



Nebraska Medical Association

Advocating for Physicians and the
Health of all Nebraskans

Members of the APRN Technical Review Committee:

The Nebraska Medical Association (NMA) has reviewed the Board of Nursing's single proposal for credentialing review of three of the four Advanced Practice Registered Nurse (APRN) professions. Although the proposal does not specifically identify the statutory changes sought for these professions, the NMA submits to you this opposition report based upon what is included in the proposal and on the assumption that the Board of Nursing seeks to expand the scope of practice for three of the APRN professions to match that of states with the least restrictive scope. However, there are several instances where providing the statutory changes sought would be beneficial to the Technical Review Committee during your review process; those areas are highlighted in this report.

The NMA believes that physicians must maintain the ultimate responsibility for coordinating and managing the care of patients in Nebraska, and as such we support the use of patient-centered, team-based patient care. We believe the increased use of physician led teams of multidisciplinary health care professionals can have a positive impact on the state's primary care needs. A team-based approach involves all health care professionals working together, sharing decisions and information, for the benefit of the patient. This is why we have worked diligently with physician assistants, emergency medical service providers, and athletic trainers in their credentialing review applications over the last two years, to ensure this team-based model of care remains at the forefront of any modernization of scope of practice.

Unfortunately, we have not received the same level of drive towards a team-based approach with this applicant group. The application remains extremely broad, which makes it difficult to come together and find common ground on how we can work towards benefiting the patient. Generally, the NMA's position remains that this application should be three separate proposals because it seeks to alter three distinct practice acts in Nebraska law. The approach by the Board of Nursing makes your task of determining how this proposal weighs against the statutorily mandated criteria a difficult one, and as the previous meetings of the Technical Review Committee have shown a lot of information can get lost in fray due to jumping back and forth between professions and practice acts.

Nebraska law is ambiguous on whether different health professions are able to bring an application forward together as one. An "applicant group" is defined as any health professional group which proposes to change the scope of practice of a regulated *health profession*.¹ A "health profession" is defined as a vocation involving health services...requiring specialized

¹ Neb. Rev. Stat. 71-6204

knowledge and training.² Arguably, because each APRN professional requires separate certification by a separate body, each APRN license is a separate vocation that requires specialized knowledge and training. For example, a clinical nurse specialist could not obtain a license as a certified nurse midwife, unless that clinical nurse specialist possessed the specialized knowledge and training to meet the requirements of certification for nurse midwives.

The following information is meant to add perspective to the claims set forth in the Board of Nursing's proposal and to better inform you of additional considerations that have been glossed over by the application. The NMA maintains it is clear the primary object of this proposal is to align with recommendations set forth by the National Council of State Boards of Nursing (NCSBN), a national organization that seeks to expand advanced nursing practice beyond and outside the traditional role and norm of team-based care. In fact, on page 35 of the proposal, the applicant group even provides you with NCSBN's broad opinion on when scope of practice laws should be expanded. However, NCSBN carries no weight of authority in Nebraska and desire to align with a national organization's objectives is not one of the criteria Nebraska law demands for successful credentialing review proposals.³

At the forefront of our state's credentialing review process is the safety, benefit, and need to the public. Part of the NMA's mission statement is to be advocates for the health of all Nebraskans, which includes ensuring patient safety is protected in Nebraska's health care system. We firmly believe this proposal neither guarantees patient safety nor does it clearly exhibit a benefit to the public, and it makes assumptions as to addressing the need for more rural access to care, which has not been the case in other states or in Nebraska since nurse practitioners were allowed practice independence in 2015.

I. Patient Safety

The World Health Organization defines patient safety as the absence of preventable harm to a patient during the process of health care, and the reduction of risk of unnecessary harm associated with health care to a minimum.⁴ At the core of patient safety, is whether a health professional has the education and training necessary to perform the tasks and provide the care necessary to achieve the absence of preventable harm. There is no dispute that APRNs have undergone nursing training at both the bachelors and graduate level, however the key question of this proposal is whether that nursing training is sufficient to guarantee patient safety during independent practice. Especially when nursing training, particularly at the bachelors level where the bulk of the education takes place (4 years vs 18-24 months) is focused on the team-based approach to health care.

The State of Nebraska found the education and training of certified nurse midwives to be insufficient for guaranteeing patient safety the two previous times the profession attempted to

² Neb. Rev. Stat. 71-6210

³ Neb. Rev. Stat. 71-6221(3)

⁴ Patient Safety, World Health Organization. <https://www.who.int/patientsafety/en/>. Accessed on September 10, 2020.

remove the collaborative agreement requirement with a physician. Nothing in the application describes what has changed in nurse midwife education and training to warrant a diversion from this state policy.

