Minutes of the First Meeting of the Nurse Practitioners Technical Review Committee

March 19, 2025

9:00 a.m. to 11:00 a.m.

Members Participating	**Members Absent**	**Staff**
Jeffrey Wienke Jr., DPM, CWSP (Chair)	Joshua Schlote B.A.S., LVT, VTES	Maggie Mills
Christine Chasek, PhD, LIMHP, LADC		Caryn Vincent
Ally Dering-Anderson, BA, PharmD, FaAIM, FAPhA		
Darrell Klein, J.D.		
Wendy McCarty, Ed. D		
Stacy Waldron, PhD		

I. Call to Order, Open Meetings Law, Approval of Agenda, Introduction of TRC members

Chairperson Wienke called the meeting to order at 9:02 a. m. Members of the committee and the public were made aware of the Open Meetings Law, as they were both posted online and in the meeting room. A roll call vote was taken, five members of the committee were present and two were absent. A sixth member joined the meeting at 9:05 a.m. Dr. Wienke asked for a motion to approve the agenda. Ally Dering-Anderson motioned, with a second by Darrell Klein. A roll call vote was taken to approve the agenda, and it was approved. Dr. Wienke asked if each of the Technical Review Committee members could introduce themselves to the applicant group.

II. Presentation on the Proposal by the Applicant Group

Karen Wenner, APRN, DNP began the applicant group's presentation by giving the basics on Nurse Practitioners. She continued that there are four distinct types of APRNs, Nurse Practitioners (NP), Certified Nurse Midwives, Certified Registered Nurse Anesthetists (CRNA), and Clinical Nurse Specialists. Dr. Wenner pointed out that the CRNAs had gone through a 407 process to include fluoroscopy into their scope, and that they already have this scope increase.

Dr. Wenner continued, reviewing their goals of the 407 review. Those being to update Nebraska Medical Radiography Statute to include Nurse Practitioners,

remove barriers to allow Nurse Practitioners to practice to the full extent of education and training, and to define Nebraska state regulated training/ education requirements for fluoroscopy. She proceeded by detailing what fluoroscopy is, saying it makes a real-time video of the movements inside a part of the body. Images are captured by passing x-rays through the body over a period. Dr. Wenner added, there can be higher radiation doses compared to plain x-ray, but the benefits of using fluoroscopy when needed, outweigh the risks of the added radiation exposure. She built upon those concepts by including images of different machines that perform fluoroscopy. The first machine she identified would be used in an interventional radiology room, cardiac labs, or neuro-interventional radiology, where the equipment is fixed. In this setting, the patient is on the table, and everything is done in the suite, usually involving a radiology technician. The second machine identified was the “C-arm.” This machine is portable and can be used throughout facilities, most used in the operating room because it can be draped and part of the sterile field. Often, a radiology technician will be taking these images. The third machine identified is referred to as the “mini-C-arm.” This machine is draped and can be used in the operating room. She continued that this machine can be moved around when instrumenting, reducing fractures, with smaller dosages of radiation compared to the larger one. Radiology technicians often do not operate this machine, an assistant of the surgeon is typically the one performing the imaging. These are mobile so they can be used in Emergency Department or throughout clinics.

Darrell Klein clarified for other committee members that “rad tech” is what Medical Radiographers are referred to as in Nebraska.

Continuing in the presentation, Dr. Wenner highlighted the current restrictions seen in the State. Key points include that the Nebraska Board of Radiography recognizes a ‘licensed practitioner’ as a person licensed to practice medicine, dentistry, podiatry, chiropractic, osteopathic medicine, and surgery, or as an osteopathic physician. Meaning, the ‘licensed practitioner’ may perform and supervise fluoroscopy without any further training requirements set forth by the State, and use the machines previously explained. With that, it is implied that they receive it in their core curriculum, and a lot of people go on to get more training, but it is not required by Nebraska statute. Anything nursing was left out of the Medical Radiography statute. She continued that since the Medical Radiography statute was created in the 1980s it was not because there was a deficit in their training and rather, a response to lesser prevalence of those professions in the state.

