

BEFORE THE DIALYSIS TECHNOLOGISTS' TECHNICAL REVIEW
COMMITTEE, DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
STATE OF NEBRASKA

_____))
IN THE MATTER OF)) TRANSCRIPT
A PUBLIC HEARING REGARDING THE)) VOLUME I of I
DIALYSIS TECHNOLOGIST LICENSURE)) (Pages 1 through 63)
APPLICATION.))
_____))

Nebraska State Office Building
14th and M Streets
Conference Room Lower Level F
Lincoln, Nebraska

Convened, pursuant to notice, at 1:00 p.m.,
July 25, 2016,

BEFORE:

Dr. Travis Teeter, Chairperson.

COMMITTEE MEMBERS PRESENT:

Dr. Allison Dering-Anderson, Dr. Susan Meyerle,
Dr. Michael Millea, Dr. Michael O'Hara, and
Ms. Corinne Pedersen

- - -

DHHS STAFF PRESENT:

Ron Briel, Administrator
Matt Gelvin, Administrator
Marla Scheer, Administrative Staff

I N D E X

Reporter's Certificate 3

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TESTIMONY: PAGE

FOR THE PROPONENTS:

Matt Bauman	6
Tim Neal	22
Jina Ragland	25

FOR THE OPPONENTS:

Kandis Lefler	30
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SUMMARY BY THE PROPONENTS:

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REPORTER'S CERTIFICATE:

State of Nebraska)
) ss
County of Lancaster)

I, LINDA W. ROHMAN, reporter for GENERAL REPORTING SERVICE, and a Notary Public duly commissioned, qualified and acting under a general notarial commission within and for the State of Nebraska, certify that I reported the proceedings in this matter; that the transcript of testimony is a true, accurate, and complete extension of the recording made of those proceedings; that the transcript consists of:

Volume I - Pages 1 through 63;
and, further, that the disposition of any exhibits is referenced in the index hereto.

IN TESTMIONY WHEREOF, I have hereunto set my hand officially and attached my notarial seal at Lincoln, Nebraska, this _____ day of August, 2016.

Reporter

- - -

1 PROCEEDINGS:

2 MS. SCHEER: Dering-Anderson.

3 DR. DERING-ANDERSON: I'm here.

4 MS. SCHEER: Meyerle.

5 DR. MEYERLE: Here.

6 MS. SCHEER: Millea.

7 DR. MILLEA: Here.

8 MS. SCHEER: O'Hara.

9 (No response.)

10 MS. SCHEER: Pedersen.

11 MS. PEDERSON: Here.

12 MS. SCHEER: Teeter.

13 CHAIRPERSON TEETER: Here.

14 And then, just as a reminder, this is a public
15 meeting. The Open Meeting Law is posted around.

16 The next announcement that I have is that, if
17 anyone has not signed in to comment, please let us know now.
18 Otherwise, we're going to have the lists up here and go off
19 the lists that are up here.

20 So, the first thing we'll do is approve the agenda
21 for the public hearing today.

22 DR. MEYERLE: So moved.

23 DR. DERING-ANDERSON: Second.

24 CHAIRPERSON TEETER: Are there any objections?

25 (No response.)

1 We don't have to roll-call those, do we?

2 MR. BRIEL: Just -- yeah. Just -- you don't need
3 to roll-call. Just voice vote.

4 CHAIRPERSON TEETER: Any objections?

5 (No response.)

6 Okay. We'll approve the agenda as noted.

7 And then, approval of minutes from the prior
8 meeting.

9 MR. BRIEL: Better do a roll-call on that. Move
10 and second.

11 DR. DERING-ANDERSON: Move to approve.

12 MS. PEDERSEN: Second.

13 CHAIRPERSON TEETER: Roll call.

14 MS. SCHEER: Meyerle.

15 DR. MEYERLE: Yes.

16 MS. SCHEER: Millea.

17 DR. MILLEA: Yes.

18 MS. SCHEER: Dering-Anderson.

19 DR. DERING-ANDERSON: Yes.

20 MS. SCHEER: Pedersen.

21 MS. PEDERSON: Here. Yes.

22 MS. SCHEER: Teeter.

23 CHAIRPERSON TEETER: Yes.

24 And then, we will go ahead and enter into the
25 public hearing. The first thing we will do is have

1 testimony from the applicant group.

2 MR. BRIEL: And each group has 60 minutes, however
3 they want to use it, total. And questions from the
4 Committee will not be taken out of your time.

5 MR. BAUMAN: Do you need my name for the record?

6 MR. BRIEL: And spell your name.

7 MR. BAUMAN: Matt Bauman, B-a-u-m-a-n.

8 MATT BAUMAN

9 I work for the Dialysis Center of Lincoln,
10 Lincoln, Nebraska. I'm here representing the Nebraska
11 Kidney Coalition. I'm just going to read my testimony. I
12 will not take an hour.

13 Since April of 1991, the dialysis industry in the
14 state of Nebraska has utilized the skills of the dialysis
15 patient-care technician in the safe provision of dialysis
16 care as directed by the Board of Nursing's Advisory Opinion.
17 The Advisory Opinion, titled *Delegation, Direction, and*
18 *Assignment in the Outpatient Dialysis Unit*, was adopted in
19 1991. It was revised in 1996, was reaffirmed in 2000,
20 revised again in 2003, and reaffirmed again in 2005, before
21 its retirement this year. Or, I should say, in October of
22 2015.

23 In June of 2015, dialysis leaders in Nebraska were
24 notified that the Advisory Opinion, which specifically laid
25 out duties of the dialysis patient-care technician in the

1 outpatient dialysis clinic, had been under review by the
2 Board of Nursing since September of 2015. Representatives
3 of those industry-leading dialysis providers sit before you
4 today as members of the Nebraska Kidney Coalition.

5 We met several times with the Practice
6 Committee --

7 Actually, I should go back. I have my dates -- I
8 think we were notified in September that it was under review
9 since June of 2015.

10 We've met several times with the Practice
11 Committee of the Board of Nursing seeking direction on how
12 to proceed with the provision and the use of the dialysis
13 patient-care technician in the absence of the Advisory
14 Opinion, which was around for over 20 years. We were
15 encouraged to enter into the 407 process, as it's called, in
16 an effort to define a range of duties that we are proposing
17 would be very near identical to those that were previously
18 existing in the Advisory Opinion for over 20 years.

19 Initially, we sought a very simple process of
20 registration in the state of Nebraska. We felt that, by
21 registering the patient-care technicians, they would still
22 be required to complete all the education outlined in the
23 ESRD Conditions for Coverage laid out by Medicare, which are
24 the regulations that dialysis providers nationwide must
25 follow to be licensed to provide dialysis and receive

1 financial reimbursement from CMS. Also as a note, as many
2 dialysis providers have, and as we have for probably the
3 last month, we are surveyed by State surveyors from the
4 State of Nebraska every 36 to 39 months, and those surveyors
5 actually survey us based on the CMS core survey.

6 For decades, patient-care technicians have worked
7 safely under the direction of qualified licensed registered
8 nurses in the state of Nebraska. Moving forward, it appears
9 as though the Technical Review Committee is seeking a more
10 specific oversight and accountability of the patient-care
11 technician, more so than was initially proposed. The
12 Nebraska Kidney Coalition amended the proposal to seek
13 licensure for the patient-care technician. We believe
14 licensure will provide a specific scope of practice, versus
15 a range of duties, and will allow the patient-care
16 technician to continue to provide care within the guidelines
17 of the State of Nebraska.

18 There's four criteria that this Technical Review
19 Committee and through this credentialing process, the
20 questions that are asked or criteria to be met. Criteria 1
21 is unregulated practice can clearly harm or endanger the
22 health and safety or welfare of the public. Criteria 2 is
23 the regulation of the health profession does not impose
24 significant new economic hardships on the public,
25 significantly diminish the supply and quality of

1 practitioners, or otherwise create barriers to service that
2 are not consistent with the public welfare and interest.
3 Additionally, -- and I will get to Criteria 3 -- but the
4 other criteria that I would also address would be the public
5 cannot be protected by a more effective alternative.

6 To address those top -- the 1, 2, and 4 criteria,
7 many of the requirements the patient-care tech must meet are
8 already laid out in the Conditions for Coverage from CMS.
9 We believe that these requirements can serve as a path to
10 licensure without the creation of an additional process or
11 an additional bureaucracy to create an economic hardship for
12 the public and/or potentially diminish the supply of
13 qualified providers. The State of Nebraska could use the
14 regulations related to the patient-care technician of
15 orientation, training, education requirements, continued
16 education, that already exist and are part of the ESRD
17 federal regulations.

18 Patient-care technicians could continue to provide
19 dialysis and care for patients as part of the health care
20 team as licensed professionals. Nationwide, dialysis
21 patient-care technicians have been providing safe and
22 effective ESR- -- care to ESRD patients, working alongside
23 registered nurses, LPNs, and physicians. Dialysis patient-
24 care technicians do not function in a vacuum, and we're not
25 asking that they should. Quite frankly, there just aren't

1 enough nurses of any licensure in the state of Nebraska to
2 provide the type of dialysis care that we need without the
3 assistance of the patient-care technician. Not allowing a
4 patient-care technician to assist in the provision of care
5 for ESRD patients may lead to diminished access to care in
6 the state of Nebraska, an alternative that may actually be
7 less beneficial to serve the patients that need dialysis in
8 Nebraska.

9 Criteria 3 is related to the public needs
10 assurance from the State of initial and continued
11 professional ability. And I would contend that we will meet
12 -- will be able to meet this, but with the advent of a
13 license for the patient-care technician, they would be
14 responsible to the State of Nebraska and a board providing
15 the regulatory oversight. It would be that board, using
16 orientation, education criteria, oversight of the proposed
17 scope of practice, and continuing education that would
18 provide a system of accountability to provide the assurance
19 of continued professional ability, no different than any
20 other licensed provider in Nebraska.

21 The members seated before you as part of the
22 Nebraska Kidney Coalition understand the industry of
23 dialysis in Nebraska. Our organizations provide care to
24 both urban and rural residents. ESRD is the only disease
25 specifically paid separately as part of Medicare, Part B.

1 We are a unique industry. We serve a unique population. We
2 are innovative, but we're also cautious. The use of RNs,
3 LPNs, and patient-care technicians allow for safe, quality
4 access to dialysis in the state of Nebraska. We're asking
5 for licensure for the dialysis patient-care technician with
6 the conditions and parameters outlined in our submitted
7 application.