Similarly, the Legislature had concerns about nurse practitioner education and training and practicing independently immediately upon graduation, resulting in the 2,000 hour transition-to-practice (TTP) requirement with a physician being set into law, which this application seeks to remove. The application incorrectly characterizes this requirement on page 18 as a “legislative concession”. This is misleading, as it is clear this was a decision by policymakers to implement this requirement for the protection of their constituents.

Additionally, clinical nurse specialists have only been a recognized profession in this state for 15 years, at which point the Legislature decided it was not prudent to include prescriptive authority, and arguably was silent on the ability to treat and diagnose patients given the administrative role these professionals play.⁵ Nothing in this application describes what has changed for these professions to merit alteration of the scope of practice policy recently set by the Legislature.

The application makes the presumption that the education and training of APRNs is sufficient as it only lists a broad outline of objectives APRNs focus on at the graduate level. The description of the education and training on page 19 of the application uses terms such as, “be comprehensive”, “prepares the graduate”, and “ensures coursework is comprehensive”. It never explains how or why this education is enough to justify the scope of practice changes sought, as required by Nebraska law⁶; rather, the applicant group forces the Committee to assume it is adequate. In fact, the proposal only specifically mentions *three* courses that APRNs take, which are presumed and cited by the applicant group to be enough to warrant practicing and prescribing drugs independently. It is hard to believe that three courses are enough to gain the knowledge and training necessary to seek removal of physician oversight, especially when those courses are roughly equivalent to one semester’s worth of a true four-year medical education.

This is concerning, especially when considering that a recent survey focused on online education found that graduate level nursing was the second most popular program for online graduate students, right behind business administration.⁷ The difference being that business administration teaches concepts fully adaptable to online learning; whereas, online graduate nursing programs might be able to teach basic courses but any hands-on experience with patients in a clinical setting is surely lacking in adequacy, if even present at all.

The application is silent on the number of hours APRNs spend gaining valuable hands-on experience in clinical settings; the NMA had to ask members of the applicant group directly what this sort of training looked like for APRNs. What we learned was troubling to us, and should be to the Committee as well. Nurse practitioners are only required to have 500 clinical hours at the

⁵ See, Neb. Rev. Stat. 38-906, which does not include the terms “diagnose” and “treatment”

⁶ Neb. Rev. Stat. 71-6221(3)(d)

⁷ Clinefelter, D.L., & Aslanian, C.B. (2015). *Online College Students 2015: Comprehensive Data on Demands and Preferences*. Louisville, KY: The Learning House Inc.

graduate level and 1,000 clinical hours at the doctoral level, which is grossly insufficient when compared to the 16,000-18,000 hours obtained during the medical education process. Nurse midwives only have to *attend* 30-50 births as part of their training, which is about 1% of the amount OB/GYNs conduct during their training.

When the NMA brought up these figures at the most recent meeting of the Committee, some Committee members gave feedback that it was unfair to compare the training of APRNs to physicians, because the applicant group is not claiming to have the requisite knowledge and experience gained through medical school. Yet this is exactly the problem, because what this application attempts to do by removing all collaborative agreement requirements and restrictions on prescribing drugs results in all APRNs essentially engaging in the practice of medicine. There would be no oversight for nurse midwives attempting to deliver newborn babies, there would be no oversight for clinical nurse specialists prescribing controlled substances, there would be no oversight of nurse practitioners diagnosing complex health issues.

The applicant group attempts to confuse this issue by stating that part of the advanced nursing education focuses on collaboration and knowing when to consult “other members of the health care team”. While the NMA believes that professionals will act professionally and responsibly for their patients, relying on this belief does not get us closer to the minimum amount of risk and unnecessary harm that the World Health Organization describes as patient safety. Rather, this is predominately the reason that scope of practice laws and laws in general exist, to safeguard against the potential for risk to the public.

