REPORT OF RECOMMENDATIONS AND FINDINGS

By the APRN
Technical Review Committee

To the Nebraska State Board of Health, the
Director of the Division of Public Health, Department of Health and
Human Services, and the Members of the Health and Human
Services Committee of the Legislature

November 3, 2020

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Part One: Preliminary Information

Introduction

The Credentialing Review Program is a review process advisory to the Legislature which is designed to assess the need for state regulation of health professionals. The credentialing review statute requires that review bodies assess the need for credentialing proposals by examining whether such proposals are in the public interest.

The law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Department of Health and Human Services, Division of Public Health. The Director of this Division will then appoint an appropriate technical review committee to review the application and make recommendations regarding whether or not the application in question should be approved. These recommendations are made in accordance with statutory criteria contained in Section 71-6221 of the Nebraska Revised Statutes. These criteria focus the attention of committee members on the public health, safety, and welfare.

The recommendations of technical review committees take the form of written reports that are submitted to the State Board of Health and the Director of the Division along with any other materials requested by these review bodies. These two review bodies formulate their own independent reports on credentialing proposals. All reports that are generated by the program are submitted to the Legislature to assist state senators in their review of proposed legislation pertinent to the credentialing of health care professions.

LIST OF MEMBERS OF THE APRN TECHNICAL REVIEW COMMITTEE, 2020

Jeromy Warner, PsyD, LP, Chair

Allison Dering-Anderson, Pharm.D., R.P.

Su Eells

Benjamin Greenfield, Perfusionist

Denise Logan, BS, RT

Wendy McCarty, Ed.D.
College Instructor, University of Nebraska at Kearney

Mary C. Sneckenberg

Part Two: Summary of Committee Recommendations

The committee members approved the applicants' proposal by a vote of three ayes to two nays. The details of this recommendation can be found in the last section of this report beginning on page 54.

Part Three: Summary of the Applicants' Proposal

The following text summarizes the applicants' proposal:

- Modernizing the licensure and regulation of APRNs in Nebraska:
    i. Create a single APRN practice act
    ii. Align scope of practice for all APRNs with the national consensus model for APRN regulation
    iii. Position Nebraska to enter the APRN licensure compact
- What advanced practice nurses are covered under this proposal?
    i. Certified Nurse Practitioners (CNPs / NPs)
    ii. Certified Registered Nurses (CRNAs)
    iii. Certified Clinical Nurse Specialists (CNSs)
    iv. Certified Nurse Midwives (CNMs)

- What is the consensus model for APRN regulation and why is it important?

  This model is the product of a four-year collaboration between the National Council of State Boards of Nursing and nurse leaders from twenty-three nursing organizations. This consensus work group recognized that APRNs would play an increasingly significant role in improving access to high quality, cost-effective care, but that, currently, inconsistent standards in APRN education, regulation, and practice limit mobility from one state to another.

- What does APRN consensus model alignment mean?

  The APRN consensus model provides states with a framework and guidance to adopt uniformity in the regulation of APRNs. Consensus between the states was originally projected to have been accomplished by 2015. A numeric system is used to assign progress towards implementation of the model. Nebraska has 25 of the 28 points required to fully align with the model.

  The following proposed scope of practice changes represent consensus model alignment:
  i. Full practice authority for CNMs
  ii. Prescriptive authority for CNMs and CNSs
  iii. Removal of Transition to Practice requirements for NPs

- Why is APRN consensus model alignment important for Nebraska?

  The importance of this is that it addresses access to care needs in remote rural areas of Nebraska where access of the care pf physicians has been steadily declining for many years.
  This model provides an opportunity for regulatory simplification and consistency across all of the APRN specialties.
  This model provides an opportunity to improve the portability of the variety of services provided by advanced practice nurses from one state to another.

The full text of this summary can be found under the APRN topic area on the credentialing review program link at http://dhhs.ne.gov/Licensure/Pages/Credentialing-Review.aspx

Part Four: Discussion on issues by the Committee Members

Dr. Warner asked the applicants how many nurses they represent. Linda Stones responded by stating that there are approximately 3000 APRNs in Nebraska. Ben Greenfield asked the applicants if they know of any opposition to what they are proposing. Linda Stones responded that the Nebraska Medical Association has concerns about the proposal particularly as it relates to nurse midwifery practice.

Linda Stones commented that the proposal seeks to streamline the regulatory process for all four advanced practice nursing groups so as to improve efficiency, portability of services, regulatory consistency, and accessibility of services for patients.

Dr. Dering-Anderson commented about the complexity of current regulatory rules defining which advanced practice nurses can or cannot prescribe certain medications, stating that it is very difficult for a pharmacist to determine whether a given advanced practice nurse is allowed by law or rule and regulation to prescribe certain, specific medications. She expressed the hope that the credentialing review of the current proposal will provide at least some assistance to those tasked with determining which medications advanced practice nurses can / cannot prescribe. Linda Stones responded that this is one of the issues that the proposal is intended to address.

Linda Stones continued her comments on those aspects of advanced practice nursing that the proposal seeks to improve by stating the proposal also seeks to establish greater uniformity of education and training among all advanced practice nursing groups, as well as to assist in determining exactly what services each of the four respective advanced practice nursing professions does best. Ms. Stones informed the committee members that the national regulatory model group has already developed a more streamlined, simplified, and consistent regulatory model for advanced practice nurses, and that some other states have already implemented aspects of this model. Ms. Stones continued by commenting that the proposal if it passes would also eliminate most if not all current practice agreements between advanced practice nurses and physicians.

Dr. Warner asked whether the proposal would have the result of eliminating at least some of the regulatory boards that currently regulate some of the four advanced practice nursing professions. The applicants responded that it's too early to know whether or not this kind of scenario might play out if the proposal were to pass.

Sue Eells asked the applicants whether or not physicians play an essential role in the clinical training of recent APRN graduates. Linda Stones responded that other health professionals can play that role as well including other APRNs, for example.

Dr. Warner asked if there is any evidence from other states that have passed similar legislation as outlined in the proposal regarding any increase in the number of complaints against APRNs. Linda Stones responded that she has not seen any such evidence.

Dr. Dering-Anderson, PharmD, made the observation that the applicants' proposal seems to preserve the identity of the four core groups within the APRN community but yet wants to

standardize how they are educated, trained, and regulated which seems contradictory and raises the question why have four separate APRN groups if they're all to be trained, educated, and regulated the same?

Dr. Warner then asked is this four proposals or one proposal? An applicant representative responded by stating that there are four APRN statutes but there is only one APRN credentialing proposal.

A CRNA representative indicated that the applicants need to clarify what exactly each of the four APRN component groups would be allowed to prescribe and expressed the desire to see all the prescriptive details of the proposal.

At this juncture Committee chairperson Warner opened up the meeting to comments from other interested parties including those who have concerns about the proposal.

Dr. Jodi Hedrick, MD, OBGYN, speaking on behalf of the Nebraska Medical Association expressed opposition to the proposal for the following reasons:

1) There is no public need for this proposal
2) The safety standards inherent in the proposal are inadequate
3) The educational and training standards are not sufficient to protect the public

Dr. Hedrick went on to state that the proposal also fails to satisfy the credentialing review criteria.

Dr. Hedrick also stated that the NMA opposes consolidating the four APRN professional groups into one profession, adding that this idea seems to have been advanced to review without input from the members of the four nursing professional groups in question. Dr. Hedrick commented that improving efficiency, access, and educational and training standards can be accomplished without pursuing the extreme option of getting rid of four well-known advanced nursing professions in order to get these things done.

Dr. Dering-Anderson asked Dr. Hedrick why she considers the idea of regulating all APRNs under the auspices of a single regulatory act to be unacceptable when physicians have been regulated under the auspices of a single regulatory act in Nebraska for more than a century. Dr. Hedrick indicated that she did not perceive these two regulatory examples as being analogous.

Dr. Warner then asked the applicants for more information on how well the proposal has worked in other states where similar proposals have passed. He also asked the applicants for more information on how many of the members of the four affected nursing professions are supportive of the ideas in this proposal.

APRN Applicant Group Answers to Questions Raised by Committee Members during the First Meeting are as follows:

Many questions or points of confusion center around "Access."

25 of Nebraska's 64 critical access hospitals do not offer labor and delivery services, but we're only talking about 56 Nurse Midwives. Is this proposal really going to help bridge that gap?

Applicant Group: Questions regarding access are formulated in Credentialing Review question **1: What is the problem created by not regulating the health professional group under review or by not changing the scope of practice of the professional group under review?**

Pertinent to Criteria One and Two:
4-008.01 Criterion One: The health safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.

4-008.02 Criterion Two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public

Applicant Group: As noted in the Application, pg 26, the removal of supervisory practice requirements by physicians for certified nurse midwives (CNMs) has been demonstrated to increase the CNM workforce and subsequently access to the services that they provide in other states.

The National Bureau of Economic Research concluded that removing practice barriers on CNMs "…will not harm mothers and infants…" (Markowitz, Adams, Lewitt, & Dunlop, 2016). A joint statement between the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM) affirm that healthcare is most effective when in occurs in a system that facilitates communication across care settings and among clinicians. "Obgyns and CNMs are experts in their respective field of practice and are educated, trained and licensed independent clinicians who collaborate depending on the needs of their patients" (ACOG, 2018). The American College of Obstetricians and Gynecologists and ACNM advocate for health care policies that ensure access to the appropriate levels of care for all women (ACOG & ACNM, 2018).

As noted in the Application, pg. 28, clinical nurse specialists (CNSs) provide health promotion and maintenance through assessment, diagnosis, and management of acute and chronic patient problems that includes pharmacologic and non-pharmacologic interventions. Prescriptive authority is an essential component for practice to the top of educational preparation. Research and demonstration projects have shown that the CNS role is uniquely suited to lead implementation of evidence-based quality improvement actions that also reduce costs throughout the health care system. The CNS also plays an essential role in care coordination and transitions of care that result in reduced hospital length of stay, fewer hospital readmissions and hospital-acquired conditions. The CNS is uniquely prepared to engage in teaching, mentoring, consulting, research, management and systems improvement. The CNS is able to adapt their practice across all settings (American Association of Colleges of Nursing (2006).
According to the most recent updates in July 2020 by the National Association of Clinical Nurse

Specialists (NACNS), CNSs have independent practice authority in 28 states and in 19 states (National Council of State Boards of Nursing, 2015) are required to have an agreement with a physician to prescribe drugs and durable medical equipment. Nebraska is unclear on its regulations therefore limiting the practices of CNSs who were educationally trained as providers.

The Veterans Health Administration (VHA) provides a remarkable snapshot of the integration of APRN services that include the CNS in a model of care. The VA is the largest employer of licensed nurses with more than 5,700 APRNs, including 482 CNSs. In 2016, the Veterans Health Administration (VHA) announced its ruling permitting full practice authority for APRN's. In the VHA, the use of APRNs in the delivery of health care, including primary, specialty, acute, and home health care, expanded greatly after the implementation of the Veterans Integrated Service Network (VISN) structure in October 1995 and the Veterans Health Care Eligibility Reform Act in 1996 (Public Law 104-262). These changes resulted in a shift to local and regional networks grounded in ambulatory and primary care, an increase in the number of patients served by the VHA, and an increase in the percentage of patients seeking primary care services: 20% in fiscal year 1994 to 76% in fiscal year 1996.

Although a single unrestricted license allows APRNs to work at any VA facility, the VHA observes state-by-state rules regarding prescribing and admission privileges and physician supervision for APRNs. Advocates for "federal supremacy" argue that overriding state laws would "increase access to health care services, reduce costs and improve the quality and availability of health care" for Veterans by eliminating bureaucratic complexity and "artificial barriers" such as supervisory requirements (McCleery, Christensen V, Peterson, Humphrey & Helfand, 2014). They note that varying regulations for diagnosing and prescribing can delay appropriate care and waste time and resources, particularly for CNSs in cardiology and other specialties working in VA facilities that serve patients from more than one state. Crossing state lines (especially states like Nebraska without defined prescribing practices) as an active duty military member CNS or as a CNS that provides care to veteran's via telehealth can delay appropriate care to veterans.

Are Nurse Midwives going to continue to work where they are?

Applicant Group: The relocation of CNMs within the state (or, the location of new graduates and CNMs from other states) is entirely dependent upon the proximity of a physician whose practice includes obstetrics and willingness to engage in a practice agreement with the CNM. The newly revised Nebraska Healthcare Workforce report (UNMC, 2020) concludes that access to practicing Obstetrics/Gynecology (OB/GYN) physicians "*has deteriorated significantly in only two years, particularly in rural communities*" consequent to a decrease in the number of counties with actively practicing OB/GYN physicians. Out of 93 counties, only 39 counties have active OB/GYN physician in 2019 compared to 49 counties in 2017. These findings coupled with the decrease in the number of critical access hospitals offering obstetric services (Application, pg. 26) implicates an increasing re-distribution of OB/GYN physicians away from rural communities and widening dichotomy in access to care between rural and urban communities.