Darrell Klein stated that what happened at the onset of the Medical Radiography statute was that there were big turf wars because at that time the Nebraska Medical Association (in the 1980s if the NMA opposed something it would not become law) there had been a move to increase the training requirements. These requirements were for what were then referred to as “X-ray system operators” and their statute was a one-liner that gave the Department authority under the Radiation Control Act. X-ray system operators were governed by the Radiation Control Act and the Department wanted to increase the training requirements for that. In 1987, the Radiology Technicians had their own Credentialing Review, wanting to become

credentialed which ended up failing. That Credentialing Review had approval from the Technical Review Committee, approval from the State Board of Health, and was denied by the Director. That was seen as the first step toward licensure for the X-ray System Operators. The concern raised from a Family Medical Practice because they believed that there would be increased costs passed on to the practitioners. Mr. Klein added that what it really came down to is they were doing it in Colorado and not having any problems, so they dropped their opposition. So, when the original Medical Radiography Act was created, it was done with a review of the Law and the people who were originally included in the list of licensed practitioners were considered to already have Radiography in their scope of practice. There is a provision in the Constitution that prevents unlawful taking of property, which professional licenses are viewed as a type of property. Thus, the new bill was intended to not affect them. So, 'licensed practitioner' at the time was viewed as anyone that already had it in their scope of practice. The actual limitation was intentional.

Dr. Dering-Anderson asked, if this is current law, and that a CRNA can perform fluoroscopic imaging, is what was being presented current law or not. A member of the applicant group, Jillian Negri APRN, DNP answered, yes, it is current law, and that CRNAs have a line that is written into their Practice Act, as do the Physician Assistants. So, they are not written into the word of Radiography.

Darrell Klein added that scope of practice and competency overlap, but just because a given profession has it within their scope of practice does not mean that every individual practitioner is competent to do it. He stated that the Credentialing Review (407 Process) just makes a recommendation to the Legislature.

Dr. Wenner continued in the presentation. She began by saying there are different specialties that Nurse Practitioners work in and not all of them will require the use of fluoroscopy. The specialties that Nurse Practitioners could benefit from this increased scope include Orthopedic Surgery, Neurosurgery, Cardiology, Pain Management, Urology, Emergency Medicine, Fertility, Gastroenterology, Nephrology, OB/GYN, and Surgical First Assisting. In all those settings, fluoroscopy is used and with this limitation NPs cannot fulfill the full role and expectation of their job. In interventional radiology settings, they cannot hire a Nurse Practitioner as a physician extender or assistant, so those settings are limited to Physician Assistants. In other states, fluoroscopy is included in the scope of practice for Nurse Practitioners, and it is included in their education, creating a barrier for those practitioners to move or practice in Nebraska. Dr. Wenner wanted to make the clear distinction that most of the time when people hear fluoroscopy, they think of the more invasive procedures such as retrieving a clot from the brain, she continued that NPs are not trained to do those procedures. She added that she would argue that they are trained, in NP core curriculum, to perform radiation, and in practice they order X-rays, CT scans, nuclear medicine procedures, and to go to interventional radiology to have them done. With that, they understand the consideration and risks/benefits of receiving that type of radiation.

Dr. Wenner went on to explain the need for the proposal. The greatest need comes from access to care, specifically within rural communities needing these specialty services. There is a lack of ability to recruit trained specialists to Nebraska and unnecessary work arounds. Other reasons included prolonged procedures, repeat sedation/ x-rays, and patients must travel for specialized procedures. One example she gave was that they have had Nurse Practitioners who work in Emergency Departments in the Panhandle reach out to them, some of them practice in Wyoming where there is no issue when it comes to using fluoroscopy. Those NPs have a fracture that they want to reduce, and they determine using fluoroscopy would allow them to perform the procedure better and see real-time, the alignment of the fracture, but in Nebraska that is not an option. The alternative, which is what would happen, is they would have to sedate the patient, do the procedure, apply the splint, then get a plain x-ray, and when assessing it, if it is not aligned to standard, you are looking at doing a repeat procedure. The cost, expense, time, and still getting multiple x-rays which is something that the NPs must consider. Another need for the proposal is in relation to the workforce. Specialists cannot hire qualified nurse practitioners for the desired roles. One of the stories that the applicant group was told, a registered nurse was working in interventional radiology. Her role included sedating, setting up, providing barriers for protection from radiation. Once she graduated as a nurse practitioner, the interventional radiologist wanted to hire her to be able to assist in procedures but then they learned with this limitation in place, it was not possible. She was offered a job with that interventional radiologist in Colorado so she could practice, however her family resides in Nebraska, so she switched into Family Medicine instead to stay in the State. In rural communities throughout Nebraska that creates a loss of access to care.

