

Use of Midlevel Practitioners for Primary Care

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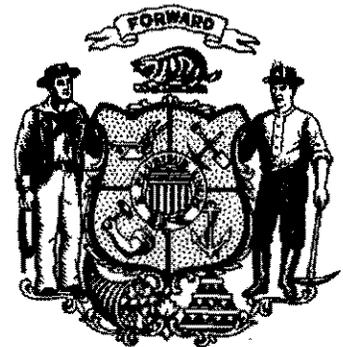


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USE OF MIDDLELEVEL PRACTITIONERS FOR PRIMARY CARE

I. INTRODUCTION

Access to primary health care is becoming increasingly restricted in Wisconsin and throughout the country for both financial and geographic reasons. The problem is particularly severe in rural and inner city areas. While many factors contribute to this situation, it is generally agreed that increasing the number of primary care providers is an important step toward improving access. One way to accomplish this goal is to make greater use of midlevel practitioners (MPs) such as physician assistants, nurse practitioners and certified nurse midwives. In recent years, the trend among the states, including Wisconsin, has been to increase the number of MPs and expand their scope of practice.

The 1993 Wisconsin Legislature created a loan assistance program for MPs, increased Medical Assistance reimbursement rates for MPs who choose to work in health professional shortage areas, and expanded prescription privileges for advanced practice nurses. Also, the University of Wisconsin System and the Medical College of Wisconsin are exploring ways of expanding MP training.

II. BACKGROUND

Approximately 35 million people nationwide live in federally designated "health professional shortage areas" where the physician-to-population ratio is less than 1:3,500. In Wisconsin, the number of such areas increased from 20 in 1980 to 52 in 1993. These areas face an even more severe shortage of doctors willing to provide obstetrical care. Even if an area is not underserved under the federal definition, factors such as language or cultural barriers, poverty or institutionalization (such as in a nursing home) may limit access to health care for certain populations.

One trend fueling these shortages is that the number and percentage of general practitioners is declining steadily, despite an increase in the overall number of physicians. Most experts believe that, ideally, half of all physicians should be in general practice, which includes family medicine, general internal medicine and general pediatrics. However, by 1992 only 15% of medical students graduating in the nation intended to enter general practice. A projection by Dr. David Kindig of the UW-

Madison School of Medicine concluded that, even if 50% of all medical students could be induced to choose general practice starting in 1997, the overall 50% target would not be reached until 2040. In addition, while the supply of primary care physicians is decreasing, the demand for them by health maintenance organizations (HMOs) and other managed care plans is increasing, further reducing the number of physicians available to areas and populations not covered by such plans.

III. HISTORY OF MIDDLELEVEL PRACTITIONERS

The various MP professions were created to improve access to care in areas lacking physicians, and their numbers are increasing rapidly, although not fast enough to meet the demand. (The 2-page table in Section VII provides an overview of the MP professions.)

The first training programs for physician assistants (PAs) and nurse practitioners (NPs) were established in the 1960s. The first PAs to graduate from the initial training program, established in 1965 at Duke University, were Navy hospital corpsmen who wanted to continue to use their skills in civilian life. Although NPs and PAs are trained differently, governed by different laws, and have different philosophies of care, they often perform very similar functions.

Unlike NPs and PAs, nurse midwives did not create an entirely new profession. Instead, they applied the professional nursing model to the existing tradition of lay midwifery. Frontier Nursing Service was established in Kentucky in 1925 as the country's first nurse midwifery service, and seven years later, the first training program was started in New York. However, a national certification examination for certified nurse midwives (CNMs) was not developed until 1971. Wisconsin recognized nurse midwifery as a specific nursing specialty in 1980. CNMs now attend 3-4% of births nationwide and 2% of births in Wisconsin. Florida is one state that has been particularly aggressive in promoting CNM practice. In 1992, more than 11% of Florida births were attended by CNMs and the state is evaluating the feasibility of raising that proportion to 50% by the year 2000. (By contrast, midwives attend approximately 70% of all births in European countries.)

At the same time that CNMs have increased in number and recognition, the use of direct entry midwives (i.e. lay midwives) has seen a resurgence as well. A number of states have updated or reinstated licensure for these providers. Direct entry midwives need not be nurses and their training varies widely. The 17 states which regulate these midwives establish their own training requirements. Women often employ direct entry

midwives because they wish to give birth at home. (CNMs are prevented from attending home births by law in Wisconsin, and physicians generally are not willing to do so.) Direct entry midwives attend an estimated 1% of births per year in Wisconsin and the other states where they are not licensed. The percentage increases in states where they are licensed. For example, licensed midwives in Washington attend more than 4% of all births.