Analysis by the Nebraska Center for Nursing (CFN, 2020) demonstrates that the increase in the CNM workforce in the state between 2010 and 2018 is limited to urban areas. This is in stark

contrast to two CNMs working in rural areas in 2014 that were not reported in subsequent 2016 and 2018 licensure surveys (Appendix A). The Nebraska CFN analysis is limited to the number of CNMs reporting practice in Nebraska and differs from the number reporting licensure (i.e., 40 practicing vs 56 CNMs licensed in the state in 2018).

Appendix A also details the location of the clinical nurse specialist (CNS) workforce in the state. No CNSs were reported practicing in rural areas for the time period between 2010 and 2018. The analysis shows that the majority of CNSs practice in urban locations. In 2018, there was a decline in the number of CNSs reporting urban practice compared to urban clusters.

The 2020 Nebraska Healthcare Workforce report notes that nursing professionals along with physician assistants continue to be critical in mitigating the decline in physician workforce or poor access to physicians in rural communities. The report cites the impact of policy initiatives such as LB 107 (passed in 2015), which granted full practice authority to nurse practitioners (NPs) has significantly enhanced access to care in rural and underserved areas in Nebraska. The report indicates that there was a 16.3% increase in NPs since 2017 (UNMC).

There are currently 8 CNMs and 8 CNSs that hold dual licensure in Nebraska as NPs in the DHHS Nursing Licensure data base. Nurse practitioner licensure enables practice in blended clinical roles and prescriptive authority.

How do these proposed changes impact under-served hospitals?

Removal of the practice agreement requirement will provide CNMs with increased opportunities to practice in these communities to provide women's, maternal, and newborn care. More women will have the opportunity to receive prenatal/antenatal and postpartum care closer to their home. Hospitals will have the option to explore models of care to resume and continue existing newborn deliveries.

Certified nurse midwives effectively consult/collaborate/refer to physicians for limited portion of the antepartum/prenatal care and the intrapartum/labor and delivery care for conditions complicating pregnancy. They can also assist in identifying maternal health complications linked to maternal deaths (deaths occurring during pregnancy up to 1 year after delivery). The U.S. has the highest maternal mortality rates of developed countries. Per the CDC during 20112015 the majority of deaths occur outside of the immediate labor and delivery period: 31% during pregnancy, 33% 1 week to 1 year after delivery, and 36% occurring during delivery and up to 1 week after delivery (CDC, 2019; CDC, 2020). In the first week after delivery "heavy bleeding, high blood pressure, and infection cause most deaths…" (March of Dimes, 2019).

How many babies were born "somewhere else" who would have been delivered in these hospitals if there was staffing?

This data does not exist. The Applicant group is working with the Department of Vital Statistics to obtain information that might enable a reasonable proxy measure.

If there are 56 Nurse Midwives and 85 Clinical Nurse Specialists and that is 4% of the total Advanced Practice Nurses in Nebraska, then we have 2,880 who are either Nurse Practitioners or Nurse Anesthetists. Using the numbers provided today 2,296 of them are Nurse Practitioners and 725 are Nurse Anesthetists. There is very little change to the Nurse Practitioners or the Nurse Anesthetists practice authority or regulation, so we're focusing on 4% of the Advanced Practice Nurses in Nebraska. Is that correct? Perhaps a table showing the 4 practices and the impact of this proposal on each would be useful to my understanding.

Growth in the NP and certified registered nurse anesthetist (CRNA) workforce in the state parallels full practice authority for those professions. The Nebraska CFN transitioned to a regional workforce model in 2017 which stratified 2018 license renewal data in Department of Labor economic regions (Appendix B). Census data for each year (2010, 2012, 2014, 2016 and 2018) were used to calculate number of NPs and CRNAs per 100,000 people. Negative changes are shown in red, and positive in blue (Appendices C and D).

For CRNAs (Appendix C), the Central and Northeast economic regions experienced a decline in number of NPs per 100,000 between 2016 and 2018. The remaining regions experienced a higher number of CRNAs per 100,000 people 2016-2018.

The Central and Sandhills regions experienced a decline in number of NPs per 100,000 between 2016 and 2018 (Appendix D). The remaining economic regions experienced a higher number of NPs per 100,000 people 2016-2018, the time period immediately following implementation of full practice authority for NPs in 2015. Between 2014 and 2018, the overall number of licensed NPs increased an unprecedented 43% (Hoebelheinrich & Ramirez, 2019a). The number of NP practice owners is estimated to have increased by nearly 60% between 2015 and 2018 (Hoebelheinrich & Ramirez, 2019b).

Overall, both CRNAs and NPs increased their numbers per 100,000 people in all economic regions between 2010 and 2018 (see black bars on each chart Appendices C & D). As noted on pg. 27 of the Application, a Nebraska CFN study (Hoebelheinrich, Ramirez & Chandler 2019) confirmed migration of the NP and CRNA workforce into rural communities by the demonstrated proximity of their residences and practice to Rural Health Clinics (RHCs) and Critical Access Hospitals (CAHs). Rural Health Clinics and CAHs are the hub of health care services in our rural communities and enable consumers to access services in their communities.

It would be desirable to see how this proposal is going to impact existing prescriptive authority.

It would be desirable to have more specifics on how this proposal will solve the problem of trying to figure out who can prescribe what? The statutes being silent on Clinical Nurse Specialists means that they cannot write prescriptions. Every other profession that is authorized to write prescriptions spells that out clearly in their own statutes. Even pharmacists have express statutory authority to prescribe naloxone. This view is supported by the prescribing chart authorized by the Board of Pharmacy and provided to all dispensing

pharmacists in the state. Professionals act professionally and when they don't there are regulatory measures already in place to deal with that. The problem is that the current laws are all over the place.

Prescribing Reference Chart (Appendix E)

Applicant Group:
4-008.03 Criterion Three: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public

An objective of this proposal is a single APRN statute and license. Prescriptive authority relies upon statutory scope of practice as clearly stated in the current NP Practice Act (2019):

38-2315. Nurse practitioner; functions; scope.
(c) Prescribing therapeutic measures and medications relating to health conditions within the scope of practice.

In the APRN Consensus Model, scope of practice is the alignment of education, certification and licensure. Specialty practice is an extension of the core competencies for primary role and population foci. For example, NPs, CNMs and CNSs whose practice includes care of postmenopausal women would have competencies for that population and could be expected to prescribe therapies and medications accordingly. Conversely, the CRNA would have competencies for postmenopausal women as an older adult relative to the administration of anesthesia and pain management therapies and would prescribe accordingly. The prescriber is accountable under the law for prescribing within scope of practice.

The committee needs more specifics. The general goals of
1. Ease in regulation

Applicant Group: Appendix E shows a grid that summarizes the current statutory and pending revised regulatory requirements for APRN licensure. The reader is directed to the circled descriptors beginning with CRNAs on the far right. Certified registered nurse anesthetists have three decades of full practice authority in this state, and historically comparatively simple licensure and practice requirements limited to the maintenance of national certification by an approved certifying body. The objective of this proposal is regulatory simplification, i.e., licensure and practice requirements which can be limited to prior licensure as a registered nurse (RN) and the maintenance of national certification as an APRN.

4-008.04 Criterion Four: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.
This proposal is in compliance with Criterion Four regarding adequate education of the APRN to perform competently in their roles as advanced practice nurses. Nurses are educated in nursing science according to nursing curricula. Question 5, page 6, of the Application details a common core of education in advanced practice nursing prior to specialization in one of the four roles. Question 16, page 19 provides a more detailed explanation of education and training requirements for entry into APRN practice. The Consensus Model for APRN practice defines a common educational

standard for all four groups, which was previously lacking based on incremental legislation and different licensure authority in the states.

4-008.05 Criterion Five: There are appropriate post-professional programs and competence assessment measures available to ensure that the practitioner is competent to perform the new skill or service in a safe manner.

The Applicant Group meets Criterion Five regarding ensuring continuing competency for the APRN practice role. The first line of accountability for professional competency is the individual APRN. Licensed nurses at all levels are responsible for maintaining competency for the practice role. Question 5, page 31 of the proposal outlines organizations and methods for ensuring continuing competency for the specific APRN role. Based on the requirement for the APRN to maintain professional certification for licensure, each certifying body generally requires a combination of continuing education and practice for renewal of certification over a specific period of time. Other groups involved in ensuring providers competency are organizations that provide professional continuing education, employer credentialing and privileging, and credentialing agencies for facilities, such as The Joint Commission.

4-008.06 Criterion Six: There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

The applicant group meets Criterion Six regarding ensuring continuing competency for the APRN practice role as noted in Criterion Five above. Authority to discipline or remove an incompetent APRN from practice falls under the Uniform Credentialing Act and Mandatory Reporting Act in Nebraska. Question 2, pg. 27 details the Nebraska DHHS complaint based system for reporting professional incompetence or danger to the public. The intended outcome of regulation is public protection. Complaint-based discipline has not changed over the last 20 years for any of the four APRN groups in this state. The reader is referred to pg. 29 of the Application.

Joining the reciprocity compact is laudable, but the proposal doesn't tell me enough to wrap my arms around the key elements. More information is needed on HOW these goals will be met.

Is the reciprocity compact "all or nothing" or is there a middle ground? That is, can Nurse Practitioners be a part of the compact if our Clinical Nurse Specialists are not? Does every state in the reciprocity compact use the same titles for these people? Does every state in the reciprocity compact differentiate between the various advanced nurse practitioners?

Applicant Group: Alignment with the APRN Consensus Model positions Nebraska for entry into the APRN Compact which will necessarily be a separate legislative initiative. It is premature to suppose exactly what that proposal would look like or at what point legislation would be introduced. As the

APRN Compact is written today, all four groups of APRNs must meet criteria for participation. Advanced practice registered nurse titles will be uniform across state lines, e.g., Nebraska would adopt the title of certified nurse practitioner (CNP). Party states in the Compact would follow licensure-accreditation-credentialing-education specifications according to the Consensus Model.

Why is it so important for Nebraska to be a part of the nursing reciprocity compact. Is this good idea? Do we have any kind of information if opening the process to interstate transfers ends in a net gain for us or a net loss?

Applicant Group: Licensure reciprocity across state lines functions best when the practice environments are equally conducive to practice. Twenty-three (23) % of CNMs licensed in Nebraska do not practice here, compared to 14% of CNSs, 18% of CRNAs, and 14% of NPs.

We want to make it easier for advanced practice nurses to come to Nebraska, but the door swings both ways. It also makes it easier for advanced practice nurses to leave. Do we know what happens?

Applicant Group: There is no trackable data on which RN, LPN or APRN licensees are practicing in the state or who have left the state at any given time, based on the multi-state privilege. There is strong support for the Nurse Licensure Compact (NLC) post COVID-19, with only two states in the country who have never introduced NLC legislation, with 33 active states and one in partial implementation. However, there were still barriers that needed to be cleared by Executive Orders at state and federal levels, one being mobility of nurses (LPN, RN (noncompact states) and APRN (with no licensure compact) to practice across state lines. This attention to detail has not been lost on folks at the national level. Organizations such as the Cato Institute, a primarily conservative public policy think tank in Washington D.C., has recently called for third-party organizations to certify competency of health professionals due to the cumbersome nature of state-based licensing systems (Svorny and Cannon, 2020).