Furthermore, the applicant group again confuses this issue by pointing out that “collaboration” and “consultation” are defined in both the certified nurse midwifery practice act and the nurse practitioner practice act. However, this is a misstatement about how statutes and the law function and given the context of what is included in these sections, is grossly misleading to the Committee. The sections cited in the application for nurse practitioners are merely definitional in purpose⁸ and have no legal function unless used elsewhere in the practice act. One section of law that does mention these terms for nurse practitioners, the requirement of a transition-to-practice agreement, is the very section this application seeks to do away with.⁹

This misrepresentation of the law is even more egregious when looking at the certified nurse midwifery practice act, as the statutory sections the application cites (Neb. Rev. Stat. 38-607 & 38-610) for collaboration and consultation are the sections this application seeks to remove. These two sections define the collaborative and supervisory consultation requirements nurse midwives are required to have with physicians. Because the application did not submit proposed statutory language, the Committee must take the asks of this proposal on its face, and as such, must assume that these sections will be outright removed by their proposal. These misstatements of the law are unfortunate for the committee to have to decipher, given that it is comprised of health professionals and laypersons, not lawyers.

⁸ See: Neb. Rev. Stat. 38-2308 & 38-2309

⁹ Neb. Rev. Stat. 38-2314.01

When presented with the opportunity on page 29 of the application to recognize any potential harms to the public that might result from their scope expansion proposal, the applicant group only put forth complaint data submitted to the Board of Nursing, and missed the chance to be self-reflective and recognize any potential shortcomings of their proposal. For certified nurse midwives, the proposal broadly suggests that removing practice restrictions will not harm mothers and infants, citing an organization that does economic research, not one that does health care centered research. The proposal then implies that because there have been no disciplinary actions against certified nurse midwives, this means that there is not potential harm to the public. This angle conveniently forgets that is highly likely there have been no complaints or disciplinary actions against certified nurse midwives because they currently practice under the supervision of a physician. This shows that collaborative agreements work to ensure patient safety, and directly contradicts the claim on page 11 of the application that “there is no evidence collaborative practice agreements or transition-to-practice agreements change practice outcomes”.

One final concern about patient safety and the lack of education and training of these different APRN professions centers around continuing education and competency. Again, the Committee is asked by the proposal to assume that the continuing education and competency is sufficient, as the applicant group never specifically explains the continuing education requirements and appears to defer these requirements to national organizations, removing control and oversight from the state. When discussing the maintaining of competency on page 31, the application goes into detail on how the process works in an employed hospital setting. However, it is silent on how competency is to be measured when APRNs would be practicing independently in their own clinics, which this proposal seeks to allow.

II. Access Issues

For at least the last three decades, Nebraska, other rural states, and the federal government have been trying to solve the increasing issue of access to health care for the rural population. Lack of availability to primary and specialty care does play a part in this issue, but it is not the only piece of the equation. Compared to urban areas, rural populations have lower median household incomes, a higher percentage of children living in poverty, fewer adults with postsecondary education, and more uninsured residents, all of which can lead to negative health outcomes.¹⁰

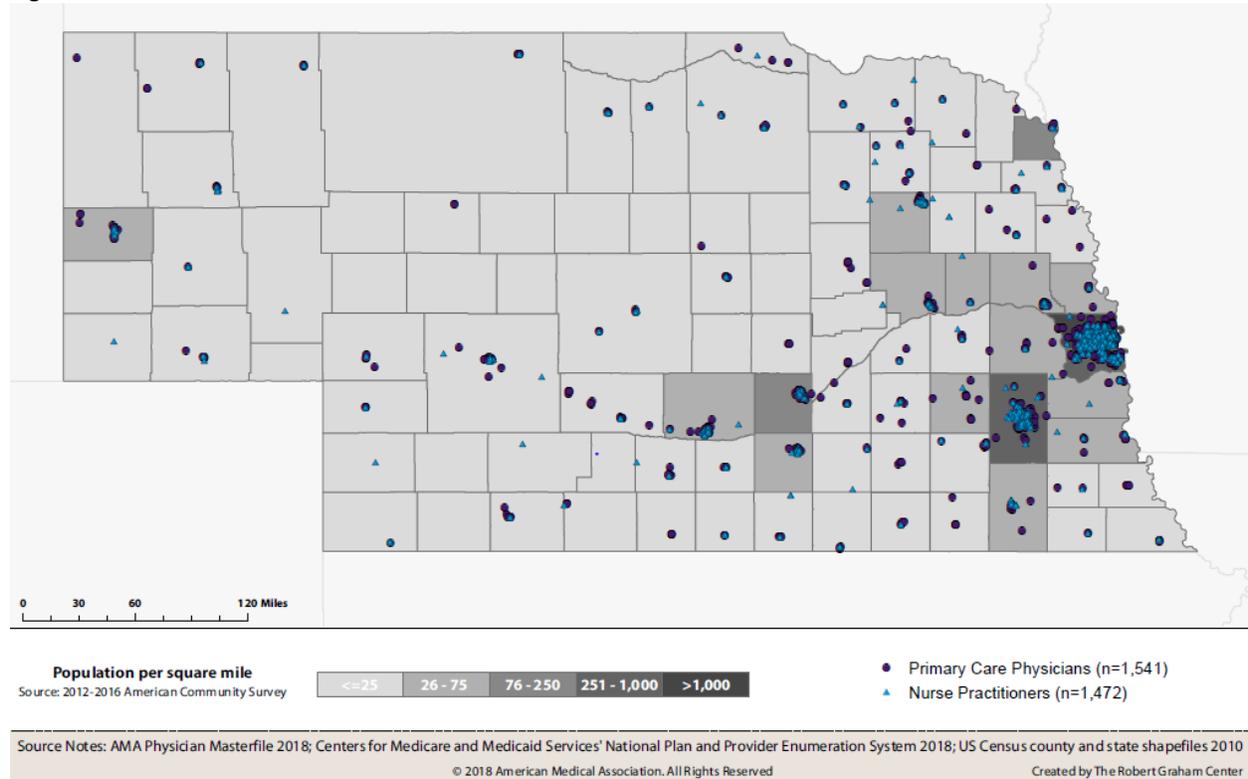
The applicant group asserts on page 28 that full practice authority for all APRNs could help build the rural workforce necessary to meet primary care needs. Unfortunately, the data does not support this claim. At the national level, a recent study conducted by *Health Affairs* found that between 2006 and 2018, those states that require some relationship with a physician in order to practice saw the fastest growth of nurse practitioners in the workforce.¹¹

