October 20, 2020

Good morning, my name is Dr. Anna Dalrymple. I am a Family Physician practicing at Gothenburg Health in Gothenburg, Nebraska. I am speaking to you on behalf of the Nebraska Academy of Family Physicians (NAFP) as a Board Director and a rural Family Physician. The NAFP would like to thank the Technical Review Committee for affording us the opportunity as this process progresses to provide feedback and insight on the proposed changes sought by the Board of Nursing regarding advanced practice registered nurses.

The NAFP joined the last Technical Review meeting to get a better understanding of the intent behind the application and more details. After review of the application and listening to the presentation of the applicant group, the NAFP is in opposition to this proposal.

The NAFP strongly supports team-based implementation of healthcare. This model of delivery provides optimal care and outcomes for patients in Nebraska. It allows multidisciplinary teams to work collaboratively while focusing on the safety and needs of our patients. As part of the team-based approach, we believe that physicians should be the leaders of those health care teams to reduce risks to patients and liability.

The NAFP and our member physicians remain deeply concerned about the safety of Nebraska patients if this proposal were to be adopted. We do not believe this application meets the six statutory requirements for scope of practice changes for these distinct health professionals.

First, I would like to address the statutory requirement stating current education and training for the health profession adequately prepares practitioners to perform the new proposed skill or service in a safe manner. We strongly disagree that they meet this requirement. For example, Certified Nurse Midwives must only participate in 25-40 births during their education and training for certification. This means they participate in the delivery, not necessarily perform the delivery independently. Certified Nurse Midwives also do not have training on cesarean section births, as surgical procedures are not something the APRN education programs teach. In contrast, Family Physicians have 11 years of education and training and more than 12,000 clinical hours. I personally delivered more than 100 babies in residency, not including cesarean deliveries. I have been out of residency for 3 years and delivering babies regularly in my practice. I still call on my colleagues for consultation and referral services regularly. I cannot begin to imagine someone with less education and training being able to safely perform these services independently.

To help demonstrate the NAFP’s position, I would like to talk about what it is like to be a Family Physician in a rural area.
I live in Gothenburg, Nebraska. Population is approximately 3,500. We are 3.5 hours from Omaha and 4 hours from Denver, right off of Interstate 80. We have one grocery store, one pharmacy, 2 banks, a Dollar General, and an Orscheln Home and Farm store. Our Shopko closed last year, and the closest Wal-mart is 30 miles away. The biggest employers in town are the hospital where I work and the public school system. Our hospital is a designated Rural Health Center. We have approximately 12 hospital beds, including 2 labor and delivery suites. We have 2 OR’s and an endoscopy suite. We have 4 Family Practice physicians, 2 Nurse Practitioners, 3 Physician Assistants, and 2 CRNA’s on staff. We all share clinic obligations, inpatient rounds, ER coverage, and for two of us, obstetric call. Our nurses have to be ready for anything. They are our floor nurses, ER nurses, OB nurses, respiratory therapists, social workers, and the list goes on.

I grew up in Omaha where my high school class was 1/6th of the entire population of my current hometown. I attended large universities and completed my medical training at UNMC and in Lincoln, so I can really appreciate the stark differences between the limitations of a rural hospital setting and a large hospital system. In a rural hospital, we have fewer resources and are farther away from specialized care. I firmly believe we provide excellent care, but it is still different than what is available in a larger hospital.

In addition to the limitations of a rural hospital, medical complexity is increased by the characteristics of rural populations. In general, rural citizens have less income, less job stability/mobility, decreased health literacy, limited access to safe housing, healthy food and clean water, and more transportation issues. In addition, rural populations are more likely to be obese, use tobacco products and illicit drugs, and be the victims of domestic violence.

When it comes to our maternal population, the data is equally as concerning. In general, women today are more likely to have existing chronic medical conditions that set them up for life threatening complications in pregnancy. These problems are compounded by the added negative impacts found in rural areas. In fact, a study released last year out of the University of Minnesota found that women who live in rural areas are 9% more likely to experience a life threatening pregnancy complication compared to women who live in urban areas.