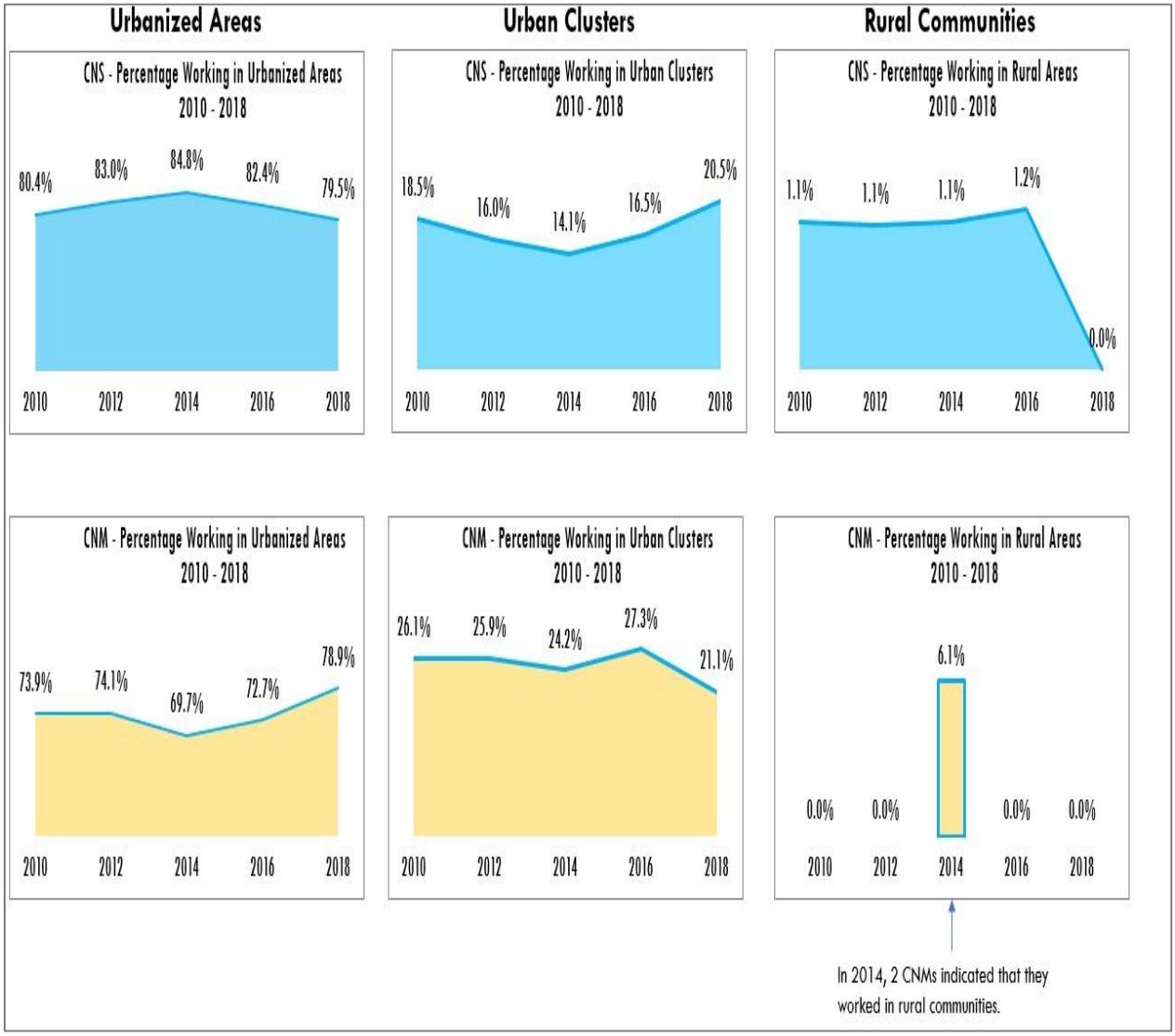
The NLC was one of the first health care licensure compacts in the U.S. over twenty years ago. Since that time, compacts have evolved for physical therapy, physicians, mental health providers, etc. However, not all compacts are created to allow mobility of practice across state lines, some are simply expedited licensure compacts. Telehealth services, in particular, present unique challenges since many licensees (at all levels) do not realize they need a license to practice in the state where the patient resides.

The Niskanen Center has provided an analysis of licensure compact inconsistencies across the country, which creates a great visual of states that promote licensure mobility vs. those who do not (Orr, 2020). The Department of Defense (DOD) supports licensure mobility across the nation, not just for military members, but military spouses. The DOD confirms decisions regarding the location of military bases and defense funding are based on the restrictiveness of state policies for reciprocal licensing (Professional Licensing Report, 2020). Compacts are a necessary fact of life, unless we,

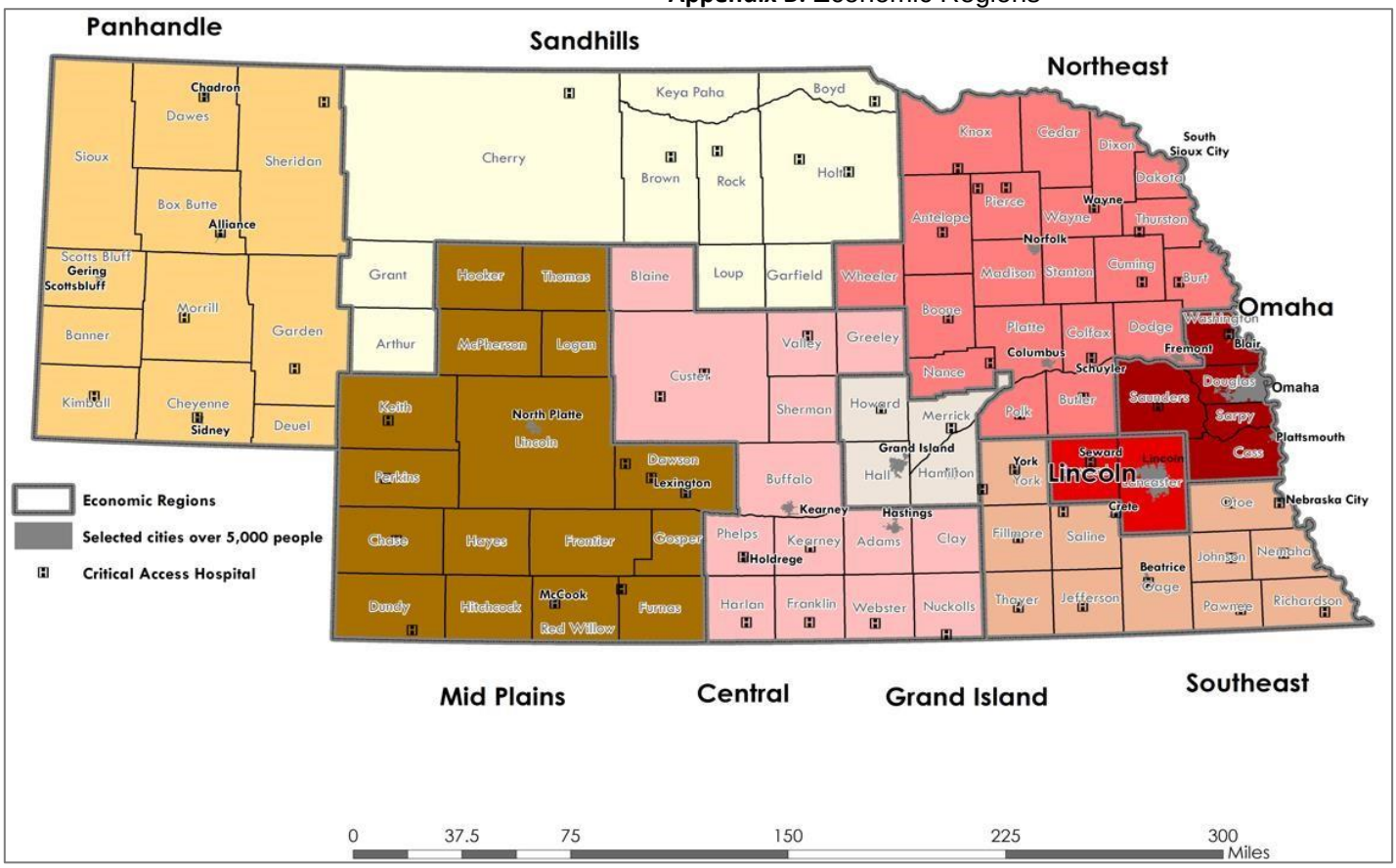
as a state, are prepared to allow others, such as the federal government or private industry, to dictate licensure requirements.

Appendix A

Percentage of CNSs and CNMs Working in Urbanized Areas, Urban Clusters, and Rural Areas in Nebraska: 2010-2018

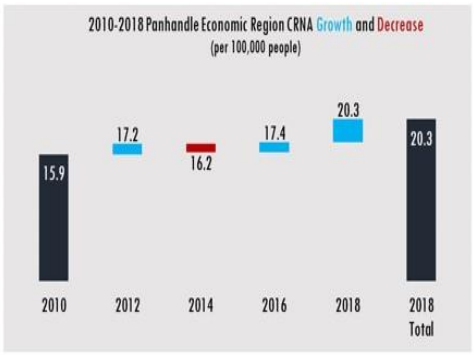


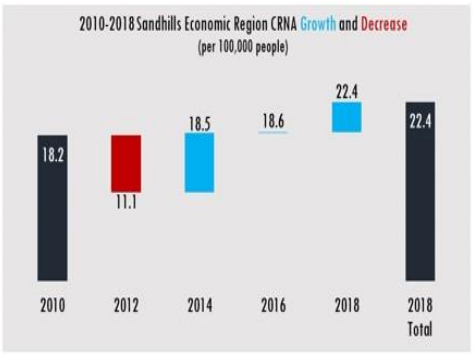
Appendix B: Economic Regions

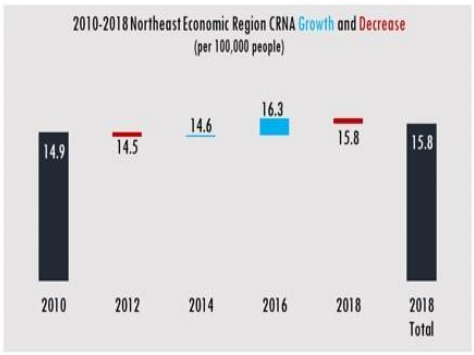


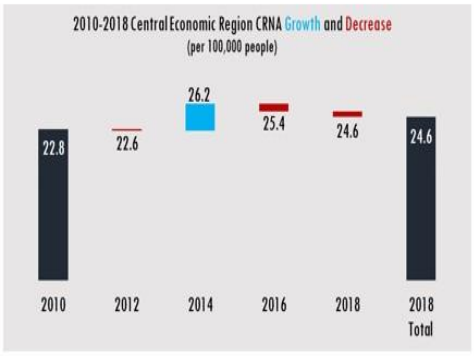
Appendix C

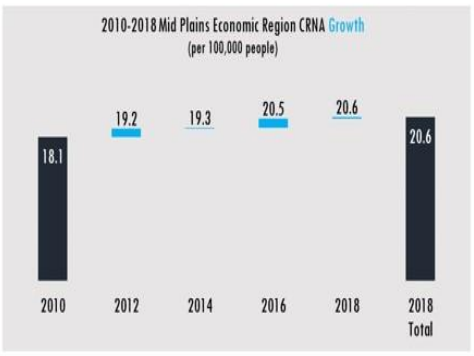
CRNA Growth and Decrease per 100,000 people by Economic Region: 2010 - 2018

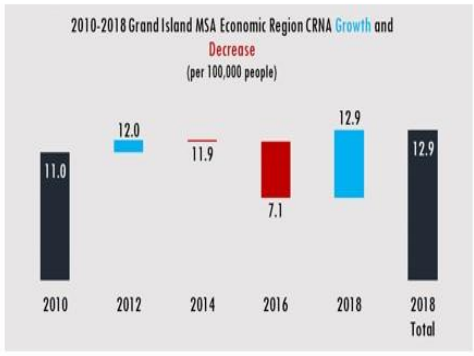


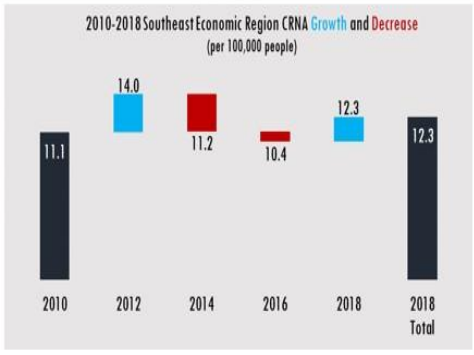


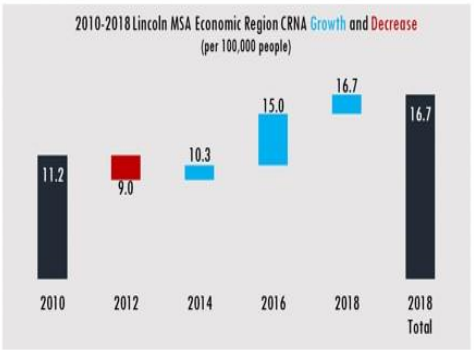


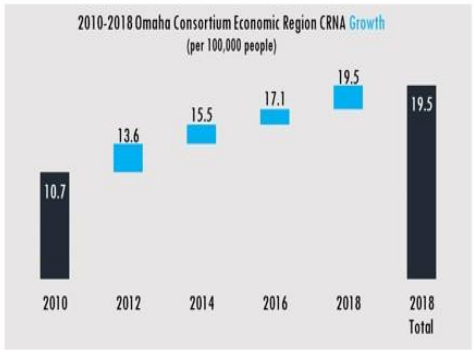








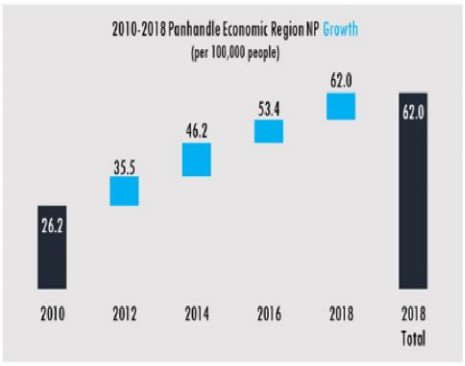


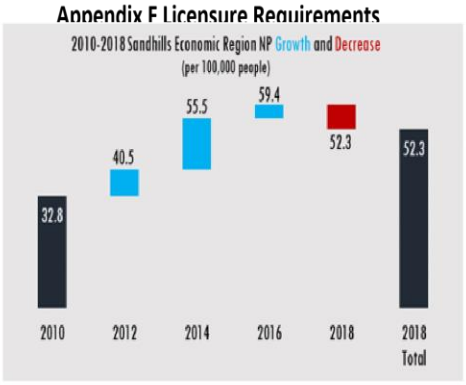


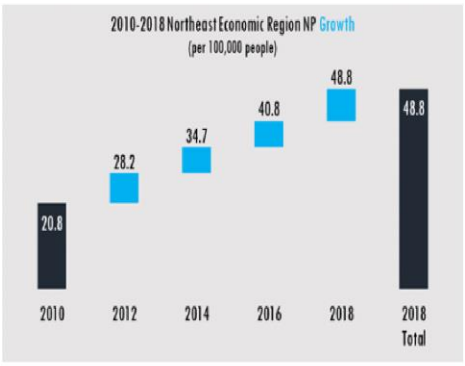
Prescriber Prescription	MD / DO	OD	DDS / DMD	DPM	PA	APRNNP	APRNCRNA	APRNCNM	DVM – treatment of animals only	RP	RDH
Controlled Substances – DEA Registration is required to prescribe	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NO	NO
Non-Controlled Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes – naloxone only	Yes – mouth washes and fluoride only
Contraception	Yes	NO	NO	NO	Yes	Yes	NO	Yes	Yes	NO	NO
Nicotine Cessation	Yes	NO	Yes	NO	Yes	Yes	NO	Yes	Yes	NO	NO
Anti-anxiety	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NO	NO
Weight Loss	Yes	NO	NO	NO	Yes	Yes	NO	Yes – not C-II	Yes	NO	NO
Controlled Substances for Personal Use (38-179)	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
Controlled Substances for family (spouse, child, parent, sibling) or household members in an emergency - within scope of practice only	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes – pets, livestock and service animals only	NO	NO