8 That's all I have, Mr. Chairman.

9 CHAIRPERSON TEETER: Questions from anyone?

10 DR. DERING-ANDERSON: You said something to us
11 just now about this is licensure no different than all of
12 the others. I heard a difference, and I need some help.
13 Tell me about the licensure exam. Who's going to write it?
14 Who's going to guarantee the psychometrics? Who's going to
15 do that?

16 MR. BAUMAN: Well, there are three national exams
17 that are used currently now for certification. They exist.
18 If there's an opportunity for the State of Nebraska to adopt
19 that as a licensure, that could serve as a licensing exam.

20 DR. DERING-ANDERSON: Okay. And so, are you going
21 to pick one? Here's my concern. I don't get to choose for
22 three different companies for my driver's license exam. I
23 don't get to choose from three different companies for my
24 pharmacist's licensure exam. And the nurses, who I assume
25 are going to say, "Gosh, this looks just like our scope,"

1 don't get to pick who writes their licensure exam. There's
2 one. So, my question is, you're asking for a license; I'm
3 asking about the exam. Where's it going to come from?

4 MR. BAUMAN: And that's part of this process, is
5 we wanted to know if, since registration isn't acceptable,
6 as we've progressed to licensure, that would be the question
7 that I would have for the Technical Review Committee, in the
8 review of those exams, which one would be pertinent for the
9 State of Nebraska. But, since we don't know if we're going
10 down the licensure road yet, I don't exactly -- and we don't
11 exactly -- know how to proceed.

12 I would say that, as we've gone through this
13 process, the feedback that we've had from the Technical
14 Review Committee there didn't appear to be a liking for the
15 simple registration. So, what we've tried to do is say,
16 okay, let's go to a licensure. But, admittedly, there's
17 still a process in place, and we'd have to work together to
18 pick that and which ones would be acceptable to the State of
19 Nebraska.

20 DR. DERING-ANDERSON: Okay. And what board do you
21 -- do you see creation of a new board, or do you see this
22 profession housed within an existing piece of the existing
23 hierarchy?

24 MR. BAUMAN: We've spoken with -- or attempted to
25 speak with the Practice Committee of the Board of Nursing

1 and ask if there would be any interest in that being covered
2 by the Board of Nursing, and they said that wasn't their
3 decision to make. We did speak with Matt Gelvin and Ron
4 Briel that there is a provision that the State could create
5 an additional board. So, we're -- we think that it probably
6 makes sense to go under the Board of Nursing, but they
7 haven't agreed to do that. In the past, you know, with the
8 Advisory Opinion, it just makes sense that that would be
9 there, but I don't know that the tone has been such that
10 they've actually agreed to do that.

11 DR. DERING-ANDERSON: Thank you.

12 CHAIRPERSON TEETER: Of the three exams, is there
13 -- what people that take them, is there one that more people
14 take than another?

15 MR. BAUMAN: Our organization, I believe we use
16 NANT. But I can't speak for the other organizations.
17 There's -- there are a couple -- other than us, we're the
18 only independent, not-for-profit in Nebraska. But there is
19 a DCI. They're nationwide. DaVita is nationwide. And
20 Fresenius is nationwide. So, again, we've batted around a
21 couple of different ideas. But until we were able to come
22 to an agreement, if we get the okay to do licensure, then we
23 would have to try and present something. We just haven't
24 done that yet.

25 MS. PEDERSEN: My question would be what are the

1 steps to licensure? Where do they begin, Ron?

2 MR. BRIEL: What do you mean "where do they
3 begin"? Where does who begin?

4 MS. PEDERSEN: If they decide to go with the idea
5 of licensure --

6 MR. BRIEL: Well, I think they've already
7 indicated that.

8 MS. PEDERSEN: They've indicated that. But then,
9 what are the steps of -- is this Committee going to be the
10 one that will work with them through that whole process?

11 MR. BRIEL: No. No. No, you will not be. No.

12 MS. PEDERSEN: No, I don't think so. So --

13 MR. BRIEL: You will not. As soon as you've made
14 your recommendations, your role in this process ends. And
15 then, the Board of Health does the same thing. And then,
16 our CEO does the same thing. And the -- when it comes to
17 working out the details of a licensing bill or process, that
18 occurs between a senator that they get to sponsor their bill
19 and the people that we call bill-writers over there. So,
20 you will not be involved and to consult regarding what exam
21 to pick or whatever. That won't happen. They have to
22 circle the wagons of their own profession and decide which
23 of these exams is the one that fits our needs here in
24 Nebraska the best. You can't farm this out to the Technical
25 Committee.

1 MR. BAUMAN: And I -- when I say "you all," I
2 guess I'm looking at the State of Nebraska.

3 MS. PEDERSEN: I understand that.

4 MR. BRIEL: Yeah, that would be clearer. Yeah.

5 MR. BAUMAN: And going through that process.

6 MS. PEDERSEN: I just know there's some steps
7 there that would be undertaken, and I wanted to get some
8 kind of direction as to how many steps and where you begin
9 to even start to look that that.

10 MR. BRIEL: And you're the experts in your area.
11 If you throw the question at someone else, whatever the body
12 is, they're going to say, "Well, look, you know, I'm not in
13 your profession. You know your profession. Which of these
14 three exams is best?" You have to know.

15 MR. BAUMAN: Absolutely.

16 MR. BRIEL: Yeah. So, I think you just need to
17 pick one.

18 DR. DERING-ANDERSON: And I have a question about
19 timing. Currently, I am making an assumption that these
20 folks are not practicing, because there is question about
21 whether or not it's legal. How long will it take to have
22 them back in this licensing process? If I decide I want to
23 be licensed today and the bill has passed and all is well,
24 how long would it take me to get licensed so that I could
25 actually do these tasks and functions?

1 MR. BAUMAN: Well, okay. Depending on how we
2 would work that out with the State of Nebraska and go
3 through the licensure process, the Conditions for Coverage
4 they have to -- they, the patient-care technicians, have to
5 take the exam after 18 months. So, they have a year and a
6 half of practice, and then they have to take the exam. And
7 then, they have to take and pass that exam after they've
8 gone through their hiring process and the orientation. So,
9 we're looking at least 18 months to be able to pass that
10 exam, depending on how they function.

11 Now, there are things in a dialysis facility that
12 patient-care techs can do that are patient-care supportive.
13 They're not direct patient care.

14 DR. DERING-ANDERSON: Right.

15 MR. BAUMAN: So, there are different things like
16 that that are able to be done to be able to use those folks.
17 But I -- and at the risk of dooming and glooming, you will
18 see the potential closure of dialysis units just because of
19 the workforce that just isn't there and the availability of
20 open chairs. It's just something that the industry will
21 have to deal with and that health care in Nebraska will have
22 to deal with.

23 DR. DERING-ANDERSON: Okay.

24 CHAIRPERSON TEETER: So, in the intermediary,
25 currently, based on what the Board of Nursing has said, they

1 feel like you guys are doing tasks that are delegated --
2 non-delegatable tasks in the current state. This is
3 obviously going to take a while to work through the system.

4 MR. BAUMAN: Yeah.

5 CHAIRPERSON TEETER: So, is there issue with
6 patient-care technicians continuing to work in their current
7 setting until this gets through the system?

8 MR. BAUMAN: Well, I will say, to address the
9 Board of Nursing and their interpretation of complex versus
10 non-complex, --

11 CHAIRPERSON TEETER: The complex and non-complex.

12 MR. BAUMAN: -- I'm not aware that there's been
13 any actual vote to that effect, other than a unilateral
14 statement by one representative of the Board. So, I think
15 that that's up for interpretation as to what's complex or
16 non-complex. And once the Board of Nursing takes that up,
17 we'll probably go through a hearing process for that as
18 well.

19 So, I can speak for what our organization has
20 done. We've modified some of the care that we've done and
21 -- through some of the conversations. But, again, I can't
22 speak for the other organizations, many of which are
23 national organizations.

24 CHAIRPERSON TEETER: Okay.

25 DR. DERING-ANDERSON: So, with these

1 modifications, do you currently have closed chairs, closed
2 clinics, shorter hours?

3 MR. BAUMAN: We have -- without hiring
4 technicians, we've hired more LPNs at an increased cost, and
5 we're having a hard time doing that. We are unab- --

6 DR. DERING-ANDERSON: So, do you have shorter
7 hours, closed chairs or closed clinics?

8 MR. BAUMAN: We are unable to expand our current
9 services. We send patients now, from Lincoln, to Fremont,
10 York, and Omaha to receive care. We are one hundred percent
11 capacity and we have been for probably six months using
12 primarily RNs and LPNs.

13 CHAIRPERSON TEETER: Questions?

14 DR. O'HARA: On the exam issue, generically,
15 statu- --

16 Michael O'Hara, for the recorder to identify
17 voice. Sorry I came in late.

18 The statute will generically give the exam to the
19 board. The board will then have to pick. And that would be
20 true for any board that was created.

21 On how fast, I can't imagine this being done any
22 faster than -- unless you have an emergency clause -- than
23 about Labor Day of '17. Is -- have you encountered any
24 effort by the Board of Nursing to enforce their new
25 interpretation?

1 MR. BAUMAN: Not at this point. Because my
2 understanding is that the interpretation has been more
3 unilateral. Again, one person or there's an interpretation.
4 But, again, because there aren't specif- -- there's not
5 specificity in what is complex and non-complex, in our
6 organization, we look to something that happens on a
7 chronically stable patient multiple times a week. We train
8 family members to do the same thing at home. We consider
9 that working under the direction in a controlled environment
10 to be non-complex. It's not an acute situation.

11 DR. MILLEA: Is there any statistical difference
12 between -- in the death rates for family-done dialysis and
13 those done in a --

14 MR. BAUMAN: I'm sure there are. I don't have any
15 here to present you. I can speak to the general wellness of
16 the patient that does frequent home dialysis. They
17 typically -- they do better. They're healthier. They're
18 more active. Because we remove the peaks and the troughs of
19 fluid and electrolyte removal. And so, it's -- there's more
20 balance to that. Pardon my hand motions, but there's more
21 balance to that. You know, that -- I think that shows. And
22 we've seen that our home folks, whether they're doing PD or
23 even HHD, which would be home hemo, they do better. They're
24 healthier.

25 DR. MILLEA: Are they -- is this because they are

1 treated more frequently?

2 MR. BAUMAN: Yes.

3 DR. MILLEA: So, the three times a week, is that
4 accurate? Is it still three times a week?

5 MR. BAUMAN: That's the industry standard for
6 in-center. Home dialysis can be a prescription of four or
7 five, six times a week. And just -- the analogy that I've
8 heard a physician at a conference say, "How many of you go
9 to the bathroom three times a week?" And so, the more
10 frequent that we're able to maintain the fluid and
11 electrolyte balance, the healthier the patients do. There
12 is a push nationally to do more home, one, because of the
13 staffing costs, the fact that there just are fewer people
14 out there to provide that; the infrastructure cost; and the
15 fact that folks, they do better at home.