¹⁰ Warshaw, Robin. Health Disparities Affect Millions in Rural U.S. Communities, Association of American Medical Colleges. <https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities>. Accessed on September 15th, 2020.

¹¹ Barnes H, Richards MR, McHugh MD, et al. Rural and Nonrural Primary Care Physician Practices Increasingly Rely on NP. *Health Affairs*. 2018;37(6). Pg. 908-914.

Additionally, a review conducted by the American Medical Association of the practice locations of primary care physicians and nurse practitioners across the country shows both physicians and nurse practitioners tend to practice in the same areas, regardless of the level of independence allowed by the state.¹² This observed trend remains true in Nebraska, which Figure 1 below illustrates using Centers for Medicare and Medicaid Services data from 2018, three years after nurse practitioner independent practice was permitted in Nebraska.

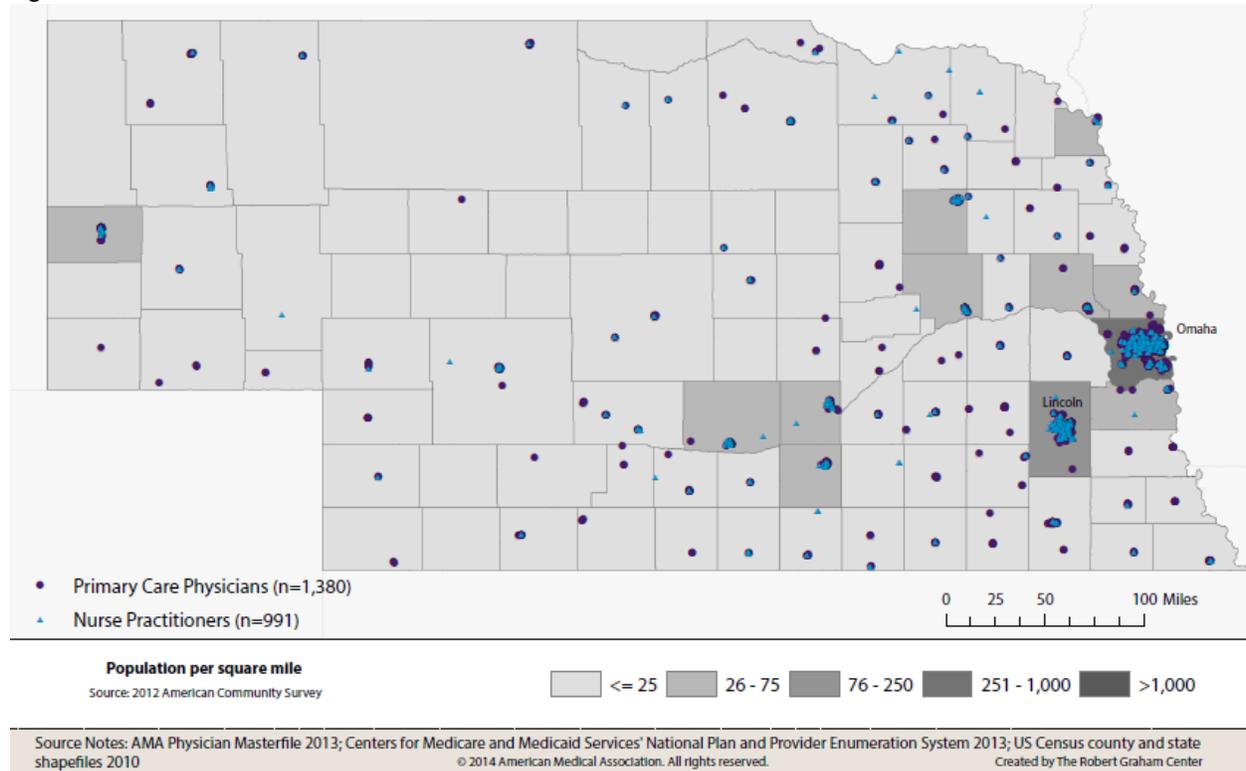
Figure 1.