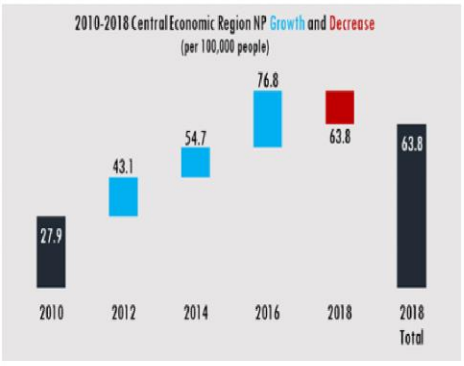
Appendix D

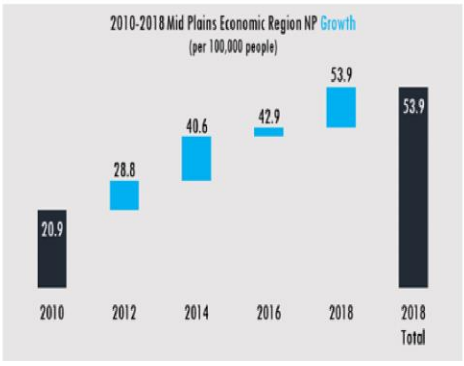
NP Growth and Decrease per 100,000 people by Economic Region: 2010-2018

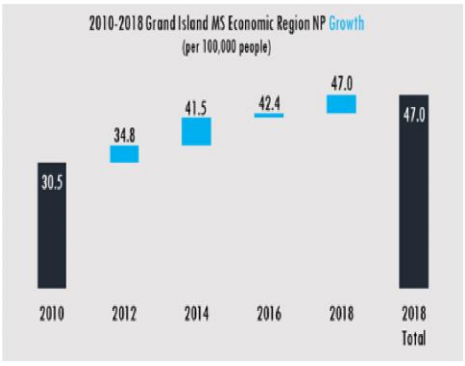


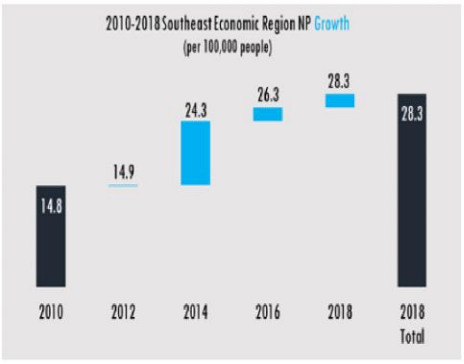


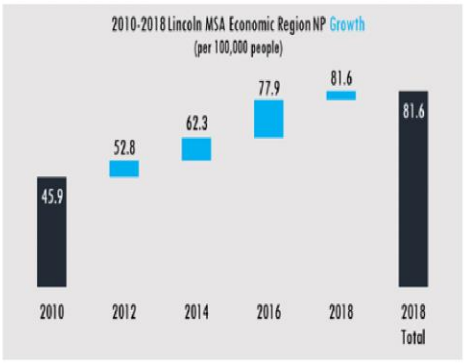


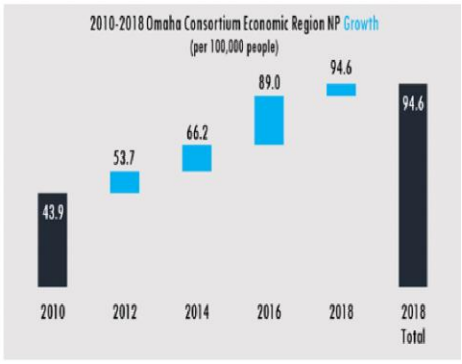












Appendix E Prescribing Authority Defined in Nebraska Statute

MD – Medical Doctor: No profession specific restrictions other than those listed in chart
DO – Doctor of Osteopathic Medicine: No profession specific restrictions other than those listed in chart
OD – Doctor of Optometry: Limited to prescribing for conditions of the eye. May only prescribe topical C-II. May prescribe epinephrine auto-injectors. May not treat infantile/congenital glaucoma. (38-2604 and 38-2605)
http://nebraskalegislature.gov/laws/statutes.php?statute=38-2604 http://law.justia.com/codes/nebraska/2013/chapter-38/statute-38-2605
DDS – Doctor of Dental Surgery / DMD – Doctor of Medical Dentistry: Limited to prescribing for human teeth, jaws, or adjacent structures, including lips. May only treat anxiety for dental visits.
DPM – Doctor of Podiatric Medicine: Limited to prescribing for the human foot, ankle, and related governing structures; expressly prohibited from treating general medical conditions causing manifestations in the foot. (38-3005)
http://dhhs.ne.gov/publichealth/Documents/Podiatry.pdf **PA – Physician Assistant:** May prescribe drugs and devices as delegated to do so by a supervising physician. (38-2055)
http://www.nebraskalegislature.gov/laws/statutes.php?statute=38-2055
NP – Nurse practitioner: No profession specific restrictions other than those listed in chart
CRNA – Certified Registered Nurse Anesthetist: Limited to those drugs necessary for preanesthesia, anesthesia and proper post-anesthesia management. (38-711) http://nebraskalegislature.gov/laws/statutes.php?statute=38-711
CNM – Certified Nurse Midwife: Must have delegated prescribing from an MD or DO. Prescribing of C-II limited to 72 hours and for pain control. (Title 172 Nebraska
Administrative Code Chapter 104; 104-005.01(6)(e). http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-104.pdf
DVM – Doctor of Veterinary Medicine: May only treat animals. (38-3312)
http://www.nebraskalegislature.gov/laws/statutes.php?statute=38-3312
RP – Registered Pharmacist: May prescribe naloxone. May dispense drugs, including controlled substances, as a part of collaborative practice, but this is not prescribing.
RDH – Registered Dental Hygienist: restricted to RDH who are trained and tested to prescribe; may prescribe mouth rinses and fluoride for decreasing risk for tooth decay. (381130) http://www.nebraskalegislature.gov/laws/statutes.php?statute=38-1130

*****This chart is intended to be a guide. Professional judgement must be used on a case-by-case basis in unusual situations**

Appendix F Licensure Requirements

NP=Nurse Practitioner; CNS=Clinical Nurse Specialist; CNM= Certified Nurse Midwife; CRNA Certified Registered Nurse
Anesthetist
S= Statute R=Regulations

	NP S=Statute	NP R=Reg	CNS Statute	CNS Reg	CNM Statute	CNM Reg	CRNA S	CRNA R
RN LICENSURE	x	x	x	x	x	x	x	x
EDUCATION								
Nationally accredited graduate level program	x	x						
Completion MSN, DNP or Graduate-level CNS program			x	x				
Completion approved nurse midwifery program					x	x		
Completion of approved course of study in anesthesia							x	x
COMPLETION CERTIFYING EXAMINATION by an approved certifying body	x	x		x		x		x
Initial an Ongoing CERTIFICATION with practice and continuing education requirements for competency		x	x	x	x		x	
If certification not available, must meet an alternative method of competency assessment			x	x				

PRACTICE	**NP S=Statute**	**NP R=Reg**	**CNS S**	CNS R	**CNM S**	CNM R	**CRNA S**	CRNA R
If previously authorized in another state must have 2080hrs of practice with the preceding 5 yrs		x						
If licensed in another state, 2080 hrs of practice in a specific advanced practice role in the previous 5 yrs				x				

If seeking certification [sic] must have practiced as a nurse midwife in preceding 5 yrs						x		
If seeking to renew or reinstate, a letter of reference from a licensed practitioner or CNM based on observation of at least 850hrs of practice within the previous 2 yrs, or at least 2080 hrs within the previous 5 yrs						x		

Additional applicant group responses to committee questions from the first TRC meeting are as follows:

Linda Stones, MS, BSN, RN, CRRN briefly summarized the key components of the proposal, beginning with a brief overview of the four professional groups that comprise advanced practice nurses, specifically, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives. Ms. Stones went on to state that these four professional groups represent about five percent of all advanced practice nurses in Nebraska. She continued by stating that these four groups currently practice under undue restrictions that the other ninety-five percent of advanced practice nursing no longer has to practice under since the passage of nurse practitioner legislation several years ago. Currently, these four professional groups are regulated under separate and distinct statutory provisions as well as distinct rules and regulations which is often the source of confusion for their employers, other health care professionals, as well as the members of the respective professions themselves.

Linda Stones went on to state that the APRN proposal seeks to establish standardization of education and training and regulation for all four of these professional groups by incorporating them under the current APRN licensure category. This course of action would have the following beneficial impacts: 1) improved "portability" of credentials, 2) improved access to advanced nursing care, 3) provide prescriptive authority for all advanced practice nurses, 4) bring an end to all practice agreements, 5) provide standardization of education and training, 6) bring an end to the requirement for a two-year transition to practice for new graduates of advanced practice nursing education and training programs, and 7) provide a common, uniform rules and regulations process for all advanced practice nurses.

Committee member Dering-Anderson asked the applicants if it is the intent of the applicant group that all advanced practice nurses be allowed to have the same prescriptive authority. Linda Stones replied in the affirmative, adding that this represents recognition that all advanced practice nurses possess the same level of education and training. Dr. Dering-Anderson replied that she remains uncertain and confused by this component of the proposal because it is not clear exactly who can prescribe what under the terms of this proposal. Linda Stones responded that the Board of Nursing will clarify this aspect of the proposal as the review process unfolds, adding that the goal of the proposal is to simplify and clarify who can prescribe what medications and why.

At this juncture Committee chairperson Jeromy Warner asked the applicants to provide data from other states—similar to Nebraska—that have approved proposals similar to the one being proposed here in Nebraska pertinent to how well these proposals are working in these states. Linda Stones responded that she would provide additional data from other states such as Wyoming, for example, which has approved a proposal similar to the one currently under review in Nebraska. Chairperson Warner repeated that he wants to see data from states that are similar to Nebraska in this regard.

Committee member Dering-Anderson asked how committee members can objectively know the difference between something that is a "barrier" to legitimate practice as opposed to something that is a disallowed because it is a risk to "patient safety." Dr. Dering-Anderson then asked the applicants to find data that can be used by the committee members to answer such a question. Linda Stones responded that the proposal includes some data on infant and maternal mortality rates that might be helpful in this regard, and that the applicants' response document also includes some data on CNM patient care that might be helpful in this regard.

Committee member Wendy McCarty questioned the implicit assumption being made by the applicant group representatives that the answer to current infant and maternal mortality rates is to increase access to advanced practice nursing care, and then asked the applicants "can we assume this?" Not waiting for a response, committee member McCarty challenged the applicants to "show us the data that demonstrates this." Linda Stones replied by stating that on page 28 of the proposal there is data on outcomes that might be helpful in this regard. Then, she asked Heather Swanson, a CNM, to respond to Dr. McCarty's question. Heather Swanson stated that in New Mexico infant and maternal mortality have declined since CNMs have been allowed to provide birthing care, but that much of the available data on these issues is agglomerated at a national level rather than state-by-state.

Amy Reynoldson, speaking on behalf of the Nebraska Medical Association, asked the applicants to clarify if the goal of their proposal was to create a common licensure for all four APRN professional specialties. Linda Stone responded in the affirmative. Amy Reynoldson then commented that recent changes in the rules and regulations for advanced practice nurses have already accomplished this objective. Linda Stones responded that this assertion is not correct because the rules and regulations to which Amy Reynoldson is referring did not and could not address the discrepancies in prescriptive authority between the four advanced practice nursing professional groups. Only a statutory change could do that. Amy Reynoldson responded by stating that NMA will respond regarding the issue of prescriptive authority in advanced nursing practice in advance of the next meeting of the committee. Linda Stone replied that her group would provide more data to answer committee questions in advance of the next meeting.