Dr. Wenner continued, in her role as Surgical First Assisting, with the mini C-Arm where there is not a Radiology Technician, and that is the preference of the surgeon, and if they need an X-ray shot the nurse practitioner is limited to tasks such as holding instruments or changing positions. Somewhere to make it so that the surgeon is performing the imaging but if she were a Physician Assistant, she would not be restricted in performing the imaging.

Dr. Negri added that she had been approached by Women's Health Practitioners. They were struggling to get intrauterine injections, which is in their scope of practice, but they cannot use fluoroscopy to do it. There were other fertility things they could not do such as assist with egg retrieval. One story from a pediatric urology nurse practitioner that was able to order a study for a child, set up the complete study in the interventional radiology suite and then they would have to call the interventional radiologist to step on the pedal for a couple of minutes to get the images. In that scenario, the nurse practitioner was standing there the whole time trying to get what she needed for her diagnostics. She was struggling to get the shot that she wanted for her procedure because someone else had to take the images.

Ann Young, APRN, commented on stories she heard from central and rural Nebraska, that the issues arise from not having practitioners to perform this imaging, and the cost of care to these patients who may need to be transferred to a higher

level of care that might be hundreds of miles away from them. Whereas, if Fluoroscopy were included in the scope of practice for Nurse Practitioners it would save money and time for these Nebraskans.

Dr. Wenner commented on efficiency for smaller hospitals, where more urgent surgeries come in and they need the radiologist technician and the C-Arm, or the mini-C-arm, and they can free up the radiologist technician and perform both procedures.

Technical Review Committee member, Stacy Waldron, PhD saying that in their application they did not want the “Act” to set the rules and rather the facilities to set the rules. She continued, that in the past she seems to remember that people could rent C-arms and put it in an office and do it on their own. She asked, how do we make sure to protect the public in that way when you are setting that up and how do you propose to do that?

Darrell Klein added that they are seeing some APRNs working in “Med Spas” and traditionally DHHS has not regulated individual offices and that some of those offices are not using best practice. Sharing in Dr. Waldron’s concern, saying that if the scope of practice changes for the whole profession, then members of the profession will have the opportunity to be practicing outside of a facility. Dr. Wenner responded saying that they want state regulated training and requirements, and they wanted it to not be so extensive that they would be creating a new barrier. They want to find what would be an acceptable minimum state required education and training because they do not want to expand a scope that would cause harm. She continued, that the procedures that they are doing there, that is more of the risk, they are already doing procedures and by adding fluoroscopy, the added risk is the exposure to the radiation.

Dr. Waldron shared her concern about how once the scope of practice is expanded, there is no narrowing which creates risk in those settings such as the Med Spas. She added that those who shared stories, their scope of practice is clearly defined, but in these unregulated facilities there is no clear definition of their scope.

Dr. Negri responded that those providers’ scope of practice is defined by Advanced Practice in the Nurse Practice Act. She added that you will find bad actors in all settings, and they do not support that, there may be more restrictions coming from credentialing and privileging in different facilities. Going on, she said she is not sure if there is a specific way that they can write this legislation to make sure that people do not make bad decisions.

Darrell Klein agreed that they cannot legislate bad actors. He asked, does the benefit of nurse practitioners being able to use fluoroscopy competently outweigh the predictable risk of the bad acting nurse practitioners? He also asked how much it costs to rent machines that perform fluoroscopy, and could that curb the potential bad practice if we expand the number of people who can do it?