16 DR. MILLEA: Do you know how sacrosanct that time
17 is -- I'm sorry. I would be speaking louder, but I'm sick.
18 Not contagious, but I am ill.

19 MR. BAUMAN: I've got bad hearing. So, I'll lean
20 in and -- you do your best; I'll do my best.

21 DR. MILLEA: Is there a -- how sacrosanct is that
22 time frame? That 18 months?

23 MR. BAUMAN: That's written. That's written in
24 the Conditions for Coverage.

25 DR. MILLEA: That's written in the law?

1 MR. BAUMAN: That's actually written in the
2 regulations for the Conditions for Coverage for ESRD.

3 DR. MILLEA: Has anyone ever attempted to -- that
4 you know of in the United States -- attempted to set up a
5 training program, perhaps for community colleges or for,
6 even, at the baccalaureate level?

7 MR. BAUMAN: I don't know specifically. But
8 there's a representative here from DCI that I think we had a
9 discussion about that. I do know, at one point, Southeast
10 Community College in Lincoln, there had been some peripheral
11 discussion, but I wasn't involved in that. It just -- I
12 heard that a conversation took place, but I don't know any
13 more about that.

14 DR. MILLEA: Thank you.

15 DR. DERING-ANDERSON: Travis?

16 DR. MEYERLE: Two questions. One is, and I'm sure
17 we've covered this before, but could you give an estimate of
18 how many patient-care technicians you're anticipating there
19 are in Nebraska?

20 MR. BAUMAN: I think at once, we looked. We came
21 up with a 97 number. Ninety-ish, if I will.

22 DR. MEYERLE: Okay. And then, my second question
23 is what's the -- how are patient-care technicians licensed,
24 credentialed in other jurisdictions outside of Nebraska?

25 MR. BAUMAN: We've covered some of that. I

1 believe some of the information that -- I don't have that
2 with me, but there's a variety of certifications,
3 licensures. ANNA provided -- American Association of --
4 Nephrology Nurses Association, they provided a document. I
5 believe we included that in our application. It lists
6 those.

7 DR. MEYERLE: I didn't go back far enough.

8 MR. BAUMAN: Sorry. I just can't speak to all of
9 them. I think there's a combination.

10 CHAIRPERSON TEETER: Does anyone have any other
11 questions from that?

12 (No response.)

13 Okay. If we have anything else, we'll call you
14 back.

15 MR. BAUMAN: Absolutely. Thank you.

16 CHAIRPERSON TEETER: Next, we'll have Jina Ragland
17 with the Nebraska Medical Association.

18 UNIDENTIFIED FEMALE VOICE: (Indiscernible.)

19 CHAIRPERSON TEETER: Okay. Tim Neal.

20 MR. NEAL: Okay.

21 CHAIRPERSON TEETER: Nebraska Kidney Association.

22 TIM NEAL

23 My name is Tim Neal, N-e-a-l. I'm the CEO with
24 the Nebraska Kidney Association. I'm going to take less
25 time than that. He is the technical guy. You know, they're

1 on the front line, the people that work in the dialysis
2 centers, the dialysis clinics, throughout the state of
3 Nebraska. The Nebraska Kidney Association is one step
4 removed, but we're here to support each one of those
5 dialysis units throughout the state.

6 We submitted a letter -- or I submitted a letter
7 to Mr. Gelvin back on March 25th. It's been posted on your
8 website. I'm not going to read the whole thing. But
9 there's a couple things I did want to point out, is that
10 we're part of the Nebraska Kidney Coalition and that we
11 support this as well.

12 And there, again, there's three tests to choose
13 from. I think the key is, you know, once we can determine
14 which one is the best one -- I mean, we look at the nurses,
15 the dietitians, the social workers, they all have
16 credentialing requirements. They all have a number of
17 contact hours or CEUs that they have to maintain their
18 license. It makes sense that the patient-care technicians
19 follow suit.

20 We also, as an organization, conduct a
21 professional education workshop every year trying to give,
22 you know, support to those health care professionals.

23 Anyway, I also think that, you know, the patient-
24 care technicians, once we get this thing nailed down, that
25 the ones that were already certified, they should be

1 grandfathered in, especially if they've already got the
2 national certification. Once they determine -- once it's
3 been determined what the additional hours are to continue to
4 meet those standards, then I think those should be put in
5 place as well. But that's my report.

6 CHAIRPERSON TEETER: Anyone have any questions for
7 Mr. Neal?

8 MS. PEDERSEN: I was under the impression that
9 they're not certified at this point. PCTs are not
10 certified. Is that -- am I wrong? Am I right?

11 MR. NEAL: They were under the national umbrella
12 through the exams that they took when they were under the
13 nursing license, from what I understand. Now, it's kind of
14 square zero.

15 MS. PEDERSEN: So, currently, right now, they're
16 kind of in limbo.

17 (Back-and-forth hand gesture as if balancing
18 scale.)

19 MR. NEAL: They are. Correct.

20 MS. PEDERSEN: Excuse my limbo.

21 MR. NEAL: Yeah, how do you do that in the
22 minutes?

23 MS. PEDERSEN: Yeah. Limbo.

24 MR. NEAL: You're correct.

25 CHAIRPERSON TEETER: Anyone else with any

1 questions for Mr. Neal?

2 (No response.)

3 Okay. Thank you.

4 Jina Ragland, Nebraska Medical Association.

5 JINA RAGLAND

6 Good afternoon. My name is Jina Ragland, J-i-n-a,
7 R-a-g-l-a-n-d. I'm here representing the Nebraska Medical
8 Association. It was our intent to have a physician before
9 you who could provide more of the technical details and what
10 have you, if there were any of those kind of questions.
11 But, due to the short notice, we weren't able to find a
12 physician that was able to rearrange their schedule to be
13 here. So, I've provided you some written testimony in a
14 letter format. Certainly, if you have additional questions
15 that I can't answer, we'll take that out back and get that
16 to you. We do know there is another physician that is
17 actually going to be submitting comments also on the
18 proposal.

19 And not to beat a dead horse, I guess, just to let
20 you know, we are supportive of the amended application. We
21 were supportive of the application in its original format.
22 You'll see at the end of our letter, we're not sure that
23 licensure really is necessary, but we are supporting that in
24 an effort to move this forward and the best means of taking
25 care of the patient possible.

1 Just a couple of little things to make note of
2 also. We feel the National Standard Core Curriculum would
3 support the Advisory Opinion that was in place since 1991,
4 and it has been reaffirmed several times since then. It's a
5 CMS federally approved standard. Therefore, we would feel
6 that that's -- that takes care of that at the State level.

7 Another piece that hasn't been noted yet, there's
8 been no adverse effects or any patient care situations that
9 have been reported. Therefore, we don't feel that this is a
10 necessary process.

11 The other thing that's of note is the training
12 that people are -- that do it at home. If they can do it at
13 home, it seems that, you know, it's appropriate to leave it
14 at the level that it's at now.

15 And then, the last thing is the access and the RN
16 shortage. We have a problem in the state, and we also have
17 a problem in the United States. All of health care is in an
18 access crisis. It seems we'd be going backwards in trying
19 to provide that type of care by not allowing something
20 that's been going on since 1991 with no adverse effects to
21 cease.

22 With that being said, I'll answer any questions
23 that you have.

24 DR. O'HARA: You conclude saying licensure may not
25 be necessary in your letter. What would be necessary?

1 MS. RAGLAND: We feel that registry would take
2 care of the issue. We would be able to -- they'd be
3 accountable to where they are. There would be the reporting
4 mechanism, so if another facility was trying to hire and
5 there were any issues, they would be on the record. So, we
6 feel registry would take care of that, but supportive of
7 licensure if that's the level the Committee feels is
8 necessary.

9 DR. DERING-ANDERSON: I don't know that the
10 Committee gets to tell you what level we think it necessary.
11 We only get to respond.

12 MS. RAGLAND: Allie (phonetic), I think, just to
13 answer -- and maybe I'm misinterpreting, but I think it was
14 a suggestion. And I know they met with Matt and Ron and
15 that was kind of the avenue that was recommended; that,
16 based on the registry, it didn't seem that the Committee was
17 in agreement to that. And so, I think that that's why the
18 Kidney Coalition came back with the next step to say that
19 licensure seemed a more appropriate level. And if I'm wrong
20 on that, certainly correct me.

21 MR. BAUMAN: It's my understanding that the
22 Technical Review Committee would make a recommendation as to
23 (indiscernible) are charged with identifying the least
24 restrictive level of credentialing consistent with
25 sufficient public protection.

1 MS. PEDERSEN: I don't remember. I think our
2 question kind of got through who will be overseeing that
3 portion of that registration.

4 MS. RAGLAND: As far as the Board of Nursing
5 versus Board of Medicine, is that what you're asking?

6 MS. PEDERSEN: Well, that's -- was where we didn't
7 know. At least, I didn't know.

8 MS. RAGLAND: From the Medical Association's
9 perspective, we really wouldn't have a preference. I guess,
10 we'd be supportive and that would be, certainly, up to the
11 State and the Boards to have that discussion. We would not
12 have a preference on that at this point in time.

13 CHAIRPERSON TEETER: If the issue of licensure
14 came more out of, once again, the representative of the
15 Board of Nursing we talked to on the phone, who was adamant
16 that these were complex tasks and the whole delegating of a
17 complex task to a non-licensed personnel. So, therefore,
18 you have to go down the avenue of licensure if that's what
19 the Board of Nursing is stipulating, that this is a complex
20 task. So, I guess, the only other avenue to keep it at a
21 registry level would be to go to the Attorney General or
22 someone else along that route and ask them whether this is a
23 complex or non-complex task and if they can rule on that.
24 And if they can rule on that, that it's a non-complex task,
25 then I think you could probably stay with the registry.

1 Leave it at that level.

2 MR. GELVIN: I just need to make a quick point.
3 If someone's going to provide testimony, they need to come
4 up to the microphone and state their name. No comments from
5 the general audience.

6 CHAIRPERSON TEETER: Anyone else?

7 DR. O'HARA: The last phrase on your first page is
8 "this becomes a routine patient-care task." By that, does
9 that mean Nebraska Medical Association is asserting it's not
10 complex?