Committee member Su Eells asked the applicants to clarify how the 2000-hour clinical education and training requirement works, specifically, is it a "one-time-fits-all requirement," or, is it something that must be repeated if a given advanced practice nurse seeks to make changes in employment and / or the services they provide? Linda Stones asked Tara Whitmore, a member of her group, to answer this question. Tara Whitmore replied that once a given advanced practice nurse has completed their 2000 hours there is no need to repeat this just because the nurse in question has decided to make changes in their employment or in the services they

provide. At this juncture Dr. McCarty expressed concerns about this because it seemed to her that this means that this might allow a given advanced practice nurse to provide services they are not qualified to provide. Tara Whitmore then clarified that her comment had been misunderstood. Any advanced practice nurse seeking to make changes in their employment or services for which their current education and training is inadequate must attain whatever additional education and training is necessary to make up for the shortfall. However, this additional education and training has nothing to do with the 2000-hour clinical requirement. This additional education and training would occur outside of this particular requirement.

Dr. Jodi Hedrick, MD, OBGYN, speaking on behalf of the NMA, stated that the applicants' proposal would not result in safe and effective patient care and should be rejected by the committee. She added that the education and training of each of the four professional groups lacks a sufficient degree of commonality with one another for the proposal to work for the benefit of the public.

Dr. Schrodt, also speaking on behalf of the NMA, expressed the desire to see a legislative version of the proposal and challenged the applicant group to create such a document for review. Only this way, he argued, can we see what the proposal would actually do if passed.

Several committee members commented that they would like to see a chart or a graph that would clarify the similarities and differences between the four advanced practice nursing groups under discussion in the applicants' proposal with the following question in mind: What do they all have in common vis-à-vis education, supervision, CEUs, safety, and clinical practice training and experience? Is there sufficient similarity among the four nursing groups under review to enable them to be merged into a single credentialing category?

Applicant group responses to technical committee questions raised during their second meeting including tables illustrating nursing education and training

Adult Gerontology Clinical Nurse Specialist Plan of Study

Year 2	NRS 822	Maternal & Children Nursing Theory	3	NRS 812	Adult Nursing Theory II	3	NRS 832	Population Health	3
	NRS 808	CNS Practicum I	3	NRS 818	CNS Practicum II	3	NRS 750	Health Care Finance	3
	SSC 734	Epidemiology	3	NRS 754	Health Care Policy	3	NRS 880	Capstone I	1
Year 3	NRS 758	Health Systems, Informatics & Leadership	3	NRS 838	CNS Practicum IV	3	NRS 840	Residency	3
	NRS 828	CNS Practicum III	3	NRS 886	Capstone III	3		Elective	3
	NRS 882	Capstone II	3		Elective	3	NRS 890	Capstone IV	1

Total Credits: 75

AGCNS Practicum hours 1080

	FALL TERM			SPRING TERM			SUMMER TERM		
	Course Number	**Title**	**Credits**	**Course Number**	**Title**	**Credits**	**Course Number**	**Title**	**Credits**
Year 1	NRS 700	Program Orientation	0	NRS 712	Advanced Health Assessment	3	NRS 706	Summer Intensive	1
	NRS 716	Advanced Pathophysiology	4	SSC 730	Biostatistics	3	NRS 802	Adult Nursing Theory I	3

	NRS 746	Role Development of APRN	2
	NRS 720	Advanced Pharmacology	3

NRS 738	Theory Foundation	3

NRS 742	Research	3

SCHOOL OF NURSING
UNIVERSITY OF MINNESOTA
Driven to Discover℠

Doctor of Nursing Practice: Nurse-Midwifery Specialty: Three Year Plan

Program plan for students admitted fall semester 2020 or later

Consult with your advisor every semester before registering for courses

Year 1 Fall	CR	Spring	CR	Summer	CR
Nurs 5222 Advanced Human Physiology+	2	Nurs 5226 Advanced Human Pathophysiology	2	Nurs 7300 Program Evaluation	3
Nurs 5228 Pharmacology for APN+	2	Nurs 5229 Clinical Pharmacotherapeutics+	3	Nurs 5200 Holistic Health Assessment and Therapeutics for APNs+	3
Nurs 7000 DNP Proseminar	1	Nurs 6110 Epidemiology in Nursing	2	Nurs 7200 Economics of Health Care	3
Nurs 7202 Moral and Ethical Positions and Actions in Nursing	2	Nurs 7600 Nursing Research and Evidence Based Practice	4	CSpH 5101 Introduction to Integrative Healing Practices	3
Statistics**	3				
Total	10	Total	11	Total	12
Year 2 Fall	**CR**	**Spring**	**CR**	**Summer**	**CR**
Nurs 6305 Women's Reproductive Healthcare	3	Nurs 6308 Women's Primary Care Practicum	2	Nurs 6210 Midwifery Care of the Childbearing Family	3
Nurs 6306 Women's Reproductive Healthcare Practicum	1	Nurs 6925 Advanced Concepts in Women's Health	3	Nurs 6211 Midwifery Care of the Childbearing Family Practicum	2
Nurs 6501 Assessment and Management of Health for Advanced Practice Nurses I	3	Nurs 7610 System Leadership and Innovation	3	Nurs 7400 Health Policy Leadership	3
Nurs 6200 Science of Nursing Intervention	3	Nurs 7100 Quality Improvement and Implementation Science in Health Care	3	Nurs 7110 DNP Project Direction*	1
Nurs 5505 Assessment/Support of Women in Labor++	2	Nurs 7110 DNP Project Direction*	1		
Total	12	Total	12	Total	9
Year 3 Fall	**CR**	**Spring**	**CR**	**Summary**	
Nurs 6213 Reproductive Healthcare for Women at Risk	2	Nurs 7213 Midwifery Clinical and Professional Integration	3	Total Credits: 82 **Practicum Hours** Nurs 6306 - 1 cr: 120 hrs Nurs 6308 - 2 cr: 240 hrs Nurs 6211 - 2 cr: 240 hrs Nurs 6214 - 2 cr: 240 hrs Nurs 7213 - 3 cr: 360 hrs	
Nurs 6214 Reproductive Healthcare for Women at Risk Practicum	2	Nurs 7900 Scholarly Teaching and Learning in Nursing	3		
Nurs 7102 Scholarly Dissemination and Advanced Professional Engagement	2	Nurs 5115 Interprofessional Healthcare Informatics	3		
Nurs 7110 DNP Project Direction*	1				

Total	7	Total	9	(Nurs 5505 - 120 hours as needed) Total practicum hours: 1200 hrs + 160 hrs scholarly project

*Students are required to take a minimum of three (3) credits for Nurs 7110. The semesters in which the credits are taken, and the number of credits taken, are determined in consultation with the student's DNP Project Advisor.

**Recommended graduate inferential statistics courses: EPsy 5261, PubH 6414. Other options include: EPsy 5231, Stat 5101 & 5102, and Stat 5021 (prereq Stat 3011). +Required before registering for specialty/practicum courses.

++Required of students without labor and delivery experience as a Registered Nurse

For more information visit www.nursing.umn.edu

Rev.1.2020-fb

Family Nurse Practitioner Plan of Study

	FALL TERM			SPRING TERM			SUMMER TERM		
	Course Number	Title	Credits	Course Number	Title	Credits	Course Number	Title	Credits
Year 1	NRS 700	Program Orientation	0	NRS 712	Advanced Health Assessment	3	NRS 706	Summer Intensive	1
	NRS 716	Advanced Pathophysiology	4	SSC 730	Biostatistics	3	NRS 802	Adult Nursing Theory I	3
	NRS 746	Role Development of APRN	2	NRS 738	Theory Foundation	3	NRS 742	Research	3
	NRS 720	Advanced Pharmacology	3						
Year 2	NRS 822	Maternal & Children Nursing Theory	3	NRS 812	Adult Nursing Theory II	3	NRS 832	Population Health	3

	NRS 806	Practicum I	3	NRS 816	Practicum II	3	NRS 750	Health Care Finance	3
	SSC 734	Epidemiology	3	NRS 754	Health Care Policy	3	NRS 880	Capstone I	1

Year 3	NRS 758	Health Systems, Informatics & Leadership	3	NRS 836	Practicum IV	3	NRS 840	Residency	3
	NRS 826	Practicum III	3	NRS 886	Capstone III	3		Elective	3
	NRS 882	Capstone II	3		Elective	3	NRS 890	Capstone IV	1

Total

Credits 75

Total

Practicum hours 1080

sample

DNP Nurse Anesthesia Focus Course Plan				
Program/Focus	BSN DNP SRNA			
Advisor:	O'Sullivan		Program Length	3 yr
Course #	Course Title	Course	Semester	Practice
	SUMMER	Hrs	Hrs	Experience
MPB:5200	Medical Physiology Online	5		
NURS:5040	Genetics/Genomics for Advanced Nursing Practice	2		
NURS:6000	Human Anatomy for Advanced Practice	3	10	
	FALL			
PCOL:6204	Pharmacology for Health Sciences	5		
NURS:5009	Evaluating Evidence for Practice	3		
NURS:5023	Pathophysiology for Advanced Clinical Practice	4		
NURS:6809	Advanced Practice Role I: Introduction	3	15	
	SPRING			

NURS:5010	Clinical Data Management and Evaluation	3		
NURS:5017	Quality and Safety	3		
NURS:5031	Health Promotion and Assessment for Advanced Clinical Practice	3		
NURS:6004	Scientific Principles of Anesthesia Practice	4		
NURS:6006	Pharmacology of Anesthesia Practice	3	16	
	SUMMER			
NURS:6007	Basic Principles of Anesthesia Practice	5		
NURS:6050	Introductory Clinical Anesthesia	2	7	400
	FALL			
NURS:6010	Advanced Principles of Anesthesia Practice I	4		
NURS:6051	Clinical Anesthesia I	2		500
NURS:6826	Doctor of Nursing Practice Project I	2	8	148
	SPRING			
NURS:5002	Leadership and Management Essentials	3		
NURS:6012	Advanced Principles of Anesthesia Practice II	1		
NURS:6052	Clinical Anesthesia II	2		500
NURS:6827	Doctor of Nursing Practice Project II	1	7	74
	SUMMER	Hrs		
NURS:6055	Rural Anesthesia	2		500
NURS:5015	Health Systems, Finance, and Economics	3	5	
	FALL			
NURS:6054	Obstetrical Anesthesia	2		500
NURS:6802	Health Policy, Law, and Advocacy	3		
NURS:6828	Doctor of Nursing Practice Project III	1	6	74
	SPRING			

NURS:6053	Advanced Clinical Anesthesia	2		500
NURS:6810	Advanced Practice Role II: Integration	3		
NURS:6829	Doctor of Nursing Practice Project IV	1	6	74
	TOTAL HOURS		80	3270

Advanced Practice Registered Nurse (APRN) Credentialing Review

Clinical Nurse Specialist (CNS)—Certified Nurse Midwife—(CNM) Nurse Practitioner (NP)
Certified Registered Nurse Anesthetist (CRNA)

Executive Summary -- October 8, 2020

Full Practice Authority for CNSs and CNMs

The proposal – create a single statute for regulation of all four advanced practice registered nurse (APRN) roles, removing regulatory barriers to practice for 4% of Nebraska's APRNs. Under the proposal Clinical Nurse Specialists (CNSs) and Certified Nurse Midwives (CNMs) would join Certified Registered Nurse Anesthetists (CRNAs) and nurse practitioners (NPs) with full practice authority in this state. Full practice authority means that CNSs and CNMs will not have a mandatory practice agreement requirement and will be able to prescribe medications and treatments under the authority of their license. The proposal also calls for removal of the transition to practice (TTP) requirement for new graduate NPs.

Consensus Model

The model for state implementation is the 2008 Consensus Model for APRNs. Historically, state sovereignty has dictated that each state has its own approach and incremental legislation for licensure of APRNs. After more than 40 years, all four groups came together and created the Consensus Model, which standardizes APRN accreditation, education, certification and licensure. Twenty-four (24) states have full practice authority for all four APRN groups. There is no one model for change. Workforce and patient outcomes are as varied as the states themselves. No state has ever reversed full practice authority for APRNs.