Dr. Negri asked what procedure in a Med Spa would require fluoroscopy? Dr. Dering-Anderson jumped in and said that Med Spas are injecting water-soluble vitamins that are easily absorbed orally, all to say that they could find a way to use fluoroscopy.

Dr. Wenner addressed that she had never heard of someone renting a C-arm, stating that they have to make sure it has been checked by a med physicist and the Radiation Control Act and as soon as it is brought into a facility, you increase your regulatory requirements because now you are radiating a patient. If they are doing that, they would be breaking laws or at the very least, doing things inadequately which would then be reported. Dr. Negri added that the problem there is that they would be acting outside of their Standard of Care rather than their scope.

Darrell Klein stated that by removing the barrier and adding this to the scope of practice, we increase another profession's bad actors to invade another profession's scope of practice. He touched again on Med Spas and how the nurse practitioner is the main provider in those facilities and that any report of what unprofessional conduct would have to be made by a subordinate, usually those who have been fired. He added asking if the benefit of increased access sufficient to outweigh the known increased risk from bad actors. He clarified that if these Med Spas were to rent these fluoroscopy machines, they would be held to additional standards under radiation laws.

Dr. Wenner added that Chiropractors can have independent practice, and they are not restricted in fluoroscopy and that they have not seen any bad things from them. Clarifying they have not seen harm from fluoroscopy. Ann Young added that they have great concern over the bad practice in Med Spas too but how do you stop it. Dr. Wenner expressed that they want to see potential unforeseen consequences and address them during this time in addition to emphasizing training and education.

Dr. Wenner continued in the presentation, stating that their proposed change is to update the Medical Radiography Statute to include nurse practitioners as 'licensed providers.' Which would allow nurse practitioners to supervise and/or perform fluoroscopy after didactic and clinical training requirements have been met.

Dr. Wenner went on about the benefits of increasing the scope of practice. These benefits included increased access to care, efficiency in healthcare delivery, cost-effectiveness, increased quality of care, and greater usage of workforce utilization.

Potential risks that the applicant group looked at included the prolonged use of fluoroscopy which can cause tissue damage, burns, or hair loss to the region although it is extremely rare, and several safety mechanisms are in place to avoid this. This is usually the result of higher doses of radiation that are not used much anymore. Dr. Wenner added that when it has occurred in the past, an interventional radiologist performed it. Another identified risk is stochastic which is an increased risk of cancer with cumulative radiation dose over time. Depending on the number of times you need to get diagnostic studies, the greater likelihood of developing cancer due to the amount of radiation your body has been exposed to. Other posed risks are

the misinterpretation of imaging and insufficient radiation or inadequate study that would require additional testing, thereby subjecting the patient to more radiation.

Dr. Wenner continued in the presentation explaining how to mitigate the risks, previously stated. She began by talking about putting a strong emphasis on education and training on radiation safety and equipment. Going along with that equipment, many of the machines used now have improved and have an automatic dosage rate or radiation based on the tissue it is going through. There are also alarms on the machine if you are exceeding the optimal amount of time. Using radiation, you are also taught As Low as Reasonably Achievable or ALARA. In facilities there are radiation safety members/ committees or radiology technicians who can be used as a resource in addition to the oversight of collaborating physicians, surgeons, and radiologists. Additionally, there are reporting systems already in place-time, what needs to be recorded is the time and cumulative dosage. Another way the risks are mitigated is the concept of credentialing and/ or privileges within facilities. If this were to change the statute and add requirements, facilities may still decide they do not want NPs to perform fluoroscopy. If they are not performing it adequately, it is a privilege that can be taken away. Dr. Wenner added that the NNP did not find any reported instances of harm from fluoroscopy in Nebraska, or by nurse practitioners nationwide.