Now, Certified Nurse Midwives (CNM) training is focused on average-risk births, with the understanding that they will know when a patient becomes high risk and will appropriately refer. This idea is predicated on the assumption that specialty referral services are readily available. When you think about everything I have just discussed: limitations of a rural setting, characteristics of rural communities, and the increasing prevalence of pregnancy risk specifically in rural areas, one would think you would want more support in a rural area, not less. The common sense side of me says this is actually scary to imagine.
I would like to give you an example. I had an obstetric patient a few months ago, young, healthy, and no comorbidities. What you would call a ‘low risk patient.’ She went into labor and was progressing nicely towards a vaginal delivery. This was her first baby. In fact, she was at 9 cm. I was going to change into scrubs, when I got an urgent call from the nurses. Upon returning to the room, the patient was laying flat, dusky, gray, and barely responsive. Her blood pressure was 60 over 40 and there was no fetal heart tones appreciated. Nothing on her exam gave us any clues as to what happened. At this point, we were treating her as what we call a ‘code.’ Resuscitating her with fluids, medications to increase blood pressure, and oxygen. And at the same time, immobilizing our OR team. With the help of one of our amazing CRNA’s who was able to quickly do what is called a rapid sequence induction, the patient was asleep and baby was born in 7 minutes once she was brought back to the room, which was 17 minutes after this episode started. Thankfully, both mom and baby did great and recovered without issue, and even after an internal review with other providers, we were still not able to determine the etiology of her deterioration or rapid recovery. In fact, I just saw this baby for their 6 month checkup. Now if I had not been able to do a cesarean section, or have a colleague in the facility who could, I would have had to transfer this patient to an outside facility. Our closest hospital with a higher level of care is 38 miles away. In the best of circumstances, with paperwork, phone calls, and even a helicopter that was available and no inclement weather precluding their flight, this process would take 45 minutes. I am certain that if her care had been delayed to 45 minutes or longer there would have been a major adverse outcome, particularly for the baby. This seems like an unacceptable risk to take on for any provider or hospital.

This may be why there is not a large migration of CNM’s to rural areas. I believe that CNM’s understand the need for surgical backup in obstetric care and rightly do not want to practice in an unsafe environment. I know I would not. In light of this, I would like to address a comment that was made in the previous meeting regarding access in rural settings. Last meeting the applicant group showed you a map of our state and where APRNs and OBGYNs practice and how short our state is on providers. However, what they failed to show you is where the Family Physicians were practicing. Many Family Physicians in rural Nebraska are delivering babies, and I firmly believe that Family Physicians being recruited to rural areas is going to be the driving force for improving healthcare in rural areas, helping lead the rest of the healthcare team.

The applicant group also noted during their testimony at the last meeting that their CNM’s outcomes were overwhelmingly positive, but please keep in mind they are only taking on low risk pregnancies that they can safely manage. If you are only taking on the healthiest patients and referring all your complex, high risk cases, outcomes are going to look overwhelmingly positive because you have the healthiest patient caseload.
Another area of the application discusses removing the hours of transition to practice. This is another area that gives us great concern. In most professions requiring a license, there is a provisional period where a supervisor is supporting newly licensed professionals. Many of us welcome that support, particularly in a field as complex and unforgiving as medicine. Your learning does not stop once you have received your degree, but really develops more as you start moving into practice. You have many questions in the first years of practices (trust me I would know!) as you are seeing complex patient needs and integrating your learning. Taking this oversight away not only harms the new provider by making them feel ‘alone’, particularly in isolated rural areas, but will also be harmful to the communities that they are practicing in.

The final point I will make is on prescription authority. The NAFP disagrees with extending the prescription authority to the groups named in the application. As noted in the applicant’s testimony, CNS primary responsibilities are usually in administrative and system improvement roles, which would not put them in a clinical setting therefore making prescriptive authority inappropriate. In addition, without further training requirements, they are not adequately trained on the breadth of available pharmaceuticals to be able to safely prescribe all medicines. To demonstrate this point, I’d like to point out that 50 years ago, there were only a handful of prescription medicines that one could prescribe. Now, the FDA regulates approximately 20,000 drugs, and there are more all of the time. To fully appreciate the complexities of full prescriptive authority takes more training than what we feel is currently required from the applicant group.

The premise for this proposal is to align with a national compact and to streamline licensing and credentialing requirements. This is stated in the proposal, and in our opinion, does not put the safety of Nebraskans as the main priority, particularly in rural populations. Nothing should come before the safety of our patients, particularly for the ‘sake of convenience’. Moreover, many rural health centers in Nebraska have already adopted policies to not employ advanced practice providers without collaboration with physicians, to guarantee patient safety. My hospital is one of them. Therefore, it is highly unlikely that even if this proposal is passed, that advanced practice nurses could get jobs in rural hospitals independently because they have their own rules and regulations.

I would like to end on a positive note. I work with some fabulous advanced practice nurses every day and could not do my job without them. The NAFP strongly feels that the healthcare system works best when we align as a team. This allows us to utilize the strengths of each team member to tackle the complexities of our current healthcare system. I would like to reiterate that we believe that APRNs play a valuable role on the healthcare team. As part of the team-based approach, physicians should lead those health care teams to reduce risk to patients and liability.

I want to thank you for your time and am happy to answer any questions you may have.