11 MS. RAGLAND: Again, I think that that's up for
12 determination and discussion. Our understanding though is,
13 from what -- with the dialysis patient, they're assessed
14 every time that they come in. At the beginning, when
15 they're a new patient, that assessment is done, and I know
16 there's the issue with the heparin. Certainly, the
17 physician and the nurse, at that time, determine what that
18 level is. The care that they receive every time they --
19 before they're given dialysis or any treatment, an RN does
20 an assessment on the patient and determines. So, it's the
21 patient-care technician's responsibility to follow that set
22 of guidelines. Until there's an adverse situation where,
23 then, they're reassessed and that protocol may change or the
24 treatment they receive may change.

25 CHAIRPERSON TEETER: Any other questions?

1 (No response.)

2 Thank you.

3 At this point in time, I have no one else on my
4 list of proponents. We still have approximately half-an-
5 hour or so. Is there anyone else that wishes to speak in
6 favor of the applicant group's proposal?

7 (No response.)

8 Seeing none, we will move on to the opponents.
9 Same thing. You will have a total of one hour for
10 testimony. I have one person listed on my list. And is it
11 Kandi or Kandis?

12 MS. LEFLER: Kandis.

13 CHAIRPERSON TEETER: Kandis. Sorry, I can't --
14 I'm not sure --

15 MS. LEFLER: The reason I'm dressed, I'm working
16 today.

17 CHAIRPERSON TEETER: So, if you could tell us your
18 name and then who you're representing?

19 KANDIS LEFLER

20 Okay. I am Kandis Lefler, and I am representing
21 the LPNAN Board. I'm a resident of Malcolm, Nebraska. I'm
22 a license practical nurse, and was licensed by the State of
23 Nebraska since 1985 after receiving my degree at Southeast
24 Community College. I also teach nurse aide and med aide
25 classes. And I'm familiar with license requirements and

1 limitations of my license and the activities to be performed
2 by a nurse aide and medication aide.

3 I am familiar with the request for the DPCTs
4 receive -- they want to receive a license to provide care in
5 the outpatient dialysis clinic setting. I have nothing -- I
6 want everybody to know, I have nothing but respect for these
7 people. Okay? They do a good job. So, I'm not here to,
8 you know, come down on them or anything like that. But I am
9 concerned about the extent of care being provided by
10 patient-care technicians. Following also are my concerns.

11 In the materials, applicant states that the DPCTs
12 mix the dialysis solution. I believe it is the compounding
13 of drugs and, as an LPN, I would not do this. I understand
14 the FDA considered acid-concentrate additive spikes to be
15 medical devices, however, if anytime there are adjustments
16 to the dialysis solution by adding different products, the
17 individual is using nursing judgment for he or she is not
18 trained and could impact the patient's safety.

19 LPNs and dialysis patient-care technicians are not
20 the same. Even if dialysis patient-care technicians are
21 licensed instead of placed on a registry, the LPNs have more
22 education and are trained in subcutaneous, intramuscular,
23 and intradermal injection administration. Also, LPNs know
24 that they -- know or they should know to never give a
25 medication mixed by somebody else.

1 In my opinion, heparin is a high-risk drug even in
2 the routine dialysis treatment. The administration of the
3 injection of the dose may not be high-risk; however, because
4 of the complications that can occur, the evaluation of the
5 patients must be performed by someone with the ability to
6 exercise some nursing judgment.

7 Medication aides have the ability to give, also,
8 subcutaneous IMs, too, but I will tell you, in saying that,
9 the nursing homes that I've dealt with and the assisted
10 living that I work for now, they only allow them to give the
11 subcu insulin. They do not allow them to give the
12 intramuscular and stuff. They'll have, like, -- like, at my
13 place, I go give them for them. Okay? The place where they
14 work, though, can go ahead and train them on that. But they
15 do have steps they have to go by.

16 Because there is already a licensed category for
17 all the actions to be performed by the DPCT, the licensing
18 of DPCTs is unnecessary, I feel. If you have any questions,
19 I'm happy to answer them at this time. Why I feel it's
20 unnecessary, there's a lot of LPNs out there, med aides out
21 there, that, you know, would be more than glad to have a job
22 doing something like that.

23 DR. DERING-ANDERSON: I have a couple of
24 questions.

25 MS. LEFLER: Sure.

1 DR. DERING-ANDERSON: You said to us that you're a
2 licensed LPN. We have a letter from someone whose last name
3 is Boddy, B-o-d-d-y. Heath Boddy.

4 MS. LEFLER: Oh, Heath. Heath, yes.

5 DR. DERING-ANDERSON: President and CEO of --

6 MS. LEFLER: Yes. Yes.

7 DR. DERING-ANDERSON: Okay. And this letter talks
8 about something that's an LPN, hyphen, C?

9 MS. LEFLER: Uh-huh.

10 DR. DERING-ANDERSON: Are you that?

11 MS. LEFLER: No. I'm an LPN. LPN-Cs can do
12 intravenous -- they can start IVs. They can give certain
13 drugs through the IVs. But then, there's certain drugs they
14 cannot give.

15 DR. DERING-ANDERSON: Okay. So, in your opinion,
16 this patient-care technology person is already covered under
17 LPN or LPN-C or both or --

18 MS. LEFLER: I think both. It could be covered
19 with both.

20 DR. DERING-ANDERSON: Okay. Thank you. I get
21 confused. There's, like, different flavors of chocolate and
22 I can't figure out which one I want. Yeah.

23 MS. PEDERSEN: But is the training for that
24 patient-care technician the same as what an LPN-C would be
25 getting?

1 MS. LEFLER: I don't believe so. I can't tell you
2 for sure, but I don't believe so. LPN-C, they go in depth
3 on what medications are, what they're used for, what actions
4 to look -- what reactions to look for, and that kind of
5 stuff. It's just like with -- even with med aide training,
6 all they go is 40 hours. We do a lot of the medication
7 training, what they need to do. You know, there's some meds
8 that you don't give unless you do a blood pressure before.
9 There's all kinds of certain things that you have to look
10 for when you're giving meds. It's not just going in and
11 pushing a drug and walking out.

12 DR. MILLEA: How long does a -- how long is the
13 training for an LPN-C, assuming that they already are an
14 LPN?

15 MS. LEFLER: You know, I really don't know that.
16 I want to say three months, but I could be totally off board
17 there.

18 DR. MILLEA: Would that be full-time, three
19 months, like --

20 MS. LEFLER: No. Unh-unh. No. It's like a
21 couple of days a week.

22 DR. MILLEA: A couple of days a week meaning --

23 MS. LEFLER: Yeah. Like I say, I may be off board
24 there.

25 DR. MILLEA: -- in the evening?

1 MS. LEFLER: You actually can take it online now,
2 and then you would go and you would do your clinical in
3 front of an instructor and work with that instructor.

4 DR. MILLEA: Thank you.

5 CHAIRPERSON TEETER: How long is LPN training?

6 MS. LEFLER: A year.

7 CHAIRPERSON TEETER: You become a medication aide,
8 it takes 40 hours?

9 MS. LEFLER: Yes.

10 CHAIRPERSON TEETER: So, you can essentially do
11 that in one week?

12 MS. LEFLER: Yes. Uh-huh.

13 CHAIRPERSON TEETER: Okay. And you said, right
14 now, that there's many LPNs in the state who aren't
15 employed?

16 MS. LEFLER: Well, they would like to have a job
17 like that, you know, day hours. It would be nice. And see,
18 what has happened is all the hospitals now do not use LPNs.
19 So that put a flow out there, that they're looking for other
20 jobs now.

21 CHAIRPERSON TEETER: Okay.

22 MS. LEFLER: I'm, for instance -- I mean, I have a
23 job now. But I worked almost 29 years for the hospital,
24 when they decided LPNs couldn't work there any longer.

25 CHAIRPERSON TEETER: So, is there a shortage of

1 LPN jobs right now in the state?

2 MS. LEFLER: I can't guarantee that, but I'd say,
3 yeah, probably. Any -- a job that you would want, I guess I
4 should say. You have different kinds of nurses, RNs and
5 LPNs both. You have some nurses, RNs and LPNs, that love
6 nursing home work. You have some that wants more of the --
7 how do I say this?

8 DR. DERING-ANDERSON: Ambulatory.

9 MS. LEFLER: Ambulatory or more of the emergency,
10 fast-paced stuff. You know, it's like in any job, you have
11 your specialty that you really like. You know.

12 CHAIRPERSON TEETER: A cursory search that I just
13 did shows that there's 335 LPN jobs in the state of Nebraska
14 right now, so --

15 MS. LEFLER: Open?

16 CHAIRPERSON TEETER: Yeah. I mean, I don't know
17 whether they're open or not. I haven't called the places.
18 Does that sound like it could be correct?

19 MS. LEFLER: Yeah. That could very well be.
20 Uh-huh.

21 CHAIRPERSON TEETER: So then, you think that,
22 since there's 335 jobs that are open that need an LPN, and
23 then, if we would not do patient-care technicians, then have
24 another 95 jobs that would need an LPN, wouldn't it be hard
25 to find staffing for all of these positions?

1 MS. LEFLER: Honestly, if they paid decent, no, it
2 wouldn't be hard.

3 CHAIRPERSON TEETER: Okay.

4 MS. LEFLER: I mean, I'm just being honest.

5 CHAIRPERSON TEETER: Okay.

6 MS. LEFLER: You know. And this is probably -- I
7 probably might not should say this, but the less education
8 you have, the less you have to pay.

9 CHAIRPERSON TEETER: Okay.

10 MS. LEFLER: Anyone else?

11 DR. O'HARA: I'm going to work off of the letter
12 from the Licensed Practical Nurse Association of Nebraska
13 that was referenced. I'm trying to figure out how to fit
14 this in to some different phrases: complex, not complex,
15 routine patient-care task. And -- which is the phrasing
16 used by the Nebraska Medical Association in their letter.
17 In the LPA letter, it describes, and I'm sure it's
18 boilerplate, that an LPN works at the direction of an RN.
19 So, we would not be working at the direction of an RN --

20 MS. LEFLER: Who wouldn't?

21 DR. O'HARA: -- if we're dealing with a dialysis
22 patient-care technician?

23 MS. LEFLER: Oh, you should be.

24 DR. O'HARA: I didn't ask if you should. I asked,
25 "Would we?"

1 MS. LEFLER: I would be if I was there. I can
2 tell you that.

3 DR. O'HARA: If you were there. But if we're
4 using a dialysis patient-care technician, if that context
5 requires working at the direction of an RN, then it is
6 complex?

