice nursing care, diagnose, treat, manage patient care, order necessary diagnostic tests and procedures, prescribe pharmacological and non-pharmacological agents, and consult and collaborate with, and refer patients to other health professionals as appropriate to their role (e.g. CNS, CNM, CNP, CRNA) and their specific focus population (e.g. Pediatric NP or Adult/Geriatric NP).

We believe this bill does expand the scope of practice of APRNs in two ways. First, while many of the functions included in the bill can currently be performed by APRNs, it is a significant expansion when these functions can be done with complete independence, especially prescribing where a delegated prescribing agreement is required.

Second, the bill as introduced does include an expansion of scope for certified registered nurse anesthetists (CRNAs). This bill would allow CRNAs, who today practice in the operating suite, to expand into outpatient practice in the area of pain management and more. Interventional pain management is a specialized field of medicine that is not the delivery of anesthetics. The treating physician often must prescribe complex medication management and coordinate long-

term physical therapy, oncology, rehabilitation, surgical consultations, psychology services, and many times complex surgical procedures. All aspects of this type of care lie fully outside the scope of perioperative "anesthesia-related care."

Since 1999 -- when the Institute of Medicine published the safety report "To Err is Human" -- physicians, nurses, ancillary providers, and health care administrators have agreed that organized physician-led teams deliver the best, safest medical care. This has been the goal and direction of the Legislature in efforts to reform our health care system. The entire Health Care Home model is based on the patient-centered, physician-lead, medical home model that is being embraced across the country.

In addition, anesthesiology has been a pioneer in recognizing the value of physicians and nurses working in highly organized teams (termed the Anesthesia Care Team (ACT)). Physician directed anesthesia delivery is critical in handling some of the most complex health care conditions -- an area that APRNs agree is best addressed by team-based care. Anesthesiology is by definition complex health care, and thus best addressed by physician-delivered care or the anesthesia care team model. Thus, an anesthesiologist or another physician directs this team to ensure patient safety while delivering cost-effective care. Indeed, anesthesiologists are active in creating further refinements of this model with the futuristic Perioperative Surgical Home (PSH) concept. This includes assessment and complex medical decision making in the in pre-operative assessment clinic, the operating room, the recovery room, and the ICU.

3. How would the public benefit by the occupation's ability to practice in the new proposed areas of practice? Is there any potential detriment to the public? Who would monitor practitioners to insure high quality service?

Increase access to care for Minnesota citizens. Removing barriers to APRN practice will benefit the public. First, it allows all licensed APRNs who are educated and trained to deliver health care, without restraint of trade by another profession. This increases consumer access to care and choice of provider. Minnesota has 106 primary care health provider shortage areas (HPSAs) and 53 mental health HPSAs (MDH, June 2012). APRNs have the requisite education and training to meet specific health care needs of citizens in these HPSAs.

Decrease health care costs. Removing barriers to APRN practice has the potential to control or decrease health care costs by increasing competition in the health care market place and allowing for full utilization of APRNs who deliver care at a lower cost to the system. Not all patient health care needs to be delivered by a physician. In fact, often times patients need health care that requires nursing intervention or expertise in procedures that can very safely be performed by APRNs (e.g. routine physician exams, health promotion, education about chronic disease management, control of high blood pressure, diagnosis of strep throat, routine maternity care, problem-solving social determinants of health or lifestyle issues that interfere with health or chronic disease management). Management of health care costs should include determining the requisite education and training needed to provide the level of health care needed by a patient at a particular time in the health care experience.

Whenever the legislature debates licensing bills they must balance the need to allow practitioners to practice what they want and the need to protect the public from possible harm. The reason the legislature has require collaborative practice for APRNs and physicians is to ensure the protection of the public. Licensing laws are not intended to protect us against the good practitioner, they are there to protect from the less then good practitioner. This bill removes a level of protection from the law.

Second, there is not good data that this bill will help decrease health care costs. While supporters will cite statistics that APRNS are less expensive because they generally have lower salaries than physicians, there are other studies that show that APRNs order more diagnostic tests and images adding to overall health care costs.