The applicant group will likely blame the transition-to-practice agreement requirement as the reason for nurse practitioners not moving to rural areas of Nebraska. However, this argument is flawed for two reasons. First, the 2,000 hour requirement equates to, at most, a year of supervision under a physician (assuming a 40-hour work week), meaning when this data was pulled in 2018, nurse practitioners could have been in their second full year of independent practice; and second, when comparing Figure 1 above, to the same data from 2013 in Figure 2 below, you can see there was minimal movement of nurse practitioners to rural areas resulting from the independent practice legislation of 2015. Upon closer examination, there actually appears to be more primary care physicians in rural areas in 2018 compared to 2013 due to efforts undertaken by medical schools and the state to recognize the shortage and work to address it.

¹² AMA Geographic Mapping Initiative. 2018.

Figure 2



For clinical nurse specialists, it is difficult to comprehend how adding prescriptive authority to their scope of practice will increase access to primary care in rural areas when page 21 of the application describes the key elements of their practice as “creating environments through mentoring and system changes that empower nurses to develop caring practices.” In fact, according to page 28 of the application 75% of clinical nurse specialists spend their time in roles *other than* direct primary care.

Certified nurse midwives do offer a form of primary care, albeit a specialized form which reaches only half of the population; however, the care they are able to provide does not rise to the level of meeting the demands for comprehensive primary care. The applicant group on page 27 recognizes that certified nurse midwives are the slowest growing profession of the APRNs in the state, predominately due to there being no Nebraska based education program. Which begs the question of why out-of-state certified nurse midwives would come work in rural Nebraska when there is likely work available in rural areas in the state in which they were educated. This argument by the applicant group is further flawed when considering that according to the 2017 Center for Nursing Workforce Forecasting Model, Omaha and Lincoln will face some of the most extreme APRN shortages in the state through 2025, again posing the question of if movement to rural areas will actually occur. Obviously, other considerations factor into the decision to move to rural areas, but it is wishful thinking to believe the rural primary care shortage can be addressed by permitting certified nurse midwives to practice and prescribe independently.

The applicant group is likely correct on page 27 of the application that the requirement in Nebraska law for certified nurse midwives to work under the supervision of an OB/GYN might be artificially inflating the congregation of certified nurse midwives in urban areas. However, independent practice authority is not the answer to solving this problem as many rural hospitals likely will not take on independent certified nurse midwives because the risk of their limited skill set outweighs the benefit they would provide. A more thoughtful approach would have been to amend Nebraska law to strengthen and expand the relationship between certified nurse midwives and physicians, seeking more flexibility in practice and supervision. This once again shows the primary of this application does not have the Nebraska patient and the public at the forefront.

III. Costs and Risks to the Nebraska Health Care System

One significant area that has been overlooked by the applicant group thus far is the potential cost impact to the Nebraska health care system. The submitted application does not consider any rise in potential liability due to the changes the applicant group is seeking, nor does it offer any requirements for liability coverage. Furthermore, studies have shown that independent practice for APRNs has led to an increase in the ordering of diagnostic tests and imaging, as well as an increase in prescribing of both opioids and antibiotics. More details on these studies are below, but together these items can have a negative impact on patients by increasing the costs to insurance premiums and the health care system overall in Nebraska, with the costs ultimately trickling down to the patient in the form of either increased out-of-pocket charges or increased premiums.