7 MS. LEFLER: Uh-huh.

8 DR. O'HARA: Okay. Going through what LPNs do,
9 they assess the health status. When an LPN's assessing the
10 health status, is there going to be a variability in the
11 patient's health status that is greater than -- in the
12 general population -- greater than, equal to, or less than
13 the variation in your routine patient care for dialysis?

14 MS. LEFLER: I don't --

15 DR. O'HARA: If you know you have a kidney
16 patient.

17 MS. LEFLER: Right. Right.

18 DR. O'HARA: Everyone who walks through the door
19 is a kidney patient getting dialysis, is the assessment more
20 difficult?

21 MS. LEFLER: I don't -- I don't -- I would say
22 it's more difficult as you need to know what you're looking
23 for. Does that make sense?

24 DR. O'HARA: Okay. You're supposed to record
25 data. Is the recording more difficult?

1 MS. LEFLER: I wouldn't think so. I've never
2 worked in dialysis. But, no, I would not think so.

3 DR. O'HARA: You're supposed to assist in the
4 diagnosis. Would there be significant diagnosis going on in
5 dialysis?

6 MS. LEFLER: A nurse is -- a nurse don't diagnose.
7 A doctor diagnoses.

8 DR. O'HARA: Let's see. "LPNs contribute to the
9 establishment of nursing diagnoses."

10 MS. LEFLER: They contribute. There's the magic
11 word, contribute.

12 DR. O'HARA: Would there be a significant need for
13 that contribution from an LPN in a dialysis context?

14 MS. LEFLER: I would say yes. Because, nine to
15 one, we would be the one seeing the patient more. So, you
16 would go to that RN, and you would give report to the RN
17 that's supposed to be in charge.

18 DR. O'HARA: Okay. LPNs participate in the
19 development of a plan of care. What would be the
20 development provided in the dialysis context?

21 MS. LEFLER: Plan of care could be anything. You
22 know, as simple as urine output, if they have urine output.
23 If they don't, how much fluid they're taking in. Anything
24 like that.

25 DR. O'HARA: And then, obviously, evaluation of

1 the responses of the individual would necessarily be
2 involved any time you have a patient.

3 MS. LEFLER: Uh-huh.

4 DR. O'HARA: Okay. Thank you.

5 CHAIRPERSON TEETER: Thank you.

6 Any other testimony in opposition to the proposal
7 from the applicant group?

8 (No response.)

9 Then, finally, we have just neutral testimony.
10 The time for this is limited to 10 minutes, total. I have
11 Melina --

12 MS. FLORELL: Melissa.

13 CHAIRPERSON TEETER: Melissa?

14 MS. FLORELL: Florell. Sorry.

15 CHAIRPERSON TEETER: Okay. Sorry.

16 MELISSA FLORELL

17 I brought my water with me. I apologize. My name
18 is Melissa Florell, M-e-l-i-s-s-a, F-l-o-r-e-l-l. I am here
19 today on behalf of the Nebraska Nurses Association, and we
20 are testifying in a neutral position regarding the Nebraska
21 Kidney Coalition application for registration of dialysis
22 patient-care technicians.

23 And the primary consideration in credentialing or
24 changing of scope of practice for health care must be
25 patient safety. Registered nurses understand that optimal

1 patient outcomes depend on the trust patients can place in
2 their providers and care teams. And in recent times,
3 articles, reporters, tend to shape that trust. We believe
4 that it is our obligation as nurses, as well as part of the
5 health profession, to preserve the trust that the public has
6 in our industry. And we believe that carefully implemented
7 and managed dialysis patient-care technician registry can
8 meet these goals.

9 The use of unlicensed assistive personnel is, many
10 times, motivated by finances. And increasing the cost or
11 ratio of unlicensed personnel, as opposed to licensed, can
12 lower labor cost. However, financial implications is not
13 usually the best reason -- or in the best interest for
14 patients. Researchers have found in a couple of
15 retrospective studies that increasing the number of RNs
16 providing patient care can decrease mortality. And, also,
17 substituting other types of nursing personnel for RNs in an
18 attempt to decrease personnel costs can actually increase
19 health care costs by increasing lengths of stay and adverse
20 effects. Registered nurses also believe that, with
21 safeguards in place to protect patients, unlicensed
22 personnel can safely complete certain tasks.

23 We believe that a registry, including the
24 following requirements would meet the goal of protecting
25 patients while allowing dialysis patient-care technicians to

1 fill their important role in care delivery: First,
2 education and training is critical. In the case of dialysis
3 patient-care technicians, we believe there should be
4 standardized training requirements, and that demonstration
5 of competency needs to occur prior to employment, and that
6 standardized training and ongoing competency assessment
7 should address the tasks that these individuals are
8 performing.

9 When unlicensed personnel are asked to complete
10 tasks, the tasks should be directed by protocols that are
11 approved by the appropriate licensed personnel. For
12 example, if that protocol was pertaining to a medication,
13 that the provider who had medication administration in their
14 scope of practice would oversee that protocol, and that they
15 should be specific and not have a range of orders that would
16 require independent judgment.

17 Delegation. Currently, in regulation, a
18 registered nurse can delegate a non-complex task to
19 unlicensed personnel. The delegation will ensure that that
20 patient is stable and that the use of a protocol is
21 appropriate and safe for the individual.

22 Heparin is one of the lightning rods of this whole
23 conversation. And it is a high-risk medication.

24 Inappropriate dosing or administration of the medication can
25 have serious adverse complications. There's well-documented

1 cases of individuals who have died following inappropriate
2 administration of heparin. However, in certain
3 circumstances, we believe heparin administration is
4 considered a non-complex task. In situations when a
5 patient's been receiving dialysis, set order, set schedule,
6 and that patient's medically stable, the administration of
7 heparin is a non-complex task and could be delegated. We
8 believe that when a patient is treated in a community
9 setting and following an assessment by a registered nurse, a
10 dialysis patient-care technician could safely administer
11 heparin by a facility-approved protocol.

12 Central lines, the other lightning rod in this
13 conversation, are high-risk. They go directly into the
14 central cardiovascular system and risks include systemic
15 infection and sepsis and death. Several years ago, not too
16 far in the past, central lines only occurred in the ICU or a
17 critical care setting. However, medicine changes. We all
18 know it changes at a very fast pace, and there's been
19 improvement in the central lines themselves, as well as
20 infection-control measures. They're now commonplace
21 throughout hospitals and in the community. And the Nebraska
22 Nurses Association believes that, in certain circumstances,
23 accessing a central line could be considered a non-complex
24 task and could be delegated. However, to ensure public
25 safety, it could only be delegated to an individual who's

1 been thoroughly trained and checked for competency.

2 Lastly, dialysis patient-care technicians who have
3 completed the necessary training and have demonstrated
4 competency need to be monitored. That facility needs to be
5 required to report in the event of a termination or other
6 adverse event. This is another safeguard that would protect
7 the public.

8 In summary, the Nebraska Nurses Association comes
9 to you today in a neutral capacity regarding the
10 application. And we believe that, with specific safeguards
11 that will strengthen this proposal to ensure public safety,
12 and these are: Dialysis patient-care technicians should be
13 registered, not licensed, in the State of Nebraska; training
14 and competency for the role of dialysis patient-care
15 technicians should be standardized and clearly defined;
16 training and competency must emphasize the high-risk tasks
17 of heparin administration and central line access, and the
18 scope should be limited to community settings; to require
19 the development of facility-approved protocols that are not
20 -- that are specific and don't require interpretation or
21 assessment to implement; and require the delegation of these
22 tasks by a registered nurse; and that the registration
23 should be administered by the Board of Nursing with
24 mandatory reporting for terminations.

25 And I'd be happy to answer any questions. I'm

1 sorry, I have a terrible cold, so --

2 DR. DERING-ANDERSON: Well, as a pharmacist who
3 may sell something to treat that, if you could spit in all
4 the drinking fountains and maybe sneeze at the salad bar,
5 just to improve business.

6 (Laughter.)

7 MS. FLORELL: Anything I can do.

8 DR. DERING-ANDERSON: I want to be sure I
9 understand what you have said.

10 MS. FLORELL: Okay. I will do my best.

11 DR. DERING-ANDERSON: If a bill is crafted that
12 says a defined dose of heparin in a steady end-stage renal
13 disease patient is not complex and tapping a central line in
14 a chronically stable end-stage renal disease patient is not
15 complex, you will not oppose that bill on those two grounds?
16 Is that what you're saying?

17 MS. FLORELL: If, in that defined community
18 setting, for a stable patient, who's been assessed by an RN,
19 yes, that is what our legislative --

20 DR. DERING-ANDERSON: Cool. And what does
21 community setting mean? Why are we being specific? What is
22 it that you don't want to have happen?

23 MS. FLORELL: If a patient is sick enough to be in
24 a hospital, they're not stable.

25 DR. DERING-ANDERSON: Okay. Thank you. So -- but

1 this could be an ambulatory clinic --

2 MS. FLORELL: An ambulator- --

3 DR. DERING-ANDERSON: -- in a hospital, it's just
4 they're not a patient of the hospital? That's the --

5 MS. FLORELL: Right. This is a stable patient
6 who's coming for their routine, scheduled dialysis
7 administration who's assessed upon admission by an RN who
8 then delegates using a protocol that is standard, that does
9 not require interpretation by a patient-care technician to
10 carry out those orders.

11 DR. DERING-ANDERSON: Okay.

12 MS. FLORELL: Does that --

13 DR. DERING-ANDERSON: Yes. Thank you.

14 CHAIRPERSON TEETER: Who is this letter from?

15 MS. FLORELL: This is from the Nebraska Nurses
16 Association.

17 CHAIRPERSON TEETER: Which is who?

18 MS. FLORELL: We represent the registered nurses
19 in the state of Nebraska.

20 CHAIRPERSON TEETER: All of them?

21 MS. FLORELL: We have about a thousand members, so
22 they're representing our member registered nurses, and our
23 Legislative Advocacy and Representation Committee has
24 reviewed all of the documents of the 407 hearing and in the
25 application and made the determination that we used to

1 prepare our letter.

2 CHAIRPERSON TEETER: And was this a unanimous
3 letter, or was there contention amongst this letter --

4 MS. FLORELL: Among our committee? No. It was
5 unanimous.

6 CHAIRPERSON TEETER: What about the actual --

7 MS. FLORELL: We didn't do an individual, per-
8 person survey.

9 CHAIRPERSON TEETER: But I mean, what about the
10 actual -- because you have a committee.

11 MS. FLORELL: Yes.

12 CHAIRPERSON TEETER: But then, do you have an
13 executive committee above that committee?

14 MS. FLORELL: Our board and our legislative
15 committee support this letter unanimously.

16 CHAIRPERSON TEETER: Unanimously.

17 MS. FLORELL: Yes.

18 CHAIRPERSON TEETER: And, as far as the Board of
19 Nursing goes, --

20 MS. FLORELL: I don't speak for the Board of
21 Nursing.

22 CHAIRPERSON TEETER: I understand that. But are
23 the Board of Nursing members part of the Nebraska Nurses
24 Association?