In addition, it is important to also take into account the multitude of practice settings. The APRN response specifically states that a team-based approach to health care delivery is optimal in situations involving complex patient care delivery. We agree! However, we disagree that one can predict the unpredictable, where we know that even a healthy patient having a "routine" procedure can become a crisis in a matter of seconds. Moreover, these crises occur in all settings including the hospital, ambulatory surgery center, dentist office, or outpatient clinic. Anesthetics are by definition "controlled poisons" with the intrinsic properties to do significant harm. Fortunately, thanks to the training of anesthesiologists, surgeons, physicians, CNRAs, anesthesia assistants and other health care providers working in collaboration as a team, anesthesia delivery has become safer than ever. We don't believe any patient is willing to knowingly abandon the very model that has achieved these stellar results by the proposals in the APRN bill. That said, we recognize that there are many parts of the state where there are no anesthesiologists, but as the APRN response correctly points out, the CRNA works within a collaborative relationship with the surgeon or physician responsible for the patients care. The bottom line is that anesthesia delivery is not primary care, but instead acute care delivery where it is imperative to the health and safety of the patient that a team based approach is the required standard.

7. What other professions are likely to be impacted by the proposed changes?

Positive impact on physicians. This bill has the potential to have a positive practice impact for physicians who serve in a more consultant-type role or focus their practice more on patients whose care requires the increased complex pathophysiology knowledge and skills physicians acquire during their education and training. It may also positively impact physicians by reducing the burden or misperceived liability of having to provide practice oversight or sign written prescribing agreements for APRN colleagues.

Physician Assistants. Physician assistants may perceive that this bill gives APRNs an advantage in the health care marketplace. Physician assistants practice a more limited scope of medicine and currently do so under physician supervision. APRNs practice advanced practice nursing, a different discipline than medicine, although there are some overlapping skills. The bill could have the opposite effect of causing some physicians to prefer hiring physician assistants who require supervision.

Possible financial impact on physicians. This bill has the potential to have a negative financial impact for physicians who are currently benefitting from limited health provider competition or receiving reimbursement or financial payment as a result of overseeing APRN practice or prescriptive authority in the following ways:

- The bill removes opportunity for any physician to restrain the ability of an APRN to practice, which in turn could increase competition or decrease the physicians' patient numbers.
- The bill removes practice and prescribing agreement requirements between physicians and APRNs that currently result in some physicians receiving payment of money they charge an APRN.

Anesthesiologists may oppose this bill for financial reasons. Anesthesiologists who medically direct four CRNAs simultaneously delivering perioperative anesthesia to patients with surgeries in four different anesthetizing areas receive an insurance or Medicare/Medicaid payment per each patient as a result of this supervision. This payment is in addition to the CRNAs reimbursement for anesthesia services. Patients having similar types of surgeries in rural hospitals receive CRNA-delivered anesthesia care without anesthesiology medical direction in collaboration with the surgeon, dentist, podiatrist or obstetrician. Thus, there is a substantial financial incentive for anesthesiologists to oppose this bill.

It is difficult to make far reaching conclusions about safe health care delivery, when the proposed changes—the independent practice without any physician oversight or collaboration versus physician/APRN team approach to health care—have never fully been studied. The line on safety, particularly in acute and intensive care settings, is not a line that patients should have to worry about whether one profession or another will deliver care as safe as another profession. These are the situations in which patients' health often involves multiple co-morbidities and the time for correcting a mistake, hinges on a matter of seconds. These situations demand that the expertise of the entire health care delivery team—physicians, APRNs, nurses—are all working together in a collaborative model to ensure the safest and best outcomes are achieved for each patient.

The assertion that physicians, and specifically anesthesiologists, would oppose the APRN bill for financial reasons is patently false and factually wrong. The cost of care for patients in Medicare, Medicaid, and MNSure programs is identical for anesthesia delivered by anesthesiologists or anesthesiologist-CRNA Care Teams. By statue, the charges for anesthesia services are exactly the same whether it is administered by a solo anesthesiologist or delivered in the anesthesiologist/CRNA care team mode (in the latter case, each provider gets 1/2 of the total payment). In fact, in some rural areas of the state where CRNAs deliver anesthesia without an anesthesiologist, the nurse anesthetist is getting GREATER reimbursement than what an anesthesiologist would receive due to the Rural Pass through effect.