Standardized Accreditation, Education and Certification for all Four Roles

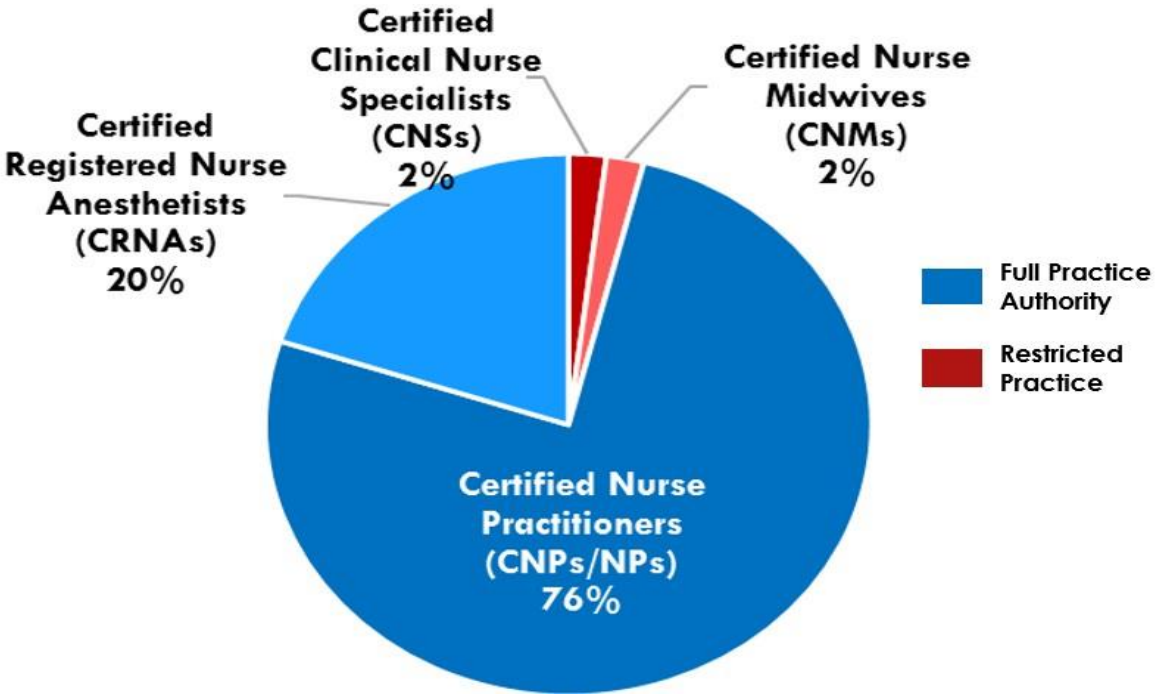
The reason that one statute can work is consistency – consistency in standards set nationally in evidence-based standards for advanced practice nursing education. All APRN roles are prepared for full practice authority through ***accredited nursing education core courses*** (advanced pathophysiology, pharmacology, and physical assessment) created by the Consensus Model, as well as role and population-specific clinical hours and coursework. ***Certification*** by an accredited certifying body upon completion of education, based upon competency for the specific role is required for initial and ongoing licensure. ***Licensure*** authorizes APRN practice.

Evidence

Full practice authority follows a substantial body of outcome evidence including chronic disease management for CNSs, as well as lower intervention rates and improved birth outcomes for CNMs. There is also evidence that Nebraskans will benefit from access to health care services provided by these two APRN groups. The prevalence of chronic disease will follow our aging population. The closure of obstetric practices and hospital delivery services in rural Nebraska in recent years coincides with an upward trend in infant mortality. Discipline data from Nebraska supports that APRNs are safe health care practitioners, with discipline cases actually decreasing after the removal of the practice agreement requirement for NPs in August of 2015.

Advanced Practice Registered Nurse (APRN) Credentialing Review October 8, 2020

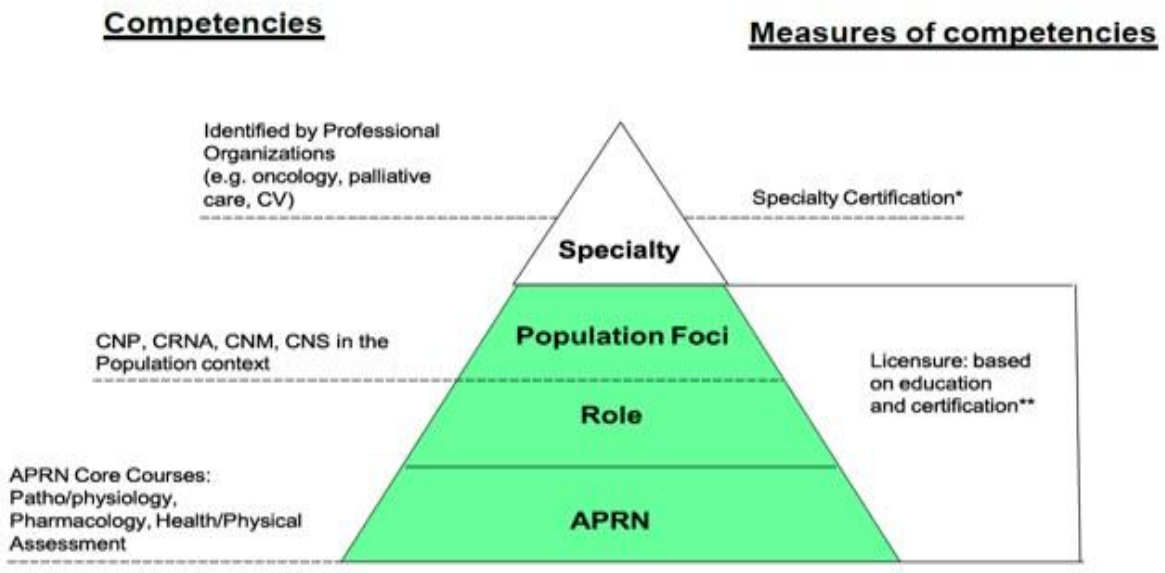
The ask: full-practice authority for 4% of the Nebraska APRNs.



	CNM	CRNA	CNS	NP
National certification	Yes	Yes	Yes	Yes
Accredited APRN Ed	Yes	Yes	Yes	Yes
Full practice authority	No	Yes	^No	Yes
Practice agreement	Yes	No	No	No
Prescriptive authority	*Yes	Yes	^No	Yes
Transition to Practice (TTP)	No	No	No	Yes

* Limited by practice agreement
^ Statute currently silent

Full practice authority for all is now possible through the 2008 Consensus Model for APRN accredited education, certification, and licensure. All APRNs are created equal at the core level. **This 407 application is to convert the "red" items on this chart to be consistent for all 4 groups.**



Accreditation, Education, Certification & Licensure	**Certified Clinical Nurse Specialist**	**Certified Nurse Practitioner**	**Certified Nurse Midwife**	**Certified Registered Nurse Anesthetist**
Completion of an **Accredited** Education Program Minimum of a Master's Degree	√	√	√	√
Education Core Content Graduate-level Advanced Pathophysiology Advanced Pharmacology Advanced Physical Assessment	√	√	√	√
National **Certification** from an **Accredited** Agency Certification is the formal recognition of the knowledge, skills and experience demonstrated by the achievement of standards identified by the profession.	√	√	√	√

Opponent concerns about the proposal:

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

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

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

Nebraska law is ambiguous on whether different health professions are able to bring an application forward together as one. An "applicant group" is defined as any health professional group which proposes to change the scope of practice of a regulated *health profession*.[1] A "health profession" is defined as a vocation involving health services…requiring specialized knowledge and training.[1] Arguably, because each APRN professional requires separate certification by a separate body, each APRN license is a separate vocation that requires specialized knowledge and training. For example, a clinical nurse specialist could not obtain a license as a certified nurse midwife, unless that clinical nurse specialist possessed the specialized knowledge and training to meet the requirements of certification for nurse midwives.

[1] Neb. Rev . Stat. 71-6204

The following information is meant to add perspective to the claims set forth in the Board of Nursing's proposal and to better inform you of additional considerations that have been glossed over by the application. The NMA maintains it is clear the primary object of this proposal is to align with recommendations set forth by the National Council of State Boards of Nursing (NCSBN), a national organization that seeks to expand advanced nursing practice beyond and outside the traditional role and norm of team-based care. In fact, on page 35 of the proposal, the applicant group even provides you with NCSBN's broad opinion on when scope of practice laws should be expanded. However, NCSBN carries no weight of authority in Nebraska and desire to align with a national organization's objectives is not one of the criteria Nebraska law demands for successful credentialing review proposals.[2]

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

I. Patient Safety

The World Health Organization defines patient safety as the absence of preventable harm to a patient during the process of health care, and the reduction of risk of unnecessary harm associated with health care to a minimum.[3] At the core of patient safety, is whether a health professional has the education and training necessary to perform the tasks and provide the care necessary to achieve the absence of preventable harm. There is no dispute that APRNs have undergone nursing training at both the bachelors and graduate level, however the key question of this proposal is whether that nursing training is sufficient to guarantee patient safety during independent practice. Especially when nursing training, particularly at the bachelors level where the bulk of the education takes place (4 years vs 18-24 months) is focused on the team-based approach to health care.

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

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

Similarly, the Legislature had concerns about nurse practitioner education and training and practicing independently immediately upon graduation, resulting in the 2,000 hour transition-topractice (TTP) requirement with a physician being set into law, which this application seeks to remove. The application incorrectly characterizes this requirement on page 18 as a "legislative

[2] Neb. Rev. Stat. 71-6221(3)

[3] Patient Safety, World Health Organization. https://www.who.int/patientsafety/en/. Accessed on September 10, 2020.

concession". This is misleading, as it is clear this was a decision by policymakers to implement this requirement for the protection of their constituents.

Additionally, clinical nurse specialists have only been a recognized profession in this state for 15 years, at which point the Legislature decided it was not prudent to include prescriptive authority, and arguably was silent on the ability to treat and diagnose patients given the administrative role these professionals play.[4] Nothing in this application describes what has changed for these professions to merit alteration of the scope of practice policy recently set by the Legislature.

The application makes the presumption that the education and training of APRNs is sufficient as it only lists a broad outline of objectives APRNs focus on at the graduate level. The description of the education and training on page 19 of the application uses terms such as, "be comprehensive", "prepares the graduate", and "ensures coursework is comprehensive". It never explains how or why this education is enough to justify the scope of practice changes sought, as required by Nebraska law[6]; rather, the applicant group forces the Committee to assume it is adequate. In fact, the proposal only specifically mentions *three* courses that APRNs take, which are presumed and cited by the applicant group to be enough to warrant practicing and prescribing drugs independently. It is hard to believe that three courses are enough to gain the knowledge and training necessary to seek removal of physician oversight, especially when those courses are roughly equivalent to one semester's worth of a true four-year medical education.

This is concerning, especially when considering that a recent survey focused on online education found that graduate level nursing was the second most popular program for online graduate students, right behind business administration.[5] The difference being that business administration teaches concepts fully adaptable to online learning; whereas, online graduate nursing programs might be able to teach basic courses but any hands-on experience with patients in a clinical setting is surely lacking in adequacy, if even present at all.

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

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

When the NMA brought up these figures at the most recent meeting of the Committee, some Committee members gave feedback that it was unfair to compare the training of APRNs to physicians, because the applicant group is not claiming to have the requisite knowledge and

[4] See, Neb. Rev. Stat. 38-906, which does not include the terms "diagnose" and "treatment" [6] Neb. Rev. Stat. 71-6221(3)(d)

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

experience gained through medical school. Yet this is exactly the problem, because what this application attempts to do by removing all collaborative agreement requirements and restrictions on prescribing drugs results in all APRNs essentially engaging in the practice of medicine. There would be no oversight for nurse midwives attempting to deliver newborn babies, there would be no oversight for clinical nurse specialists prescribing controlled substances, there would be no oversight of nurse practitioners diagnosing complex health issues.

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

Furthermore, the applicant group again confuses this issue by pointing out that "collaboration" and "consultation" are defined in both the certified nurse midwifery practice act and the nurse practitioner practice act. However, this is a misstatement about how statutes and the law function and given the context of what is included in these sections, is grossly misleading to the Committee. The sections cited in the application for nurse practitioners are merely definitional in purpose[6] and have no legal function unless used elsewhere in the practice act. One section of law that does mention these terms for nurse practitioners, the requirement of a transition-to-practice agreement, is the very section this application seeks to do away with.[7]

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

When presented with the opportunity on page 29 of the application to recognize any potential harms to the public that might result from their scope expansion proposal, the applicant group only put forth complaint data submitted to the Board of Nursing, and missed the chance to be self-reflective and recognize any potential shortcomings of their proposal. For certified nurse midwives, the proposal broadly suggests that removing practice restrictions will not harm mothers and infants, citing an organization that does economic research, not one that does health care centered research. The proposal then implies that because there have been no disciplinary actions against certified nurse midwives, this means that there is not potential harm to the public. This angle conveniently forgets

[6] See: Neb. Rev. Stat. 38-2308 & 38-2309

[7] Neb. Rev. Stat. 38-2314.01

that is highly likely there have been no complaints or disciplinary actions against certified nurse midwives because they currently practice under the supervision of a physician. This shows that collaborative agreements work to ensure patient safety, and directly contradicts the claim on page 11 of the application that "there is no evidence collaborative practice agreements or transition-to-practice agreements change practice outcomes".