A recent *JAMA Internal Medicine* study looked at diagnostic imaging, such as medical imaging, by APRNs compared to primary care physicians after office-based encounters. The study found that APRNs were associated with more ordered diagnostic imaging than primary care physicians; further, APRNs were associated with more imaging on both new and established patients, with results being more prominent with new patients.¹³ The authors suggest that policymakers should look closer at efforts to expand access to care by substituting APRNs for physicians, without appropriate mechanisms in place for imaging which may further elevate health care costs and potentially increase patients to unnecessary radiation exposure.

It is worth noting that the authors also conclude that APRNs can serve an important role in primary care access. However, they warn that expansion of APRN scope of practice must be mindful of the additional cost, safety, and quality implications that may occur, and that greater coordination in health care teams can produce better outcomes than merely APRN independent practice alone. This is the approach that physician assistants took in 2019 with their credentialing review application. They were able to successfully modernize their scope of practice which will allow for greater access of patients to physician assistants, while at the same time maintaining a

¹³ D.R. Hughes, et al., A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA Internal Med.* 2014;175(1):101-07.

physician relationship to control for situations in which a team-based approach is more appropriate for the care of the patient.

Additionally, a report by the Infectious Diseases Society of America examined APRN antibiotic prescribing, compared with physicians for all ambulatory visits.¹⁴ The proportion of visits in which antibiotics were prescribed was 12% among physicians versus 17% for APRNs, which the authors noted was a statistically significant difference. For visits treating acute respiratory tract infections, the proportion of visits in which antibiotics were prescribed was 54% among physicians compared to 61% among APRNs. This is a concern because overuse of antibiotics contributes to antibiotic resistance, increased prevalence of multidrug-resistant bacterial infections, and avoidable adverse drug events among patients, all of which can have a considerable impact on the health care system at the local level.

Moreover, additional research suggests that APRNs are more likely to over-prescribe opioids than primary care physicians. Data from the Medicare population shows that 3.8% of physicians met at least one definition of over-prescribing, compared to 8% of APRNs. A closer look at the data revealed that 1.3% of physicians prescribed an opioid to at least half of their patients versus 6.3% of APRNs. Further, only 0.7% of physicians were “high frequency prescribers”, compared to 7.5% of APRNs.¹⁵ As the last several years have shown, over-prescribing of opioids can have a significant long-term cost to the health care system, and it is worth pointing out that the data above are in the population in which clinical nurse specialists are often specialized, gerontology.

Finally, a topic that can have significant impact on health care costs, and on the health care system as a whole, is malpractice and the subsequent liability of those actions. Potential malpractice claims are a reality for any health professional, no matter the skill set or experience level. However, studies have shown the likelihood for malpractice by advanced providers, such as APRNs, is increased when there is a lack of physician supervision and/or failure of the provider to consult with a physician.¹⁶

A study conducted by a medical malpractice liability insurer examined claims against APRNs from 2012 to 2017. For nurse practitioners, the top three patient allegations were diagnosis related, which the study defined as failure, delay, or incorrect (35%), improper management of treatment (16%), and improper medication management (11%).¹⁷ After independent review of these claims, the top contributing factors of the patient injury included patient assessment issues (48%) and selection/management of therapy (23%).¹⁸ Furthermore, patient injury severity of

¹⁴ Guillermo Sanchez, Adam Hersh, Daniel Shapiro et al., Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. *Open Forum Infectious Diseases*. 2016:1-4.

¹⁵ M. James Lozada, Mukalia Raji, James Goodwin, et al. Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns. *Journal of General Internal Medicine*. April 24, 2020.

¹⁶ Advanced Practice Provider Liability: A Preventative Action and Loss Reduction Plan. *The Doctors Company*. 2018. Accessed at: <https://www.thedoctors.com/siteassets/pdfs/marketing-order-form-items/advanced-practice-provider-liability-book.pdf>.

¹⁷ Id, Pg. 10.