25 MS. FLORELL: There are some that are members.

1 There are some that are not.

2 CHAIRPERSON TEETER: Okay.

3 MS. PEDERSEN: Do you have any idea how many
4 nurses, RNs, are in the state of Nebraska?

5 MS. FLORELL: There are about 26,000, depending on
6 whether you count per-person or per-FTE.

7 MS. PEDERSEN: Twenty-six thousand. I knew it was
8 in that --

9 CHAIRPERSON TEETER: And you guys have how many in
10 your group?

11 MS. FLORELL: Eight hundred and fifty, I think, is
12 our last membership number.

13 CHAIRPERSON TEETER: There's 26,000 in the state?
14 You have 850?

15 MS. FLORELL: Uh-huh. It's about four percent.

16 CHAIRPERSON TEETER: Okay.

17 MS. PEDERSEN: Does anybody know how many LPNs we
18 have in the state?

19 MS. FLORELL: I do -- I can't -- they may --

20 MS. PEDERSEN: I figured you wouldn't know, so I
21 guess I'm just asking the question.

22 CHAIRPERSON TEETER: I don't know.

23 MS. PEDERSEN: I don't know either. Okay.

24 DR. MILLEA: Those 330 open positions belong to
25 the LPNs?

1 CHAIRPERSON TEETER: Yeah.

2 DR. MILLEA: Okay.

3 MS. PEDERSEN: I think we've got 15 or 16,000.

4 DR. MILLEA: If the association believes that
5 accessing a central line could be considered a non-complex
6 task and could be delegated, that means delegated, for
7 example, to someone like me?

8 MS. FLORELL: No. That would be to the
9 appropriately educated person in that community setting.

10 DR. MILLEA: Assuming I had an appropriate
11 education.

12 MS. FLORELL: If you were a dialysis patient-care
13 technician practicing in that setting, then, yes, you would
14 be able to be directed to perform that access.

15 DR. MILLEA: And the -- is admission to a hospital
16 required to make that a complex task?

17 MS. FLORELL: I think the delineation between
18 complex and non-complex is always -- is a conversation, but
19 that would be a sign that that patient has departed from
20 their normal, stable condition, that something else is going
21 on to make that a complex task.

22 DR. MILLEA: The reason I ask that question is, if
23 an ambulatory person walks into a hospital and is treated by
24 a PCT -- what does PCT mean anyway? Percent?

25 MS. FLORELL: Patient-care technician.

1 DR. MILLEA: Patient-care technician. A patient-
2 care -- they're there for treatment by a patient-care
3 technician, and it goes through the protocol the hospital
4 does with every ambulatory patient that comes in. And then,
5 he's treated and goes home.

6 MS. FLORELL: So, you're talking about an
7 outpatient type setting.

8 DR. MILLEA: Well, seeing that there's --

9 MS. FLORELL: Or an ambulatory --

10 DR. MILLEA: I was trying to figure out where you
11 guys were coming exactly when you said that, if a person has
12 been admitted --

13 MS. FLORELL: As an inpatient in a hospital is
14 what I was alluding to versus the ambulatory, outpatient,
15 free-standing, come-in-and-leave, for a normal
16 administration.

17 DR. MILLEA: Yeah, the problem is though, it seems
18 that the majority of these people are ambulatory.

19 MS. FLORELL: Yes, and that's what we were --
20 that's what we're saying. That in that routine delivery of
21 dialysis care, that that would be considered a non-complex
22 task versus if they were administra- -- acute --

23 CHAIRPERSON TEETER: Essentially, if they go into
24 acute renal failure and get admitted, then you can't have a
25 patient-care technician doing tasks on the inpatient unit --

1 on the inpatient side of the floor.

2 MS. FLORELL: Exactly, then they're -- then --
3 exactly.

4 CHAIRPERSON TEETER: But if a hospital has an
5 outpatient center, like if Bryan owns an outpatient center,
6 they could work in the outpatient center. They just can't
7 go into the inpatient -- for the acute renal failure
8 patient.

9 MS. FLORELL: Right. Yes.

10 CHAIRPERSON TEETER: Are there any other nurses'
11 groups in the state of Nebraska, other than the Nebraska
12 Nurses Association?

13 MS. FLORELL: Yes, there's several. There's
14 several and --

15 CHAIRPERSON TEETER: Is the Nebraska Nurses
16 Association the largest of them?

17 MS. FLORELL: Yes.

18 CHAIRPERSON TEETER: By?

19 MS. FLORELL: I have no idea the numbers, but we
20 are the largest.

21 CHAIRPERSON TEETER: By a decent number? I
22 mean, --

23 MS. FLORELL: Yes, I believe so.

24 CHAIRPERSON TEETER: Any other questions?

25 DR. MEYERLE: I just have one. I'm curious, the

1 letter supports the registry, not licensure. Could you
2 elaborate upon why that was the recommendation from the
3 nurse association?

4 MS. FLORELL: We feel that registry is sufficient,
5 that the nursing scope of practice does allow for delegation
6 of non-complex tasks. It's the two lightning rod issues
7 that created the friction before, and that registration is
8 sufficient to address those concerns.

9 DR. O'HARA: On the top of page 3 of your letter,
10 in the paragraph that starts "in summary," --

11 MS. FLORELL: Okay.

12 DR. O'HARA: Want to find out if it was a typo or
13 a genuine expression of the association's interest. You
14 responded to the call for witnesses being neutral, but we're
15 considering an amended application for licensure and it
16 refers to an application for registration. Did your group
17 not know it had been amended to licensure?

18 MS. FLORELL: We wished to speak in the neutral
19 capacity because we are in favor of the registration versus
20 licensure. So, we wanted an opportunity to delineate our
21 feeling versus taking a position in opposition or support
22 for the amended application.

23 DR. O'HARA: So, if it was accurately phrased, it
24 would say you're appearing neutral to the amended
25 application of licensure because you favor registration?

1 MS. FLORELL: Yes.

2 DR. O'HARA: Okay. Part of what we're futzing
3 with is the word "direction." That you work under the
4 direction of an RN. As you were describing the process you
5 envision, the initial appraisal of the patient would be done
6 by an RN, and then direction would be given by an RN to a
7 dialysis patient-care technician. If this was a complex
8 task, the problem would be that we would have to have an RN
9 present at all time. And am I correct in understanding the
10 word "direction," that you would have to have line-of-sight?
11 So that you have to be in the same room with someone to
12 direct?

13 MS. FLORELL: For it -- not as defined in -- you
14 don't have to have line-of-sight. But I would like to get
15 back to you specifically on that, because it gets confusing
16 in all settings, the direction.

17 DR. O'HARA: Because I'm thinking the problem is,
18 when the Board of Nursing revised its prior opinion on
19 complex versus not complex, the problem was direction.
20 That, if the RN has to be -- do -- provide direction in the
21 community setting --

22 MS. FLORELL: And that comes more to the
23 delineation of what's complex and what's not complex. But,
24 if the patient is stable and that task is not complex, then
25 you do not have to be in line-of-sight to that patient. But

1 I would like to get back to you specifically on that.

2 DR. O'HARA: I know there's a technical definition
3 to direction, but it would be far more -- for instance, what
4 you're assuming here today and in your testimony, is that
5 the RN would have done the things such as evaluate the
6 patient, written up a direction, and then the --

7 MS. FLORELL: The RN would make an assessment to
8 determine whether that patient is stable at the time of
9 admission to the facility.

10 DR. O'HARA: And that direction would not
11 necessarily be face-to-face; it might be electronic
12 communication?

13 MS. FLORELL: That I don't think has been defined
14 or delineated, so -- but the assessment --

15 DR. O'HARA: What would you envision?

16 MS. FLORELL: An assessment needs to be face-to-
17 face.

18 DR. O'HARA: The communication I'm referring to is
19 communication from the RN to the dialysis patient-care
20 technician.

21 MS. FLORELL: If the RN was in the facility, then
22 that would be a face-to-face communication.

23 DR. O'HARA: But you're not necessarily assuming
24 that?

25 MS. FLORELL: I -- not as --

1 DR. O'HARA: I'm trying to understand what you're
2 saying.

3 MS. FLORELL: My assumption is that would be a
4 face-to-face. That, I would like to get back to you.
5 That's not something that we specifically discussed as a
6 committee or a group, but my interpretation is that that
7 would be face-to-face.

8 DR. O'HARA: And my last question is the Nurses
9 Association, a subset of all nurses that are licensed by the
10 Board of Nursing, has a differing opinion from the Board of
11 Nursing on whether or not some of these tasks are complex.
12 Is that what I'm understanding?

13 MS. FLORELL: Uh-huh. Yes.

14 DR. O'HARA: That the Board of Nursing is saying
15 these are all complex. Heparin is complex definitionally.
16 Central line, complex --

17 MS. FLORELL: I don't think that that is entirely
18 correct. I think that there was a very narrow definition
19 given, and that further conversation needs to take place,
20 because I do not think that that is what we're saying. Or
21 that we're as far apart as it may appear and, probably, does
22 appear to the Committee. But there is additional
23 conversation that is taking place to define that.

24 CHAIRPERSON TEETER: With your definition of
25 complex versus non-complex that you're using in your

1 testimony, where did you obtain information, as far as
2 determining whether something is complex or non-complex? Do
3 you have any legal determination of that?

4 MS. FLORELL: Not through a legal determin- --
5 through literature review and through review of practice in
6 other states, is what was used to come to our position.

7 CHAIRPERSON TEETER: So, there's been no legal
8 ruling that you know of, in Nebraska or elsewhere, that
9 states that this is com- --

10 MS. FLORELL: No. Not that I know of.

11 CHAIRPERSON TEETER: -- this is a complex
12 procedure or this is a non-complex procedure?

13 MS. FLORELL: Not that I'm aware of.

14 CHAIRPERSON TEETER: Because you said that you had
15 consulted with your legal team as well.

16 MS. FLORELL: No. Our legislative team. Not
17 legal.

18 CHAIRPERSON TEETER: Your legislative team. Okay.
19 Anyone else have anything?

20 (No response.)