IV. TRAINING PROGRAMS

A number of groups, including the two Wisconsin medical schools and the Wisconsin Rural Health Development Council, have urged that the state increase funding for the existing MP programs and explore the possibility of establishing new ones. Creating additional educational opportunities is one of the most direct ways to increase the number of MPs practicing in Wisconsin, because MPs trained in the state are very likely to remain here to practice. For example, 80% of NPs graduating from the UW-Oshkosh go on to practice in Wisconsin.

Practitioner	Program	Established	Degree or Certification Granted	Approximate Class Size
Physician Assistant	UW-Madison	1975	BS	30 (up from 25 in previous years)
Nurse Practitioner	UW-Madison	1975	MSN (pediatrics, adult and aging, or women's health/OB-GYN)	30-35
	UW-Eau Claire*	1994	MSN (adult or family practice)	100
	UW-Oshkosh	1974	MSN (family practice or geriatrics)	30-40
	Marquette University*	1993	MSN (neonatal, pediatrics, adult or geriatrics)	80
	Planned Parenthood (Milwaukee)	1972	Certificate (OB-GYN)	20 (two classes per year); many students not from Wisconsin
Certified Nurse Midwife	Marquette University	1993	MSN	6

*Program prepares students to sit for either the NP or clinical nurse specialist exam.

Currently, the UW-Milwaukee plans to focus its master's level nursing programs on training NPs, while the UW-Madison expects an increase in the proportion of its graduate nursing students selecting NP training. The UW System plans to establish a new PA program at the UW-La Crosse and the Medical College of Wisconsin is also exploring the possibility of establishing such a program. The UW-Madison PA program is seeking funding to increase its enrollment to 50. It currently has 8 applicants per opening, compared to the national average of 4 applicants.

V. APPROPRIATENESS OF EXPANDED PRACTICE

Various sources estimate that MPs can perform 60-90% of primary care functions. On the other hand, the American Medical Association disputes these claims and warns against allowing MPs to practice independently. Several key questions arise in evaluating the appropriateness of expanded practice by MPs. Do they deliver an acceptable quality of care? Do they provide a cost effective adjunct or alternative to physician care? Do they improve access to health care, especially for underserved areas and populations? Finally, can more MPs be trained quickly enough to address current access problems?

A. QUALITY OF CARE

Many physicians express concern that MPs are not well enough trained to provide high quality care. They point out that doctors must have 8 years of college education plus 3 years of supervised practice as a resident, whereas educational requirements for MPs vary from 3 to 6 years of college education, usually with an additional 1 to 2 years of supervised clinical practice. While these formal educational requirements are less than those for physicians, successful MP applicants for the limited MP training slots generally have substantial prior health care experience.

Although quality of care is an area of legitimate concern, there is no evidence that independent practice by MPs poses any danger to consumer health. In a 1986 report, the Congressional Office of Technology Assessment analyzed a number of studies and concluded: "The weight of the evidence indicates that, within their areas of competence, NPs, PAs, and CNMs provide care whose quality is equivalent to that of care provided by physicians." An analysis of 53 studies of the care provided by NPs and CNMs conducted in 1993 by Professors Sharon Brown and Deanna Grimes of the University of Texas-Houston supports this conclusion.

B. COST EFFECTIVENESS

The cost effectiveness of increased reliance on MPs is difficult to determine and probably varies depending on the context. In general, MPs are thought to reduce the overall cost of health care so long as they improve access to primary care, charge less than physicians, and do not duplicate services.

It costs considerably less to train an MP than a physician. This provides savings to federal and state governments, which assume a substantial portion of the cost of both medical and nursing education through student financial aid and direct support of schools.

MPs also command lower salaries than physicians, although their salaries have been rising rapidly in the last few years because they are in such high demand. These lower salary requirements have made MPs particularly attractive to HMOs and larger physician practices. However, while the use of MPs may be cost effective for certain medical providers, it is unclear whether these savings are passed on to the consumer.

Another concern is that increased scope of practice for MPs might lead to duplication of physician services or expansion of the kinds of services provided. There is no evidence to suggest that duplication of services would be a problem. However, one of the aspects of MP care that has drawn positive attention is their value in providing preventive care. To the extent that increased access to preventive care results in increased use of services, immediate costs are likely to rise, although such care may save money in the long run.