¹⁸ Id, Pg. 12.

these claims was measured on the National Association Insurance Commissioners (NAIC) Injury Severity Scale, which is broken down into low, medium, and high categories. Of the claims examined for nurse practitioners, 51% were determined to be of high severity, and 40% were rated medium severity.¹⁹

For certified nurse midwives, the top three patient allegations were diagnosis related, which again the study defined as failure, delay, or incorrect (23%), improper performance of vaginal delivery (15%), and delay in treatment of fetal distress (15%).²⁰ Following independent review of those claims, the top contributing factors of the patient injury were technical performance by provider (35%), patient assessment issues (31%), selection and management of therapy (23%), and failure/delay in obtaining a referral to physician or specialist (23%).²¹

These numbers in particular should be concerning because they reflect a lack of education and training in certified nurse midwives to practice without physician oversight. In fact for all APRNs, the study contributes the bulk of the claims resulting from failure or improper diagnosis to lack of physician supervision, failure to consult with a physician, and inadequate experience of the APRN in diagnosing and managing particular conditions.²² For claims that resulted from failure or delay in obtaining a referral to physician or specialist the study contributes those claims to APRNs that that independently manage a complication that is beyond their expertise, skill set, or scope of practice.²³ Finally, the study found that claims resulting from inadequate evaluation occurs when the APRN relies on previous medical history and other sources to determine the diagnosis, rather than performing and analyzing a comprehensive exam.²⁴

Malpractice liability is a serious issue and concern, and unfortunately the Board of Nursing failed to mention it in their application, focusing rather on disciplinary complaints filed with the Board as showing that patient safety would not be compromised. This topic also shows why lack of statutory language in this proposal is disappointing. Currently, nurse practitioners in Nebraska are required to carry malpractice liability insurance,²⁵ yet, the proposal includes no such language for certified nurse midwives or clinical nurse specialists even though the potential risk will be considerably higher if this proposal is adopted.

IV. Regulatory Consensus Model and Multi-State Compact

The regulatory consensus model created by the National Council of State Boards of Nursing (NCSBN) in 2008 is the primary theme of the proposal submitted by the Board of Nursing. Multiple references to the desire to adhere to this consensus model are present throughout the proposal, even though accomplishing complete compliance with this national model is aimed at

¹⁹ *Id.*, Pg. 11.

²⁰ *Id.*, Pg. 18.

²¹ *Id.*

²² *Id.*, Pg. 19.

²³ *Id.*

²⁴ *Id.*

²⁵ Neb. Rev. Stat. 38-2320.

easing the workload for state licensure staff and the APRNs themselves, not for the patients of Nebraska.

However, there are instances throughout the proposal where the applicant group itself seems to contradict alignment with this national model. For example, page 24 of the application explains that “scope of practice laws are set by the individual states and define the range of tasks legally allowed for a given provider within state boundaries.” This raises the question of why the NCSBN insists on taking state policy out of the equation by altering existing state level scope of practice laws in order to give a board of nursing a rating of being in complete compliance with their regulatory model.

On page 29 of the proposal, the applicant group is asked to describe the problem created by not changing the scope of practice of the professionals. The first item that the applicant group lists is “regulatory inefficiency”, which again demonstrates that the primary aim of this proposal is not to address the list of criteria provided in statute needed for successful credentialing review, which focus more on benefits to the public and the health care system.

What makes this approach even more perplexing, is the proposal itself explains how the regulatory inefficiency issue is already being addressed by the Department of Health and Human Services (DHHS). Per Executive Order No. 17-04 issued by Governor Ricketts, DHHS has begun the process of reviewing the agency’s regulations in order to promote efficiency in regulations overall. In fact, the regulations that govern APRNs were consolidated from five separate chapters²⁶ to one singular chapter of regulation that removed duplicative language and requirements.²⁷ This process began on August 27, 2019, with the final regulations becoming effective on September 19, 2020.

What this shows is regulatory inefficiency can be, and has been, addressed without the need to alter scope of practice. Yet, instead of continuing to examine routes that can be taken to improve regulatory efficiency at the state level, which would fall under the purview and function of the Board of Nursing, the proposal seeks to alter scope of practice to align with a national organization under the guise of regulatory efficiency.

The proposal, on page 29, continues the topic of regulatory inefficiency by mentioning that the statutory provisions governing APRNs are outdated and conflicting, although the applicant group never goes into detail on which provisions, specifically, they believe could be improved. A prudent person could expect these issues to be solved through thoughtful legislation, similar to what the physician assistants just accomplished last year with their credentialing review. Yet once again, the proposal does not include statutory changes that seek to improve and modernize these provisions. On the same page of the application, the applicant group also mentions how regulatory duplication could be occurring because Nebraska law authorizes the existence of an APRN Board, in conjunction with the Board of Nursing. However, nothing in the proposal indicates that the applicant group seeks to dissolve the APRN Board, which further shows that if

²⁶ 172 NAC 98, 100, 103, 104, & 107.