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

II. Access Issues

For at least the last three decades, Nebraska, other rural states, and the federal government have been trying to solve the increasing issue of access to health care for the rural population. Lack of availability to primary and specialty care does play a part in this issue, but it is not the only piece of the equation. Compared to urban areas, rural populations have lower median household incomes, a higher percentage of children living in poverty, fewer adults with postsecondary education, and more uninsured residents, all of which can lead to negative health outcomes.[8]

The applicant group asserts on page 28 that full practice authority for all APRNs could help build the rural workforce necessary to meet primary care needs. Unfortunately, the data does not support this claim. At the national level, a recent study conducted by *Health Affairs* found that between 2006 and 2018, those states that require some relationship with a physician in order to practice saw the fastest growth of nurse practitioners in the workforce.[9]

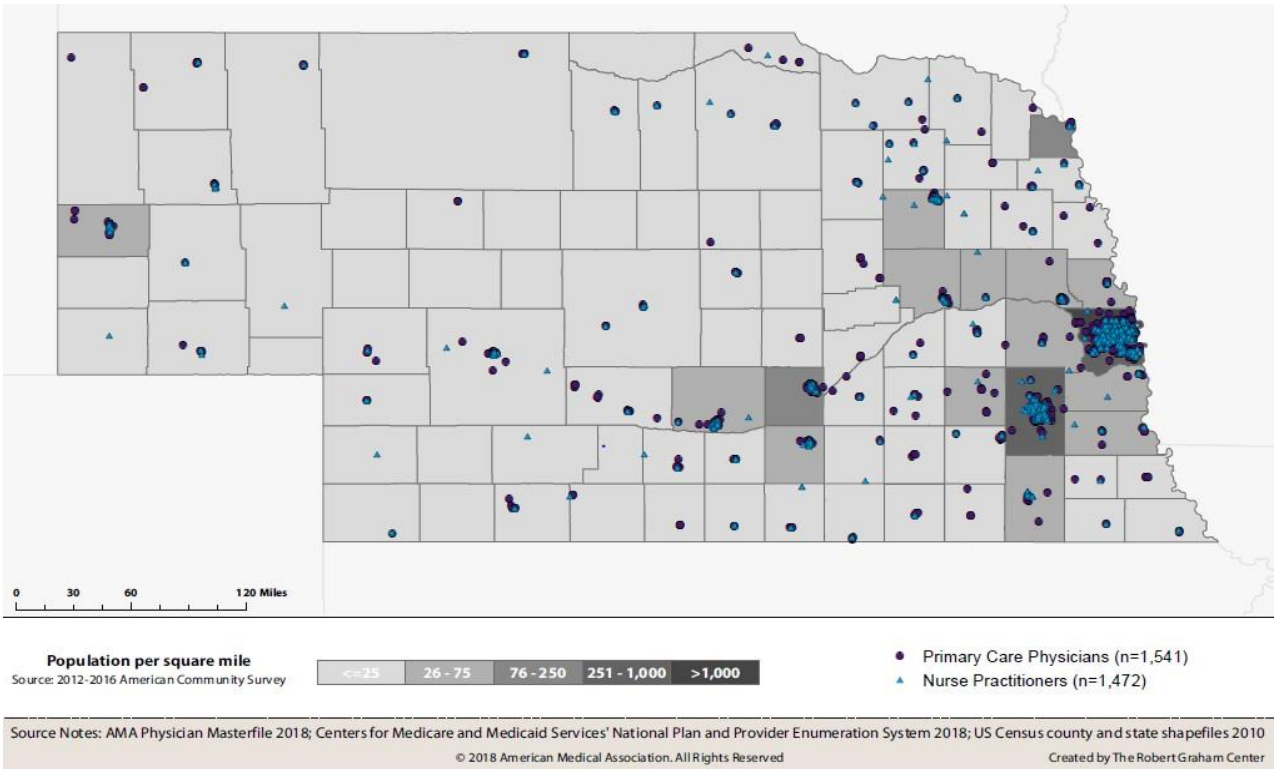
Additionally, a review conducted by the American Medical Association of the practice locations of primary care physicians and nurse practitioners across the country shows both physicians and nurse practitioners tend to practice in the same areas, regardless of the level of independence allowed by the state.[10] This observed trend remains true in Nebraska, which Figure 1 below illustrates using Centers for Medicare and Medicaid Services data from 2018, three years after nurse practitioner independent practice was permitted in Nebraska.

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

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

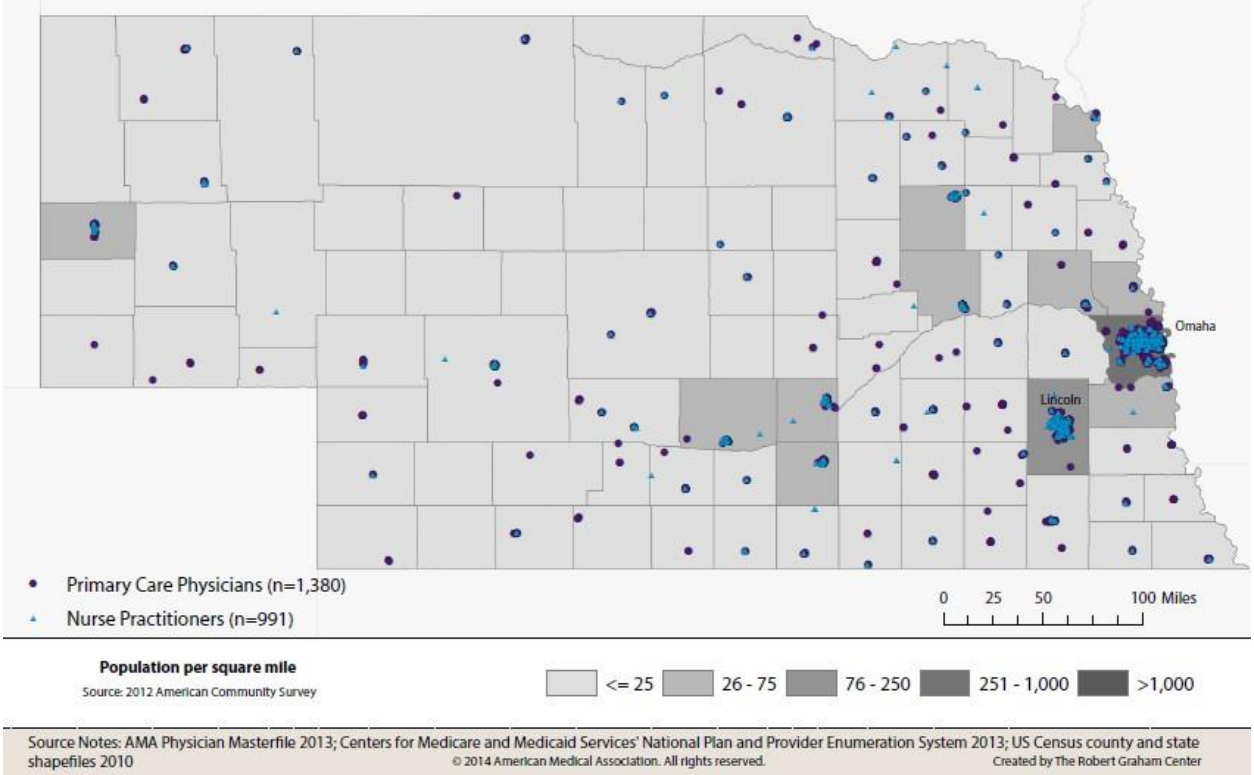
[10] AMA Geographic Mapping Initiative. 2018.

Figure 1.



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

Figure 2



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

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

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

III. Costs and Risks to the Nebraska Health Care System

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

A recent *JAMA Internal Medicine* study looked at diagnostic imaging, such as medical imaging, by APRNs compared to primary care physicians after office-based encounters. The study found that APRNs were associated with more ordered diagnostic imaging than primary care physicians; further, APRNs were associated with more imaging on both new and established patients, with results being more prominent with new patients.[11] The authors suggest that policymakers should look closer at efforts to expand access to care by substituting APRNs for physicians, without appropriate mechanisms in place for imaging which may further elevate health care costs and potentially increase patients to unnecessary radiation exposure.

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

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

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

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

Moreover, additional research suggests that APRNs are more likely to over-prescribe opioids than primary care physicians. Data from the Medicare population shows that 3.8% of physicians met at least one definition of over-prescribing, compared to 8% of APRNs. A closer look at the data revealed that 1.3% of physicians prescribed an opioid to at least half of their patients versus 6.3% of APRNs. Further, only 0.7% of physicians were "high frequency prescribers", compared to 7.5% of APRNs.[13] As the last several years have shown, over-prescribing of opioids can have a significant long-term cost to the health care system, and it is worth pointing out that the data above are in the population in which clinical nurse specialists are often specialized, gerontology.

Finally, a topic that can have significant impact on health care costs, and on the health care system as a whole, is malpractice and the subsequent liability of those actions. Potential malpractice claims are a reality for any health professional, no matter the skill set or experience level. However, studies have shown the likelihood for malpractice by advanced providers, such as APRNs, is increased when there is a lack of physician supervision and/or failure of the provider to consult with a physician.[14]

A study conducted by a medical malpractice liability insurer examined claims against APRNs from 2012 to 2017. For nurse practitioners, the top three patient allegations were diagnosis related, which the study defined as failure, delay, or incorrect (35%), improper management of treatment (16%), and improper medication management (11%).[15] After independent review of these claims, the top contributing factors of the patient injury included patient assessment issues (48%) and selection/management of therapy (23%).[16] Furthermore, patient injury severity of

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

[13] M. James Lozada, Mukalia Raji, James Goodwin, et al. Opioid Prescribing by Primary Care Providers: A CrossSectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns. Journal of General Internal Medicine. April 24, 2020.

[14] Advanced Practice Provider Liability: A Preventative Action and Loss Reduction Plan. The Doctors Company. 2018. Accessed at: https://www.thedoctors.com/siteassets/pdfs/marketing-order-form-items/advanced-practiceprovider-liability-book.pdf.

[15] Id, Pg. 10.

[16] Id, Pg. 12.

these claims was measured on the National Association Insurance Commissioners (NAIC) Injury Severity Scale, which is broken down into low, medium, and high categories. Of the claims examined for nurse practitioners, 51% were determined to be of high severity, and 40% were rated medium severity.[17]

For certified nurse midwives, the top three patient allegations were diagnosis related, which again the study defined as failure, delay, or incorrect (23%), improper performance of vaginal delivery (15%), and delay in treatment of fetal distress (15%).[18] Following independent review of those claims, the top contributing factors of the patient injury were technical performance by provider (35%), patient assessment issues (31%), selection and management of therapy (23%), and failure/delay in obtaining a referral to physician or specialist (23%).[21]

These numbers in particular should be concerning because they reflect a lack of education and training in certified nurse midwives to practice without physician oversight. In fact for all APRNs, the study contributes the bulk of the claims resulting from failure or improper diagnosis to lack of physician supervision, failure to consult with a physician, and inadequate experience of the APRN in diagnosing and managing particular conditions.[19] For claims that resulted from failure or delay in obtaining a referral to physician or specialist the study contributes those claims to APRNs that that independently manage a complication that is beyond their expertise, skill set, or scope of practice.[20] Finally, the study found that claims resulting from inadequate evaluation occurs when the APRN relies on previous medical history and other sources to determine the diagnosis, rather than performing and analyzing a comprehensive exam.[21]

Malpractice liability is a serious issue and concern, and unfortunately the Board of Nursing failed to mention it in their application, focusing rather on disciplinary complaints filed with the Board as showing that patient safety would not be compromised. This topic also shows why lack of statutory language in this proposal is disappointing. Currently, nurse practitioners in Nebraska are required to carry malpractice liability insurance;[22] yet, the proposal includes no such language for certified nurse midwives or clinical nurse specialists even though the potential risk will be considerably higher if this proposal is adopted.

IV. Regulatory Consensus Model and Multi-State Compact

The regulatory consensus model created by the National Council of State Boards of Nursing (NCSBN) in 2008 is the primary theme of the proposal submitted by the Board of Nursing. Multiple

[17] Id, Pg. 11.

[18] Id, Pg. 18. [21]

Id.

[19] Id, Pg. 19.

[20] Id.

[21] Id.

[22] Neb. Rev. Stat. 38-2320.

references to the desire to adhere to this consensus model are present throughout the proposal, even though accomplishing complete compliance with this national model is aimed at

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

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

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

What makes this approach even more perplexing, is the proposal itself explains how the regulatory inefficiency issue is already being addressed by the Department of Health and Human Services (DHHS). Per Executive Order No. 17-04 issued by Governor Ricketts, DHHS has begun the process of reviewing the agency's regulations in order to promote efficiency in regulations overall. In fact, the regulations that govern APRNs were consolidated from five separate chapters[26] to one singular chapter of regulation that removed duplicative language and requirements.[27] This process began on August 27, 2019, with the final regulations becoming effective on September 19, 2020.

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

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

[26] 172 NAC 98, 100, 103, 104, & 107. [27]
172 NAC 98.

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

Closer examination of the regulatory consensus model pushed by the NCSBN reveals that four of the ten "foundational requirements for licensure" would alter Nebraska state law and policy in order to achieve complete compliance.[23] The proposal makes no mention of how the applicant group wishes to accomplish alignment with two of these four requirements.