21 Okay. Thank you.

22 Okay, we'll go into summaries from both sides.

23 From the proponent or --

24 MR. BRIEL: And that's if they want to do that.

25 If we -- just -- it's an opportunity for someone, perhaps,

1 to summarize where they're coming from on the issue and,
2 perhaps, to respond to something that someone else had said.
3 It's just if they want to do that.

4 CHAIRPERSON TEETER: Okay. And is it 10 minutes
5 per side? Or 10 minutes total?

6 MR. BRIEL: I think it's 10 minutes each, yes.

7 CHAIRPERSON TEETER: Okay. So, in summary,
8 proponents? Ten minutes.

9 MATT BAUMAN

10 Again, Matt Bauman, from the Nebraska Kidney
11 Coalition. Just wanted to read into the record, RNs may
12 delegate non-complex interventions versus not being able to
13 delegate complex interventions. This is from Chapter 99,
14 Provision of Nursing Care, the Nebraska Department of Health
15 and Human Services, Regulation and Licensure. "Complex
16 interventions mean those which require nursing judgment to
17 safely alter standard procedures in accordance with the
18 needs of the patient or require nursing judgment to
19 determine how to proceed from one step to the next or
20 require multidimensional application of the nursing
21 process." The definition of non-complex intervention means,
22 "Those that can be safely performed according to exact
23 directions, do not require alteration of a standard
24 procedure, and for which the result and client/patient
25 responses are predictable."

1 A typical dialysis patient receives three
2 treatments a week, every week. Or I should say, every week
3 of the year. And so, 13 treatments a month is typically
4 what they do. So, 156 times a year, a dialysis patient
5 comes into an outpatient dialysis facility and receives very
6 similar care in a controlled environment, under the
7 direction of licensed personnel, specifically RNs.

8 I will comment that, just as a point from the
9 opponent, Kandis. And I apologize for not getting her last
10 name. She's been an LPN since 1985, I believe, and I don't
11 -- I didn't hear her say that she ever worked in a dialysis
12 facility, nor did she ever work with a dialysis patient-care
13 technician. So, I, again, would reiterate that it's a
14 unique field. It's a small population. And if you've never
15 done dialysis, you've just never done it. If you've never
16 seen it, you've never seen it.

17 And the provision of dialysis in the state of
18 Nebraska, there are -- and I feel like I'm whining like
19 everybody else who tries to find employees -- it's hard to
20 find good people. You know, sometimes there's a lot of good
21 people, there just aren't enough of them. So, we have to
22 look a couple layers down. We believe that we've provided
23 dialysis for many years. We've put safeguards in place. We
24 have policies and procedures. And if someone's not able to
25 meet that task, whether they be licensed or whether they be

1 unlicensed, there's a process, at least in our organization,
2 to remove those folks.

3 We started this process based on a recommendation
4 because we were told that they were going to retire the
5 Advisory Opinion that provided direction for patient-care
6 technicians as well as LPNs in the state of Nebraska for 20-
7 some years. So, here we sit, trying to find another way to
8 continue to do good care, safe care, under the direction of
9 the State of Nebraska and their guidance within their
10 regulations. So, I think that there's an opportunity to
11 continue to do the good work that we've done for decades,
12 with appropriate direction, and we're trying to respond
13 appropriately to the Technical Review Committee and some of
14 the input that you've given us to try and find that path.
15 That's all I have to say.

16 DR. DERING-ANDERSON: For Mr. O'Hara and myself,
17 tell me what "direction by an RN" means. I'm asking, is
18 there a CMS standard? Is there, in your clinic, a standard?
19 What does that mean? Can I Skype in? I checked the patient
20 in, they looked good, my kid has a soccer game. Can I Skype
21 in from my cell phone at the soccer game and say, "Yep,
22 still looking good. I'm directing you"?

23 MR. BAUMAN: No.

24 DR. DERING-ANDERSON: What's the definition of
25 direction?

1 MR. BAUMAN: You -- I don't have the Condition of
2 Coverage specifically in front of me, but you cannot provide
3 a nursing assessment electronically. It has to be eyes-on.
4 It has to be in front --

5 DR. DERING-ANDERSON: I was there. I assessed the
6 patient, we checked him in, we hooked him up, and I left.

7 MR. BAUMAN: You can't leave the facility. You
8 have to have an RN, at bare minimum, in the building. In
9 our organization, we have in them on the floor in direct
10 sight.

11 DR. DERING-ANDERSON: And whose rule is that? Is
12 that your clinic's rule or is that a CMS rule?

13 MR. BAUMAN: Well, that's our rule in conjunction
14 with the State of Nebraska, because you have an RN who's
15 delegating a non-complex task, so they have to be there.

16 DR. DERING-ANDERSON: So, there is a standard for
17 direction in the law somewhere?

18 MR. BAUMAN: Yes.

19 DR. DERING-ANDERSON: We just have to figure out
20 where it is.

21 MR. BAUMAN: Well, it -- in the --

22 DR. DERING-ANDERSON: Because, basically,
23 pharmacists can direct pharmacy technicians over a video
24 camera.

25 MR. BAUMAN: In the Conditions for Coverage, a

1 nurse, an RN, has to be physically in the building.

2 DR. DERING-ANDERSON: Under the CMS guidelines for
3 Conditions of Coverage.

4 MR. BAUMAN: Yes.

5 DR. DERING-ANDERSON: Thank you.

6 MR. BAUMAN: I will add, though, that a physician
7 can do remote video rounding.

8 MS. DERING-ANDERSON: I know. And I think that
9 that's some of the question. If we're talking about
10 heparin, if the patient's bleeding and you're not there,
11 that's a problem. But we have so many other professions
12 where supervision and direction can be electronic.

13 MR. BAUMAN: I will say, in the home environment,
14 we do have folks that Skype in from time-to-time, because
15 they are trained to do this very same procedure on a
16 different machine at home. But that's a different
17 direction, because that's not in-center; that's home. And
18 they choose to go to that modality.

19 CHAIRPERSON TEETER: Any other questions?

20 MR. BAUMAN: And I would say the primary use of
21 heparin in the dialysis facility is just to keep -- to
22 prevent coagulation of the blood in the system, because the
23 treatments are typically a four-hour treatment. Everybody
24 should be a six-hour treatment, but in the United States, we
25 have things to do. So, a four-hour treatment seems to be

1 the standard more often. But that helps to keep the system
2 from clotting off, if you will. Keeps the filter clean.
3 And technologies are improving. We use less heparin than we
4 used to.

5 CHAIRPERSON TEETER: Any other questions?

6 MR. MILLEA: A lady that raised her hand.

7 CHAIRPERSON TEETER: We'll have to get her in a
8 minute.

9 Any other questions?

10 (No response.)

11 MR. BAUMAN: Okay. Thank you.

12 MR. BRIEL: See if there's opponents that --

13 CHAIRPERSON TEETER: What's that?

14 MR. BRIEL: See if there's opponents that want to
15 do the same.

16 CHAIRPERSON TEETER: There's someone that wants to
17 make a comment.

18 MR. BRIEL: Okay. This is summary for applicants
19 and opponents in response. Yeah, right.

20 CHAIRPERSON TEETER: Okay. You want to come --

21 MS. FLORELL: Can I summarize as a neutral --

22 CHAIRPERSON TEETER: You have to --

23 MS. FLORELL: Yes, that's fine.

24 MELISSA FLORELL

25 I was just going to speak to the question. The

1 definition of direction is in Chapter 99 of the Nursing Regs
2 for the State of Nebraska. And that, if the board makes a
3 recommendation specifically and that that language goes into
4 the statute, then whatever board is supervising that
5 occupation would follow those rules and regs. Those are the
6 only two things I had to add in summary.

7 CHAIRPERSON TEETER: You need to say your name for
8 the record.

9 MS. FLORELL: Oh, yes. Melissa Florell,
10 M-e-l-i-s-s-a, F-l-o-r-e-l-l.

11 CHAIRPERSON TEETER: All right. Thank you.
12 And then, where I'll go to is summary for the
13 opponents.

14 (No response.)

15 Any summary from the opponent side at all?

16 MR. BRIEL: If they want to. If they don't,
17 that's fine.

18 CHAIRPERSON TEETER: That concludes the public
19 hearing.

20 (Whereupon, on July 25, 2016, the hearing was
21 concluded.)

22 - - -
23
24
25



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July 25, 2016

Ron Briel, Program Manager
Division of Public Health, Licensure Unit
Nebraska Department of Health and Human Services
Nebraska Nurses Association Testimony
407 Credentialing Review for Dialysis Patient Care Technicians.

My name is Melissa Florell (M-E-L-I-S-S-A F-L-O-R-E-L-L). I am here today on behalf of the Nebraska Nurses Association (NNA). NNA is testifying in a neutral position regarding the Nebraska Kidney Coalition application for registration of Dialysis Patient Care Technicians. The primary consideration in credentialing or changing the scope of practice for health care providers must be patient safety. Registered Nurses understand that optimal patient outcomes depend on the trust that patients place in their care providers and the health care system. In the recent past, articles and reporting of adverse outcomes have shaken that trust. We believe that it is our obligation as nurses, and as part of the health profession, to preserve the trust that the public has in the industry. We believe that a carefully implemented and managed Dialysis Patient Care Technician Registry can meet these goals.

The use of unlicensed assistive personnel is many times motivated by finances. Increasing the number of unlicensed personnel as opposed to licensed personnel can result in lower labor costs. However, allowing financial implications to dictate patient care delivery is not in the best interest of patients. Researchers in a retrospective observational study assessing data from 300 hospitals in 9 European countries determined that every 10% increase in the number of RNs providing patient care resulted in a 7% decrease in mortality (1). Researchers in a systematic review concluded that substituting other nursing personnel for RNs in an attempt to decrease personnel costs can result in an overall increase in healthcare costs as a result of increased length of stay and adverse healthcare events (2). Registered Nurses also believe that with safeguards in place to protect patients, unlicensed personnel can safely complete certain tasks. We believe that a registry including the following requirements would meet the goal of protecting patients, while allowing Dialysis Patient Care Technicians to fill their important role in care delivery.

- (1) Education and training is critical for tasks completed by anyone in healthcare. In the case of the Dialysis Patient Care Technicians, we believe that there should be standardized training requirements and that demonstration of competency must be completed prior to employment. Standardized training and on-going competency assessments that address the tasks performed by Dialysis Patient Care Technicians must be comprehensive and clearly defined to ensure that every individual in the state of

Nebraska receives care from individuals who are similarly trained. We ask that the committee clearly define these training requirements.