²⁷ 172 NAC 98.

regulatory efficiency was indeed an issue the proposal was seeking to solve, more approaches could have been taken to accomplish that goal.

Closer examination of the regulatory consensus model pushed by the NCSBN reveals that four of the ten “foundational requirements for licensure” would alter Nebraska state law and policy in order to achieve complete compliance.²⁸ The proposal makes no mention of how the applicant group wishes to accomplish alignment with two of these four requirements.

One of the four requirements is the NCSBN directive the applicant group is seeking with this proposal: license APRNs as independent practitioners with no regulatory requirement for collaboration, direction, or supervision; further showing the true root of this proposal is not grounded in what is best for Nebraska patients. The second requirement is an item the proposal discusses throughout, and one that this report has more discussion on below: the allowance of licensure recognition through an APRN Compact.

The third consensus model requirement that would alter state policy mandates that boards of nursing be solely responsible for licensing APRNs. As mentioned above, there exists in Nebraska law an APRN Board, and the proposal makes no mention of seeking dissolution of this Board via statutory changes. Finally, the fourth NCSBN requirement for the consensus model is a prohibition against issuing temporary licenses. This would be a drastic change from the state policy set by the Legislature. Over the last several years, the Legislature has passed into law eight bills that expand temporary licenses to professionals across the state, with improved mobility for military families being the primary motivation. It would be difficult to believe the Legislature would deviate from this policy view so that APRNs could come into full adherence with a national objective provided by the NCSBN consensus model.

Turning to the APRN Compact, as described above, adoption of the Compact is a NCSBN requirement for total compliance with the consensus model. It was launched by the NCSBN in 2015, which created a multistate license that authorizes all four APRN professionals to practice in all member states of the Compact. Licensure compacts in general must be approved uniformly (i.e., without changes made to the language of the Compact) by state legislatures and often have a minimum state adoption requirement to take effect. In those five years since introduction of the APRN Compact, only three states have joined the Compact, which does require a minimum of ten states to go into effect. This means that if adopted, Nebraska would be joining something that has not had the time to have issues worked out in other states and would have an unknown effective date in our law.

What makes the APRN Compact unique is that it supersedes state laws on scope of practice, including those that require practice under a physician, collaboration with a physician, and restrictions on prescriptive authority.²⁹ No other licensure compact adopted by the Nebraska Legislature has sought to override state law like this. All other compacts in existence seek to obtain regulatory efficiency and ability to practice across state lines through uniform provisions

²⁸ APRN Consensus Model, Pg. 14.

²⁹ See, Article III of the APRN Compact

that promote such efficiencies, while still respecting state law and policy on scope of practice. This further shows that throughout the health care professional environment, state policy towards scope of practice is respected. These compacts recognize that each state is different and unique in how they approach health care policy and the protection of its' own citizenry.

The APRN Compact has been introduced in the Legislature in both 2018 and 2019, and in both instances, the Health and Human Services Committee rejected the proposed legislation due to the overriding of state law on scope of practice. This credentialing review proposal is seeking to alter that scope of practice, but as mentioned several times before, the applicant group has not shown justification toward the benefit of the public for these changes, only desired alignment with a national objective.

V. Conclusion

The NMA remains committed to the use of patient-centered, team-based care. A team-based approach includes physicians and other health professionals working together, drawing on the specific strengths of each team member. Health care teams require leadership, just as teams do in business, government, sports, and schools. Physicians bring to the team the highest level of training and preparation, and as such are the best suited to guide the other members of the team. Health care professionals such as APRNs are indispensable members of the team, but they cannot take the place of a fully trained physician.

APRNs and physicians have skills, knowledge, and abilities that are not equivalent, but instead are complementary. The most effective way to maximize the talents of the complementary skill sets of both professionals is to work as a team. This proposal by the Board of Nursing makes no attempt to work in the team-based model of care for the betterment of the public; it instead seeks to break up the team, at the direction of national objectives. This is not what is best for Nebraska patients.

This report has highlighted the many shortcomings, inaccuracies, and misconceptions presented by the Board of Nursing in their application for scope expansion of three of the four APRN professionals. The application is thin on the details of how this proposal meets the statutory criteria for credentialing review or how it ensures patient safety. If team-based care was at the forefront of the applicant group's proposal, the NMA could have worked thoroughly with the Board of Nursing to ensure proper modernization and simplification of these three APRN practice acts. Instead, the NMA respectfully requests the Technical Review Committee reject this proposal in its' entirety.