Darrell Klein jumped in and asked the applicant group if they would be open to instead of changing the Medical Radiography Statute, doing something similar to what the CRNAs did, and have the capacity to use fluoroscopy be part of their scope of practice as long as you are in a licensed healthcare facility. He said that it would address the current concerns.

Dr. Wenner asked Chairperson Dr. Wienke if he has a free-standing clinic in which he would ever use a C-arm. Dr. Wienke said in the clinics they have x-ray machines and staff that are trained to take those images. He continued that he was hearing from the committee about potential abuse of fluoroscopy in Med Spa settings and asked about a specific procedure that any of the committee members are worried about in the instance that they added fluoroscopy to their scope. Dr. Wienke commented on the minimal exposure of radiation, to the point where they do not wear lead in the operating room anymore.

Dr. Dering- Anderson replied to the question and said that one of the biggest risks does not appear in the application. Asking people to spend money unnecessarily is the greatest healthcare risk. She said, no one would order a nuclear pharmaceutical that was not 100% necessary and there is no alternative. Dr. Dering-Anderson asked how the price of a normal x-ray compares to that of a fluorograph. How often would something that could have been managed by an x-ray, now be replaced with this new equipment/technology?

Dr. Waldron discovered that there are five companies that you can rent a C-arm from for $2500- $3500 per month to any office. The mini-C-arms were cheaper to rent per

month, noting that although there is no procedure in Med Spas right now, they will come up with something.

Darrell Klein added that these events are currently being reported to the board of nursing. He summed it up saying, he doesn't believe any of the committee members have concern about their scope of practice being expanded as long as you are in a health care facility that provides some added layer of competency and not open up the scope to those who are not competent. On top of that, Mr. Klein said that they see the potential risk and they want to figure out how to minimize it.

Chairperson Wienke restated the question of what specific procedure these Med Spas would be performing and using fluoroscopy and posing a risk for patients. Darrell Klein responded by saying what they have seen is non-sterile practices for things they are injecting into people, he continued by saying what would stop them from using a fluoroscopic procedure to just try and make money and create the unnecessary exposure to radiation.

Dr. Negri jumped in saying that the payout would have to be worth it to these Med Spas. To obtain one of the fluoroscopic machines there are requirements and layers of radiation safety and biomed that standardizes the machines. She reiterated it would cost a Med Spa more money to regulate the machine in the spa, that it would not profit enough to make it worth it.

Dr. Wenner offered the example of someone coming in to an ER but the sole provider there was a nurse practitioner and they have decided that the best thing to do would be get fluoroscopic imaging to perhaps avoid going to the operating room or performing multiple x-rays, but since the sole provider is the nurse practitioner, they do not have the option compared to their counterparts such as a physician or a physician assistant. She added that she wanted to address the concerns posed by the committee and try to ensure that fluoroscopy should only be used in best medical practice. With that, they would try and find a way to keep fluoroscopy in regulated medical facilities.

Dr. Dering-Anderson asked why there is reluctance to fluoroscopy only being done in a facility and that it could be a discussion for the next meeting.

Dr. Wenner continued through the presentation highlighting the proposed education and training. NNP proposes a minimum of four (4) hours of post graduate didactic education in fluoroscopy which includes: radiation safety, radiation production and characteristics, radiobiology, contrast media, and fluoroscopic unit operation. Clinical training must include a minimum of five (5) fluoroscopic procedures under the supervision of a formally trained preceptor (e.g., medical physicist, radiologist, or other properly trained and licensed physician). With each license renewal, a nurse practitioner who utilizes fluoroscopy must have a minimum of one (1) hour of continuing education (CME) in fluoroscopy. Those would be the requirements of the state, although further training requirements may be set forth by the organization/ fluoroscopy owner. There are twenty-two other states that allow nurse practitioners to

utilize fluoroscopy, and no significant adverse outcomes have been reported. Bordering states include Iowa, Colorado, and Wyoming with each having a variation of state regulated training requirements. Dr. Wienke asked if they have Med Spas in those states too, to which Dr. Wenner said yes with no reported harm from fluoroscopy.