C. ACCESS FOR UNDERSERVED AREAS/POPULATIONS

MPs originated specifically to provide health care for underserved areas and populations and they continue to fulfill that function. For example, CNMs in Wisconsin and nationwide attend a higher proportion of young, minority, low income or poorly educated women than physicians do.

On the other hand, MPs encounter many of the same disincentives to engage in rural or inner city practice as doctors, including relocation to an unfamiliar area, long hours, decreased income, lack of professional support, and lack of career opportunities for spouses. In addition, MPs may be limited by restrictive practice laws or a lack of physicians willing to provide backup.

Many states have established programs to encourage both physicians and MPs to work with underserved areas and populations, including:

- scholarships, student loan forgiveness, malpractice insurance subsidies, tax credits and other financial assistance;

- recruitment of students from rural and minority populations, on the theory that they are apt to return to their communities to practice; and
- clinical rotations in underserved areas to increase the chance students might practice in such areas after graduating.

1993 Wisconsin Act 16 created a loan assistance program for MPs. Loan repayments are graduated, based on the number of years the care provider works in a health professional shortage area. Local governments are urged to contribute funds to the programs. The act also increased Medical Assistance reimbursement rates for MPs practicing in shortage areas.

The Office of Rural Health at the UW-Madison recently created a new program, Primary Providers for Wisconsin, which will help communities around the state recruit MPs. The Wisconsin Primary Care Consortium, a new initiative spearheaded by representatives of professional groups, primary care providers, nursing and medical schools, and several state agencies, is also working to improve recruitment and retention of primary care providers in underserved areas.

According to the Wisconsin Rural Health Development Council, ". . . the most effective means of obtaining and keeping rural NPs is through the education of RNs already residing in the area." Many nurses, however, have families and find it difficult to give up their jobs or to travel far from home to pursue further education. In response to this reality, the Wisconsin Area Health Education Centers, joint ventures of the two Wisconsin medical schools, are working with nursing schools in the state to develop long distance learning and flexible class schedules.

Another key to the ability of MPs to work in underserved areas is the degree of independence with which they can practice. More flexible supervision requirements and providing the authority to prescribe drugs and receive direct payment are all important to enabling an MP to practice effectively in an underserved area. For example, when Texas expanded prescription authority and allowed off-site supervision for MPs in 1989, the number of rural health clinics increased from zero to 200 in four years, with corresponding increases in the number of practicing PAs and NPs.

D. TRAINING TIME FRAME

One of the advantages claimed for MPs is that they can be trained quickly. For example, the American Nurses Association asserts the number of advanced practice nurses, now approximately 100,000 nationwide, could be quadrupled within 2 years. ("Advanced practice nurses" include NPs and CNMs as well as clinical nurse specialists, nurse anesthetists and various other nursing specialties.)

One obstacle to training large numbers of new MPs is that it would deplete the existing pool of registered nurses. In addition, there are not enough MPs with advanced degrees to serve as teaching faculty, and many are drawn away from academia by the higher salaries available in clinical practice. However, creating increased opportunities for registered nurses may encourage more people to enter or advance in the field.

Thus, while MPs could be trained more quickly than physicians, it would require a concomitant investment in training and recruiting faculty and creating new and expanded educational programs.

VI. KEYS TO EXPANDED PRACTICE

Legal, financial and attitudinal barriers combine to limit the practice of MPs in many states. State governments are in a position to reduce or eliminate many of these barriers, and an increasing number, including Wisconsin, are choosing to do so. (The 2-page overview provides a summary of state laws.)

A. PHYSICIAN ATTITUDES

MPs consistently cite physician attitudes and difficulty in obtaining physician back-up as major barriers to independent practice. Many physicians and organized physician groups strongly resist such practice, whether because of concern about quality of care, fear of competition, or unfamiliarity with MP capabilities.

The most effective methods for gaining physician approval appear to be interdisciplinary training and collaborative practice. Physicians who have studied with MPs and worked with them in practice tend to respect their abilities and understand their roles to a greater degree than physicians who have not. In Wisconsin, the Area Health Education Centers promote interdisciplinary training and practice. The Wisconsin Primary Care Consortium is also working in this area, as well as assisting CNMs and NPs to obtain physician back-up where needed.