- (2) When unlicensed personnel are asked to complete tasks, these tasks should be directed by protocols that are approved by appropriate licensed personnel. For example, a protocol that would have a medication, must be approved by a provider who has medication administration in their scope of practice. The protocols should be specific and can not have range orders or allow for independent judgement.
- (3) Delegation. Currently in regulation, a Registered Nurse can delegate a non-complex task to unlicensed personnel. This delegation will ensure that the patient is stable and that the use of a protocol is appropriate and safe for the individual.
- (4) Heparin is a high risk medication. Inappropriate dosing or administration of this medication can result in serious complications. There are well documented cases of individuals who have died following inappropriate administration of Heparin. The administration of Heparin is a complex task. However, in certain circumstances, we believe heparin administration could be considered a non-complex task. In situations when a patient has been receiving a standard dose of heparin as part of a dialysis treatment and the patient is medically stable, the administration of heparin, we believe could be a non-complex task and could be delegated. We believe that when a patient is treated in a community setting and following an assessment by a Registered Nurse, a Dialysis Patient Care Technician could safely administer Heparin via facility approved protocols.
- (5) Central Lines: Central lines place a patient at high risk. These lines go directly into the central cardiovascular system. Risks include a systemic infection that could result in sepsis and death. There is also a risk of a patient having an embolism which could also result in death. In 2012, the CDC, estimated that 41,000 patients develop central line infections and 16 – 35% of those infections are fatal. Several years ago, only patients in an ICU or step down setting had central lines. However, with improvements in central lines and infection control measures, more patients have central lines outside of a critical care setting. They are now commonplace throughout hospitals and in the community. The Nebraska Nurses Association believes that in certain circumstances accessing a central line could be considered a non-complex task and could be delegated. However, to ensure public safety, the task should ONLY be delegated to an individual who has been thoroughly trained and routinely checked for their competency.
- (6) Lastly, Dialysis Patient Care Technicians who have completed the necessary training and have demonstrated their level of competency should be monitored. Mandatory

reporting by the Dialysis Patient Care Technician and the facility should be required in the event of a termination or delivery of unsafe care. This is another safeguard that will protect the public.

In summary, the Nebraska Nurses Association comes to you today in a neutral capacity regarding the Nebraska Kidney Coalition 407 Application for registration of Dialysis Patient Care Technicians, but believe that specific safeguards should be included to strengthen this proposal and ensure public safety. In review these are:

- Dialysis Patient Care Technicians should be registered, not licensed, in the State of Nebraska.
- Training and competency for the role of Dialysis Patient Care Technician should be standardized and clearly defined.
- Training and competencies must emphasize the high risk tasks of heparin administration and central line access.
- Limit this scope to community settings.
- Require the development of facility approved protocols that are specific and do not require interpretation or assessment to implement.
- Require delegation of these tasks by a Registered Nurse.
- Registrations should be administered by the Board of Nursing.
- Require mandatory reporting for individuals who hold the registration and the facilities who employ these individuals to report terminations of employment.

References:

- (1) Aiken, L. H., Cimiotti, J. P., Sloane, D. M., Smith, H. L., Flynn, L., & Neff, D. F. (2011). The effects of nursing **staffing** and **nurse** education on patient deaths in hospitals with different **nurse** work environments. *Medical Care*, 49(12), 1047-1053.
- (2) Jacob, E. R., McKenna, L., & D'Amore, A. (2015). The changing skill mix in nursing: Considerations for and against different levels of **nurse**. *Journal of Nursing Management*, 23(4), 421-426



licensed practical nurse
association of nebraska

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July 25, 2016

Technical Committee Members
407 Credentialing Review Program for Dialysis Patient Care Technicians
c/o Ron Briel, Program Manager
Credentialing Review Program
Licensure Unit, Division of Public Health
Nebraska Department of Health & Human Services
301 Centennial Mall South, P.O. Box 95026
Lincoln, NE 68509-5026

Dear Technical Committee Members:

Please accept this letter on behalf of the Licensed Practical Nurse Association of Nebraska (LPNAN). LPNAN is the professional organization that supports, promotes, and represents all aspects of practical nursing in Nebraska. LPNAN's work is accomplished through the promotion of quality health care standards, and promotion of the diverse functions of LPNs to consumers and other health care professionals. The Nebraska Health Care Association (NHCA) is the management company for LPNAN.

LPNAN applauds the work performed by individuals working in dialysis centers. Nebraskans experience better health care because of the caring staff at each dialysis center. However, LPNAN objects to the credentialing of dialysis patient care technicians (DPCT).

Licensed Practical Nurses work at the direction of RNs or licensed practitioners. LPNs contribute to the assessment of the health status of individuals by collecting basic objective and subjective data, recording and reporting data, and assisting with validating, refining, and modifying the data. LPNs contribute to the establishment of nursing diagnoses by identifying signs and symptoms of deviation from normal health status and identifying overt learning needs. LPNs participate in the development of a plan of care for individuals and participate in the assisting and giving of care. Finally, LPNs contribute to the evaluation of the responses of individuals to nursing interventions by evaluation of data and contributing to the modification of the plan of care based on the evaluation. LPNs obtain their education in the post-secondary program that generally lasts one year.

Nebraska has a classification called LPN-C. An LPN-C has an expanded scope of practice which requires an LPN license and certification as an LPN-C. LPN-Cs are allowed to perform initial venipuncture on an upper extremity with a device three inches or less, infuse intravenous fluids, administer medications through a continuous flow central line, and administer an initial dose of approved medication all under direct supervision. Under direction, the LPN-C may also administer medications through an intermittent or continuous flow peripheral or mid-line catheter; calculate the rate of flow and regulate said rate of flow; re-insert, convert, and flush peripheral intermittent devices; and administer pain medications via Patient Controlled Analgesia. Basically, the LPN-C has additional education and certification to provide limited services in intravenous therapy.

The amended proposal for credentialing review of dialysis patient care technicians asks that the DPCTs be licensed (credentialed) and that a scope of practice mirror the duties previously outlined in the Board of Nursing advisory opinion for technicians in the outpatient dialysis setting. Every one of the items identified in the Board of Nursing opinion could be performed by an LPN or LPN-C, depending on the activity. The State has made the policy determination that the administration of IV medication requires additional training, so allowing DPCTs who do not have the base level of education seems contrary to public policy.

Because there are already groups of individuals with whom the activities requested by the application have within their scope of practice the ability to complete the actions requested by the applicant, LPNAN objects to the creation of a new license/credential for DPCTs.

Thank you for the opportunity to submit comments. If you have questions or comments, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, reading "Heath G. Boddy". The signature is written in a cursive style with a large, looping initial "H".

Heath G. Boddy
President and CEO



Advocating for Physicians and the Health of all Nebraskans

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July 25, 2016

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Licensure Unit – Office of Policy, Research and Quality Improvement
Division of Public Health
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PO Box 94986
Lincoln, NE 68508

RE: Dialysis Patient Care Technicians (DPCT) 407 Review Public Hearing

The Nebraska Medical Association is supportive of the application as amended by the Nebraska Kidney Coalition, which would require licensure for credentialing DPCT's in the outpatient dialysis clinic setting. Through licensure, this will put into place an approved set of core curriculum training to provide consistent training across the state, a specific scope of practice for DPCT's, as well as adequate oversight to ensure increased protection and patient safety for those within the DPCT's care.

The National Standard Core Curriculum for the Dialysis Technician would mirror the duties that were previously outlined in the Board of Nursing Advisory Opinion, which was adopted in April 1991 and reaffirmed thereafter, for technicians in the outpatient dialysis setting. This National Standard Core Curriculum, meets the federal CMS guidelines with standard competency testing and annual continuing education requirements.

It is important to note that all DPCT's and LPN's working in the dialysis setting have direct supervision of licensed registered nursing personnel and follow policies and procedures that are developed by the Medical Director and the nursing education staff. A patient is always assessed by an RN prior to any initiation of dialysis, dosing of heparin, or any care being provided by the DPCT. The DPCT is required to follow the routine and care that have been established by the physician, evaluated with laboratory monitoring and validated by repetitive use. As long as the patient is within the parameters taught to the DPCT to start dialysis, this becomes a routine patient care task.

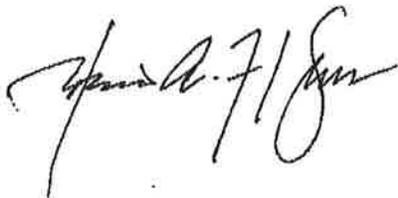
It should also be taken into consideration that these techniques are taught in the same manner to dialysis patients and their spouses whom are partaking/ assisting in dialysis through their home on a regular routine basis, which does not require nursing judgment.

We would ask that you also consider that to date, there have been no adverse events being reported that have resulted in patient harm.

We feel it is critical to continue utilizing DPCT's and LPN's that have the CMS approved training, testing and required continuing education requirements. As we continue to see an already critical nursing shortage in our state (and across the United States), elimination of the DPCT's and LPN's in dialysis units across the state would further jeopardize adequate access to care for dialysis patients in Nebraska, especially in our rural counties of the state.

The Nebraska Medical Association would ask that the committee strongly consider allowing DPCT's to continue the same tasks they have been doing since the inception of the April 1991 Advisory Opinion. Licensure of this group of healthcare providers may not be necessary but in efforts to resolve and allow access and adequate patient care to continue to be carried out, the Nebraska Medical Association supports the application as amended.

Sincerely,

A handwritten signature in black ink, appearing to read "Harris Frankel, MD". The signature is fluid and cursive, with a large, stylized initial "H" and "F".

Harris Frankel, MD
President

1337 - 1380

SIGN IN SHEET
For Public Testimony on the
Dialysis Technology Technical Review
July 25, 2016, 1:00 a.m. to 4:00 p.m.

TESTIFIERS - Please Print or Write Legibly for the Record

OPPONENT'S NAME	REPRESENTING
1. <i>Kandis Sefta</i>	<i>UP UNW</i> ✓
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1305

PROPONENT'S NAME

REPRESENTING

1. Matt Bauman

Nebraska Kidney Coalition ✓

2. Jina Ragland

Nebraska Medical Association ✓

3. ~~Fancy Dallas~~

~~Dialysis Clinic Inc~~

4. TIM NEAL

NEBRASKA KIDNEY ASSOCIATION ✓

5. _____

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SIGN IN SHEET
For Public Testimony on the
Dialysis Technology Technical Review
July 25, 2016, 1:00 a.m. to 4:00 p.m.

TESTIFIERS - Please Print or Write Legibly for the Record

NEUTRAL, NAME	REPRESENTING
1. <i>Melina Stouel</i>	<i>Nebraska Nurses Association</i> ✓
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