In reviewing the criteria, NPs are limited in the care they can provide the public, which would be considered standard of care for other people in the same positions to use fluoroscopy. They have seen that fluoroscopy would be within the scope of practice for NPs and can be safely performed. The danger that is presented by fluoroscopy is with the exposure to radiation although it has been advanced to expose the patient to minimal radiation, often less than a CT scan. They have not seen any harm done from fluoroscopy, but they do want to be able to address unforeseen consequences that could harm the public. Dr. Wenner stated that the current education and training would adequately prepare nurse practitioners. With there being varying training and exposure to fluoroscopy and in nurse practitioner school, they undergo radiation safety education but proposing the post-graduate requirements to perform this new scope. Continuing, there are several programs to provide this training and there are adequate measures to assess that NPs would be doing it competently. Dr. Wenner added that they anticipate doing this in their specialties where they are collaborating with the physicians, surgeons, interventional radiologists (if hired to work in interventional radiology). With that, there are reporting mechanisms to address radiation exposure.

Dr. Negri wanted to address Dr. Dering-Anderson's concern about the applicant group being apprehensive to adding into the language that this would only happen in a medical facility. Dr. Negri responded by saying that a colleague, working in vascular surgery, has a facility where he has a clinic and then he has his own free-standing surgical suite, or an OBL, which is a licensed surgical facility. If he chose to hire a nurse practitioner to assist with patients in the clinic and those in the operating room, in the OBL that he owns and operates independently, in the legislation it may restrict the nurse practitioner from working there versus working at say, the UNMC surgical suites. Darrell Klein added that DHHS historically has not licensed individual professional practice. There is a list of facilities under the Healthcare Facility Licensure Act. Answering the question of if you limit this scope to only licensed healthcare facilities, then no, he could not use a nurse practitioner. Unless the OBL had received a license from the State, the facility, not the professional, if it is listed under the Uniform Healthcare Credentialing Act then it would be okay.

Cora Schrader redirected the conversation of it sounding like the Med Spas have their own problems and that should be addressed separate of the practitioners. She stated that they are going to have a problem with limiting the statute that would keep nurse practitioners from providing high quality care. Darrell Klein responded by saying that the Med Spas will never be licensed because it is not possible to draft something that would not also then license every single healthcare provider's office. He added that one problem he has with the application is the use of supervision, saying that he does not have a problem with the nurse practitioner performing the

fluoroscopy but problems if that task was delegated to someone else by the nurse practitioner. Mr. Klein asked what the applicant group envisions when using the term supervising?

Dr. Wenner responded by saying it is supervising the Radiology Technician. In the Emergency Department, if they are using the larger C-arm the Radiology Technician would be operating it and they would be supervising, which is already happening with the other providers. The only person there to supervise is the physician assistant, the nurse practitioner (in other states), or the radiology technician and there is nobody else that it would be delegated to.

Dr. Waldron jumped in and said that the applicant group had mentioned multiple times that surrounding states like Iowa, Colorado, and Wyoming that they have the ability for nurse practitioners to be able to use fluoroscopy and asked if those states have the same amount of independence. Dr. Negri responded by saying yes, in all the identified states they have the same full practice authority. She added that there are a couple of states that do not have any transition to practice hours required and they are still not seeing any harm.

Dr. Dering-Anderson clarified that training in fluoroscopy is not standard. She asked that the committee sees the required training for a CRNA, the required training for a medical radiographer (also called a radiology technician), the training for a physician assistant, and compare those professions to what is being proposed. She also wanted clarification on if the four hours meant four semester hours or four contact hours.

Darrell Klein made note of the thought that there may be other “higher up” medical professionals who have had less training in fluoroscopy but are granted the authority to perform it because it is automatically within their scope.

Dr. Negri responded and said Medical Radiography is a degree, so it is more than 40 hours of contact regarding anything that has to do with radiation, which nurse practitioners are not planning to do. She continued by saying that they are trying to integrate them as a part of the team and have nurse practitioners supervise and work with them. Physician assistants and CRNA requirements are both four hours and that they would be willing to work it into future nurse practitioner curriculum but without the scope change, they cannot do that.