9. Please describe what efforts you have undertaken to minimize or resolve any conflict or disagreement described above.

Efforts to mitigate opposition. The MN APRN Coalition lobby team and several members met with opposition representatives during the 2013 legislative session twice to discuss concerns with the bill. Both groups' lobby teams met again in fall 2013.
On December 11, 2013 physicians, APRNs, and lobbyists from both sides met again with the aid of a neutral attorney facilitator. The meeting focused on four areas of disagreement: (1) level of required collaboration, (2) the written prescribing agreement, (3) physician oversight of Schedule II narcotics (APRNs may currently prescribe Schedule II narcotics under a written prescribing agreement), and (4) interventional pain management performed by CRNAs. At the conclusion of our two hour discussion, parties agreed that the physician opposition group would provide language revisions. A further meeting was proposed for in mid-January after having time to review revised language. The physician groups submitted revised language on January 15th accompanied by an email that indicated the physician opposition group posited another meeting between clinicians would not be helpful.

The language submitted pertained only to a revised definition of collaboration that defines collaboration as a formal, mutually agreed upon plan for all APRN patient management and states that each APRN role must practice in such a collaborative environment. The proposed language is not a movement or change as it continues to limit the authority of APRNs to practice to the full extent of their education and training. This language poses the same barriers, particularly in rural areas where team care is not always necessary or feasible for all patients. APRNs agree that all health care providers must at times collaborate, consult, refer, etc. However, APRNs assert a more prudent, cost-effective approach is to require all APRNs to collaborate, consult, or refer patients *when warranted by the patient's condition* not require it when it will limit access and increase cost without added benefit. The revised language, as written by the physician group, still ties all APRN practice to a collaborative team, whether or not the patient or patient condition warrants that level of collaboration. Because the physician group did not propose language revisions for the other three identified areas of concern, the APRN group is in process of drafting some revised limitations and requirements for CRNAs who engage in chronic pain management services as a significant portion of their practice. Language limiting CRNA practice in pain intervention should address the interventional pain management physician concerns. The language will be sent to the physician group in the next week.

We have had a number of meetings with representatives of the APRN Coalition that have been helpful to understand both sides' positions. We submitted language for a new definition of "collaboration" to address their concerns that the current language was being interpreted by some to require a supervisory agreement. Since that was never the intent of the current language we agreed to the need for a new definition. When we sent that language we said that we continue to support changes to the prescribing requirements but that we first needed to reach agreement on collaboration. We never heard back from the APRN Coalition.

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5. The functions typically performed by members of this occupation group and whether they are identical or similar to those performed by another occupational group or groups:
Overlapping scopes of practice. APRNs care for patients based on their nursing science framework and use all of their previously learned nursing skills in addition to performing some skills that overlap with those of physicians and physician assistants. These areas of overlap differ depending on the APRN's role and population focus. Overlapping skills for CNPs and CNSs include performing physical examinations, ordering and interpreting laboratory and diagnostic tests, diagnosing, treating, or managing acute and

chronic illnesses, prescribing medications, consulting with or referring to specialists or other health care providers, and performing various health care procedures such as suturing, splinting a fracture, or debriding a wound. In addition to the above list of overlapping skills, CNMs manage women's reproductive needs, provide prenatal care, assist women during labor, birth, and postpartum recovery, and provide examination and initial care of babies during the first few weeks of life. CRNAs perform essentially the same perioperative cares and procedures as those performed by anesthesiologists.

APRNs are already experienced registered nurses when they enter APRN graduate education programs. The discipline of nursing is unique and different than the discipline of medicine. Basic nursing education is grounded in a holistic mind-body-spirit view of persons and focuses on the import role people's environment (family, work, education, socioeconomic status, housing, social stress) plays in whether or not they achieve optimal health.

This is the biggest challenge of this bill. While the work APRNs do is greatly valued and needed, much of what they are proposing to do independently is the practice of medicine. To independently diagnose, develop and prescribe a treatment plan, and prescribe medications is regulated by the Board of Medical Practice and is defined under Chapter 147 as the practice of medicine.

In summary, we urge caution regarding radical changes to the current progress made by physician-led collaborative teams. Indeed, conclusions about the safety of changes proposed in the APRN bill—independent RN practice without any physician oversight or collaboration—are unproven and risky. There are no adequate studies to substantiate their claims. The margin for patient safety is razor thin in our complex health care environment, particularly in acute and intensive care unit settings. Patients are relying on you, our elected legislators to protect their most valuable asset – their good health. Life-threatening events happen in the OR in a matter of seconds, and these situations demand the expertise of the physician-led health care delivery team—physicians, APRNs, PAs, and nurses—all working together in a collaborative model to ensure the safest outcomes for each patient every time.