B. SUPERVISION AND EMPLOYMENT REQUIREMENTS

Currently, advanced practice nurses in Wisconsin must practice under general physician supervision, defined in Wisconsin as regular coordination, direction and inspection. 1993 Senate Bill 327, which failed to pass, would have allowed any registered nurse to provide primary care without physician supervision in primary care shortage areas of the state. The proposal would have required each primary care nurse

to have a written protocol with a collaborating physician and would have prohibited hospitals and other health care providers from discriminating against these nurses.

The bill would not have applied to PAs who, under current law, may not practice without direct physician supervision, defined in Wisconsin as continual coordination, direction and inspection. However, the law does not require that a supervising physician be physically present, so long as the PA is within telecommunications contact. Other states allow PAs to operate with even looser supervision in remote, underserved areas where direct supervision would be unfeasible.

C. PRESCRIPTION AUTHORITY

Much of the recent movement toward expanded MP practice in the states has focused on the authority to prescribe drugs. No state allowed MPs to prescribe until 1975, but most states have since changed their laws. According to the American Medical Association, at least 14 states expanded nonphysician prescribing authority in 1993 alone. MPs argue that many state prescription laws unduly limit their ability to provide effective, timely care by requiring that they prescribe only from specified lists or protocols, that they obtain a physician cosignature, or that they not prescribe controlled substances. For example, under Wisconsin law, PAs may only prescribe from written protocols, and they must obtain physician approval. The administrative rules governing PAs were amended in July 1994 to allow them to prescribe controlled substances.

1993 Wisconsin Act 138 will expand prescription authority for advanced practice nurses (APNs). The Department of Regulation and Licensing established an advisory committee, as required by the act, to suggest administrative rules to the Board of Nursing, which must submit proposed rules by April 1, 1995. The committee recommended that an APN be defined as "a registered nurse who has current licensure in the state of Wisconsin and who is currently certified by a Board of Nursing recognized certifying body as a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or clinical nurse specialist, and who, beginning in the year 2002 must hold a master's degree in nursing or other related health field." The committee also recommended requiring specific training in pharmacology for APNs. At the request of the State Medical Society of Wisconsin, the act specifies that an APN must present evidence of malpractice liability insurance coverage to receive a certificate to prescribe drugs and that an APN may not delegate prescriptive authority.

D. HOSPITAL PRIVILEGES

Hospital staff privileges allow a health care provider to admit patients in the provider's own name. Some states require that MPs admit patients under a physician's

name. Where state law is silent, most hospital policies still preclude MPs from admitting patients. Hospital privileges are most critical for nurse midwives. CNMs who are not employed by hospitals cite lack of such privileges as a major barrier to practice.

1991 Assembly Bill 615, introduced by the Legislative Council Special Committee on Prenatal Care, would have required any hospital to grant a CNM the opportunity to obtain delivery privileges if the CNM's back-up physician had staff privileges at that hospital. 1993 Assembly Bill 688, modeled on 1993 Wisconsin Act 30 relating to podiatrists, would have required hospitals to give CNMs an equal opportunity to obtain hospital staff privileges and prohibited hospitals from denying staff privileges solely because the applicant is a CNM. Both the 1991 and 1993 CNM bills failed to pass.

E. INSURANCE REIMBURSEMENT

Insurance reimbursement is essential for MPs who wish to work independently or in fee-for-service physician practices, and MPs have identified lack of reimbursement as a major barrier to practice. Insurance companies in Wisconsin are generally not required to cover MP services, although any policy that covers Pap tests and pelvic exams must also cover these services if performed by an NP. 1991 AB-651 would have required Wisconsin insurance companies to cover nurse midwifery services if they covered those services when offered by other providers.

F. MEDICAL ASSISTANCE COVERAGE

Medical Assistance (MA), commonly known as "Medicaid", has gradually expanded coverage for MP services over the past 15 years. A few states are still not in compliance with these mandates. The 1980 federal Omnibus Budget Reconciliation Act (OBRA) required direct MA payment for CNM services. Seven states also allow licensed direct entry midwives to receive MA reimbursement for their services (although in Florida, only prenatal and postpartum care are covered). In 1984, birth centers not run by physicians became eligible for MA clinic coverage. The 1989 OBRA mandated direct MA payment for pediatric and family NP services, and the Wisconsin Department of Health and Social Services expanded the initiative to all NPs.