Dr. Dering- Anderson was requesting to see the comparisons and specifications of what requirements are asked of physician assistants to perform fluoroscopy. Dr. Wenner responded saying the physician assistant programs they have talked with have said that fluoroscopy is included in their trainings but there is not a specification on number of hours that are required. Nurse practitioners have the radiation training in their schooling but whether they are exposed to practicing fluoroscopy or not is variable. This is why they want to set the specific standard in Nebraska for training on fluoroscopy outside of standard curriculum for nurse practitioner school.

Dr. Dering-Anderson expressed her concern that there is no “across-the- board” training for nurse practitioners. Dr. Wenner responded by saying it is a state-by-state situation which is why curriculum is variable, and therefore training is variable.

Dr. Chasek spoke about how it is similar in Behavioral Health. She voiced that the committee is tasked with identifying if the benefits will outweigh the harms and that feels as though there are protections in place from the bad actors. She continued that it would be beneficial to hear how their profession “polices itself” in terms of discipline for those bad actors by the Board.

III. Comments or questions from other interested parties

Amy Reynoldson from the Nebraska Medical Association (NMA) thanked the applicant group for their presentation and their application being clear. She spoke saying that the NMA will not be a barrier. Ms. Reynoldson continued, saying they recognize and appreciate the transparency of NNP. She offered a suggestion about the training portion, saying that it is spelled out well under Title 180 NAC 23 for the CRNAs. It states, the training program or equivalent course, saying that that would bring broad, equal training. Ms. Reynoldson added that it does not specify hours anywhere, but it does talk about who is providing it, which in that case was UNMC, and that it was a fluoroscopy and radiation safety training course.

Amy Reynoldson also commented on the supervision portion of the presentation. Saying that the reason the CRNAs were not listed on that was because she does not think that CRNAs can supervise. In Nebraska Revised Statute 38-711 under their performance of duties Section F states, “the use of fluoroscopy in conjunction with a licensed medical radiographer in conjunction with the performance of authorized duties and functions upon completion of appropriate training and education is approved jointly by the Department and the Board and promulgated by the Department.” She suggested that might be a way to get around the Med Spa problems. Perhaps adding the “in conjunction with a medical radiographer” to avoid further Med Spa consequences.

Ms. Reynoldson did some additional research on services or procedures that nurse practitioners are performing in Med Spas within the Omaha-Lincoln area. They are doing dermatologic care, weight loss, pharmaceuticals, laser hair removal, microneedling, pain management, and acupuncture.

Cora Schrader wanted to make a mention of the applicant group’s letters of support and assure the Technical Review Committee that they would listen to the feedback and adjust from there. Cora continued, that they worked closely with the NMA and received feedback from them to make sure they were being as professional and productive as possible. She added that the Nebraska Hospital Association, Nebraska Rural Health Association, the Platte Institute, CHI, and others all support this 407.

Amy Reynoldson made a comment about Med Spas, saying that there are states regulating them, states putting very stringent requirements, and that it is something that could be addressed in the future.

Dr. McCarty asked if there could be an expanded definition of the word supervision and supervise.

Dr. Wenner responded by apologizing for not being clearer on the supervision. When the applicant group met with the Board of Radiography, they are used to having the order come from a provider and that is the supervision. She added that that is where the nurse practitioners are wanting to be able to supervise the radiology technician to use the fluoroscopy machine. The second way would be that nurse practitioners want to be able to operate the fluoroscopy machines.

Darrell Klein added in that some of the CRNA language was to allow the medical radiographer to conduct this under the supervision. Adding that supervision is defined differently for many professions so it is important to define it in this instance.

IV. Initial discussion by the Technical Review Committee members

There was no further discussion by the Technical Review Committee.

V. Questions and information requests from the Technical Review Committee members

Questions and information requests from the Technical Review Committee will be submitted to the applicant group prior to the next meeting.

VI. Comments or questions by members of the public

There were no further comments or questions by member of the public.

VII. Adjournment

The meeting was adjourned at 10:53am.