In Wisconsin, about half of the eligible NPs and CNMs are certified to receive MA reimbursement, although very few have actually billed the program. NPs are reimbursed at the same rate as physicians. 1993 Wisconsin Act 16 increased the reimbursement rate for CNMs from 80% of the physician rate to 90%. In the case of MPs who practice in a health professional shortage area, the act also provided a bonus of up to 20% over their normal reimbursement rate. 1993 Wisconsin Act 356 increased

the bonus for obstetrical care providers in a shortage area to 50% over the normal physician reimbursement rate.

G. FINANCIAL SUPPORT

A sizable majority of MPs receive financial aid to complete their education, and this aid is a significant factor in their decisions to pursue schooling. For example, the availability of financial aid ranked among the top five factors that would encourage registered nurses to return to school, according to a 1991 survey conducted by the Governor's Nursing Education Coordinating Council. Financial aid is also used increasingly as a recruiting tool to reward MPs for locating in medically underserved areas.

The availability of financial support after graduation also affects the ability of NPs and CNMs to establish their own practices. In a 1991 DHSS survey of Medical Assistance-certified NPs, the most commonly cited deterrent to independent practice was the cost of starting a practice. To address this concern, Missouri and North Carolina have both created programs in the last few years, as part of broader health care initiatives, which provide seed money and other financial assistance for MP practices.

Taken together, the initiatives discussed in this section, which would allow greater autonomy and expand the scope of practice for MPs, have the potential to significantly enhance their ability to provide cost effective primary care and improve access for underserved areas and populations.

VII. MIDDLELEVEL PRACTITIONERS -- OVERVIEW

	Physician Assistant	Nurse Practitioner	Certified Nurse Midwife
Scope of Practice	Under a physician's supervision, diagnose, monitor and treat common ailments; work in all medical and surgical specialties (57% provide primary care)	In collaboration with a physician, diagnose, monitor and treat common ailments; focus on health maintenance and patient education; specialties include family practice, pediatrics, maternal/infant care, and gerontology	In collaboration with a physician, provide gynecological services and care of low-risk mothers and babies throughout the maternity cycle
Number in nation	23,000	20,000-50,000*	3,600
Number licensed in Wisconsin, 1994	536	322-400*	61
Wisconsin licensing	Licensed by Medical Examining Board	Licensed only as RN by Board of Nursing (can be certified as an advanced practice nurse to prescribe drugs or for MA reimbursement)	Licensed by Board of Nursing
Education required	Clinical experience; certificate or associate, bachelor's or master's degree (85% have at least a bachelor's degree)	RN with clinical experience; certificate or master's degree (almost 1/2 have a master's degree)	RN with labor and delivery experience; certificate or master's degree (2/3 have a master's degree)
Training programs	59 (one in Wisconsin)	284 (5 in Wisconsin)	41 (one in Wisconsin)
Graduates per year, nationally	1,800	2,000	400-500
Jobs per graduate, nationally	7	7.5	15
Average salary, nationally	\$53,500 in 1993	\$43,600 in 1992	\$43,500 in 1993

*While NPs must pass a national exam, many states, including Wisconsin, do not grant specific NP licenses, so it is difficult to estimate the number in practice.

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MIDLEVEL PRACTITIONERS -- OVERVIEW (continued)

	Physician Assistant	Nurse Practitioner	Certified Nurse Midwife
Supervision	Physician supervision always required; may be indirect (such as by telephone) in Wisconsin and other states	Some states allow independent practice; most states, including Wisconsin, require a written protocol with a physician; indirect supervision required in Wisconsin for delegated medical acts, but not for nursing care	Some states allow independent practice; most states, including Wisconsin require a written protocol and backup agreement with a physician; complications must be referred for co-management or physician care
Prescription authority	38 states; in Wisconsin can only prescribe from written protocols with physician approval	At least 42 states, including Wisconsin	At least 35 states, including Wisconsin
Hospital admitting privileges	Only as agent of physician	Discrimination not allowed in Oregon or Washington, DC	Discrimination not allowed in Ohio, Oregon, Tennessee or Washington, DC
Insurance reimbursement	Montana mandates coverage	At least 22 states (not including Wisconsin) mandate coverage	27 states (not including Wisconsin) mandate coverage; Alaska also mandates coverage of licensed direct entry midwives
Medicaid	40 states (including Wisconsin) cover PA services; reimbursed through physician or clinic	Federal law mandates direct payment of family and pediatric NPs; in Wisconsin, all NPs are eligible	Federal law mandates direct payment of CNMs and birth centers; 7 states also mandate direct payment of licensed direct entry midwives

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