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

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

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

What makes the APRN Compact unique is that it supersedes state laws on scope of practice, including those that require practice under a physician, collaboration with a physician, and restrictions on prescriptive authority.[24] No other licensure compact adopted by the Nebraska Legislature has sought to override state law like this. All other compacts in existence seek to obtain regulatory efficiency and ability to practice across state lines through uniform provisions

[23] APRN Consensus Model, Pg. 14.

[24] See, Article III of the APRN Compact

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

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

V. Conclusion

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

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

This report has highlighted the many shortcomings, inaccuracies, and misconceptions presented by the Board of Nursing in their application for scope expansion of three of the four APRN professionals. The application is thin on the details of how this proposal meets the statutory

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James L. Madara, MD, commented in a separate letter as follows:

On behalf of the American Medical Association (AMA) and our physician and medical student members,
I write to provide comments on the Nebraska Board of Nursing's proposal for consideration by the APRN Technical Review Committee (Committee). The AMA has serious concerns with the application including the broad focus and proposed scope expansions of certified nurse midwives (CNMs), nurse practitioners (NPs) and clinical nurse specialists (CNS). The AMA also questions the presumptive need for these changes to allow Nebraska to adopt an APRN Compact which is no longer in effect (a new APRN Compact was adopted after submission of this proposal). Finally, the AMA is deeply concerned the APRN proposal before the Committee threatens the health and safety of patients in Nebraska and will increase overall health care costs while failing to expand access to care.

As stated above, the AMA is alarmed that this proposal, which would remove the transition to practice requirements for NPs, allow CNS to prescribe and remove the requirement that CNMs maintain a practice agreement with a physician, threatens the health and safety of patients. It is our long-held belief that health care professionals' scope of practice should be based on standardized, adequate training and demonstrated competence in patient care. This is imperative in protecting the health and safety of our patients. While all health care professionals share an important role in providing care to patients, their skillset is not interchangeable with that of a fully trained physician. This is why the AMA has long supported physician-led health care teams, with each member drawing on their specific strengths, working together and sharing decisions and information for the benefit of the patient. Just as teams do in business, government, sports and schools, health care teams require leadership. With seven or more years of postgraduate education and more than 10,000 hours of clinical experience, physicians are uniquely qualified to lead the health care team. **Team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients.**

Moreover, there is strong evidence that increasing the scope of practice of APRNs has resulted in increased health care costs due to overprescribing and overutilization of diagnostic imaging and other services. For example, a 2020 study published in the *Journal of Internal Medicine* found 3.8% of physicians (MDs/DOs) compared to 8.0% of NPs met at least one definition of overprescribing opioids Nebraska Department of Health and Human Services Licensure Unit

and 1.3% of physicians compared to 6.3% of NPs prescribed an opioid to at least 50% of patients.[25] **The study further found, in states that allow independent prescribing, NPs were <u>20 times</u> more likely to overprescribe opioids than those in prescription-restricted states.**[26]

[25] MJ Lozada, MA Raji, JS Goodwin, YF Kuo, "Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns." Journal General Internal Medicine. 2020; 35(9):2584-2592.
[26] Id.

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Multiple studies have also shown that NPs order more diagnostic imaging than physicians, which increases health care costs and threatens patient safety by exposing patients to unnecessary radiation. For example, a study in the *Journal of the American College of Radiology*, which analyzed the total utilization rate per 1,000 of skeletal x-ray utilization for Medicare beneficiaries from 2003 to 2015, found ordering increased substantially – **more than 400%**– by nonphysicians, primarily NPs and physician assistants during this time frame.[27] A separate study published in *JAMA Internal Medicin*e found NPs ordered more diagnostic imaging than primary care physicians following an outpatient visit. The study controlled for imaging claims that occurred after a referral to a specialist.[28] **The authors opined this increased utilization may have important ramifications on costs, safety and quality of care. They further found greater coordination in health care teams may produce better outcomes than merely expanding nurse practitioner scope of practice alone.**

Many of these studies have been limited to NPs because few states allow prescriptive authority of CNS. However, the findings are clear, NPs tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians and overprescribe antibiotics[29] – all which increase health care costs and threaten patient safety. Before expanding the scope of practice of NPs, CNMs and, CNS we encourage the Committee to carefully review these studies. We believe you will agree that the results are startling and have significant impact on the assessment of risk to the health and welfare of Nebraska patients, as well as the impact on the cost of health care in Nebraska.

APRNs have long claimed that expansion of their scope of practice will result in increased access to care in rural and underserved areas and help fill the gaps in primary care. This is a false promise and simply not true. Despite these promises, the evidence demonstrates that APRNs tend to practice in the same areas of the state as physicians. This occurs irrespective of state scope of practice laws. For example, in Nebraska while the number of NPs have increased, NPs have **not** moved into rural areas of the state – despite being granted independent practice in 2015. Furthermore, nationwide there has been a greater growth in the number of NPs in states that support physician-led team-based care compared to states that allow independent practice. This reflects the reality on the ground: physicians and NPs prefer working

[27] D.J. Mizrahi, et.al. "National Trends in the Utilization of Skeletal Radiography," Journal of the American College of Radiology 2018; 1408-1414.

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

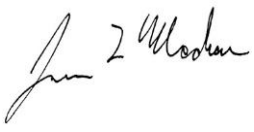
[29] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. Open Forum Infectious Diseases. 2016:1-4. Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. Infection Control & Hospital Epidemiology. 2018:1-9.

together in team-based care models, not separated in siloed models of care. Moreover, it ought to be noted that recent workforce studies suggest newly graduated NPs are choosing to pursue specialty or subspecialty degrees rather than primary care.[30] All of this points to one conclusion. **The facts are clear:**
expanding the scope of practice of APRNs will <u>not</u> solve access to care problems in rural and underserved areas.

Finally, the Nebraska Board of Nursing indicates the scope of practice expansions proposed in their application are required so that they can enter the APRN Compact, which was drafted and adopted by the National Council of State Boards of Nursing (NCSBN). Unlike compacts created for other health care professionals, which focus on license portability, the APRN Compact includes provisions that preempt state scope of practice laws. The APRN Compact was initially adopted in 2015. After only three states adopted the original APRN Compact, however, the effort came to a halt when it failed to garner adoption by the minimum 10 states required to become effective. **This is the Compact referred to in the application before the Committee submitted on June 11, 2020 and is no longer in effect.** The NCSBN adopted a new version of the APRN Compact on August 12, 2020. This version of the APRN Compact includes many of the same provisions that caused concerns among state legislatures in 20152019. To date, it is noteworthy that no state has adopted the most recent version of the APRN Compact. Like the earlier version of the APRN Compact, the AMA is vehemently opposed to the new version especially because it is being used as a vehicle to expand scope of practice as opposed to focusing on license portability, as other health profession compacts do.

Thank you for the opportunity to provide these comments. If you have any questions, please contact Kimberly Horvath, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at kimberly.horvath@ama-assn.org.

Sincerely,



James L. Madara, MD
cc: Nebraska Medical Association

[30] Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners, 2017. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; October 2017.https://www.chwsny.org/wpcontent/uploads/2017/10/New_York_NPs_Report_2017.pdf.

Additional applicant group responses to committee questions and requested information during the third meeting

Linda Stones, MS, BSN, RN, CRRN commented on the responses submitted by her group to the questions raised by the members of the technical review committee during the previous meeting. These responses included tabular information pertinent to education and training in Gerontology by advanced practice nurses, nurse midwifery education and training, a family nurse practitioner plan of study, a plan of study for nurse anesthetists, and a summary of advanced practice nursing education and training.

Ms. Stones continued her comments by stating that Patty Motel would be helping her present the requested information and related commentary about this information. Ms. Stones continued by bringing up a slide presentation to assist her in making her comments about her groups' responses to committee questions and requests for information.

Ms. Stones stated that there are four principal points addressed via the applicants' proposal and these are as follows:

- The establishment of full practice authority for CNMs and CNSs which has not as yet occurred for these two nursing groups,
- The establishment of a "consensus model" pertinent to the creation of a uniform standard of education and training for all four of the affected nursing groups defined under the proposal
- Expand access to nursing care for all Nebraskans
- Creation of a common regulated nursing licensure category under the APRN moniker for all four of these nursing professional groups.

Ms. Stones went on to state that this proposal is about helping the four percent of advanced practice nurses who were left out of the regulatory improvements made in 2015 for the vast majority of nurse practitioners by the Legislature wherein they provided full practice authority for APRNs including an end to the requirement for a practice agreement with a physician before they can practice as an advanced practice nurse. Ms. Stones commented that this four percent are important because they often care for the most needy and vulnerable patients or those that are chronically ill such as stroke victims, for example, but also pre-natal and post-natal care, as well as wound care, for example. Most of these practitioners are not allowed full practice authority under current Nebraska law.

According to Ms. Stones these practitioners—CNMs and CNSs—are as well educated and trained as the other ninety-six percent of advanced practice nurses. She went on to state that there is no good reason why these practitioners should be treated differently than other advanced practice nurses. According to Ms. Stones their education and training is on a par with other advanced practice nurses vis-à-vis their clinical background, and that they differ only in their post-graduate specialty training. Ms. Stones went on to say that the fact that their basic clinical education and training is on a par with other advanced practice nurses validates the development and utilization of the "consensus model" in the applicants' proposal.

Ms. Stones then stated that one of the most significant benefits of the proposal for patient care is

that it would allow for an integrative approach to patient care whereby the various subspecialties of advanced practice nursing could more easily work together to address patient needs in a health care playing field that would decrease barriers to providing services and increase access to care in areas where there are few if any medical doctors. Ms. Stones added that data from the state of Iowa affirms the positive connection between removing barriers to the services of advanced practice nurses and improvement in the area of neonatal care, for example. At this point Ms. Stones ended her formal presentation and asked if there were any questions from the committee members.

Committee members then began to ask the applicant representatives a series of questions about the information provided in response to their previous request for additional information, as follows:

Committee member McCarty asked the applicants: 1) if there is any way to estimate the number of Nebraskans that benefit from the services provided by this "four percent" of advanced nursing professionals, 2) is a Masters Degree necessary as a pre-requisite for entry into advanced nursing education and training or is it the result of such education and training, and 3) is there data available about disciplinary actions taken against advanced practice nurses as compared to medical doctors, for example.

Linda Stones replied to the first question by stating that as of now she is not aware of any data that would be helpful in estimating the impact of CNMs and CNSs on the needs of Nebraska patients but that she would make an effort to see what she could find such data in advance of the next meeting. Ms. Stones responded to the second question by stating that a Masters Degree is the result of the education and training under review. As for the third question she responded by stating that no such information exists as far as she knows, but that she would try to find out.

Committee member Allison Dering- Anderson made reference to a letter from the American Medical Association submitted to the committee members very recently which, among other things, included a discussion about the "consensus model" and the nursing "compact model". Dr. Dering-Anderson asked Ms. Stones to clarify the difference in meaning between these two terms vis-à-vis the context of the current advanced nursing proposal. Ms. Stones responded by stating that the compact is about an association of states nursing associations that have come together to break down barriers to the movement of advanced practice nurses between their respective states for the purpose of improving access to care. The consensus model refers to educational and training standards that the nursing compact is seeking to implement across-the-board among the various states that have joined the nursing compact.

Dr. Dering Anderson then asked Ms. Stones to respond to criticism from the Medical Association letter referenced above regarding possible negative impacts of expanding the prescriptive authority of advanced practice nurses vis-à-vis the opioid abuse issue. Ms. Stones replied that she was not prepared to answer this question until she had more time to look into it, indicating that she would do this and be prepared to respond to this question at the next meeting.

Committee member Ben Greenfield asked the applicants whether the prescriptive component of the applicants' proposal might do more harm than good because it might be too broad-based to

protect the public from a potential “rogue” practitioner who might prescribe beyond the scope of their professional competency. Mr. Greenfield went on to comment that just because a provider is licensed to prescribe a certain category of medications doesn’t necessarily mean that they are competent to do so. Ms. Stones responded by stating that the Board of Nursing deals with these kinds of issues all the time, and that it has authority to discipline providers who exceed their education, training, or professional experience regardless of what their licensed scope might be. Chairperson Warner asked Ms. Stones if she has any data that could be used to compare disciplinary actions taken against independent nurse practitioners and non-independent nurse practitioners. Ms. Stones indicated that she did not have such data but that she would make an effort to look for it before the next committee meeting.

Committee member Denise Logan asked Ms. Stones about apparent differences between the members of the four advanced practice groups under review vis-à-vis radiology. Ms. Stones responded by stating that the Board of Nursing would handle this kind of discrepancy in education and training the same way it manages discrepancies in the ability to prescribe certain kinds of medications, to wit, each nurse would be expected to only provide services and / or functions that they are competent to provide, and that those of ignore this caveat do so at their peril.

Dr. Jodi Hedrick, MD, expressed support for a team-based approach to delivering care and stated that the best way to get this kind of care is in the context of a clinic headed by a physician medical director and which includes a wide variety of health care providers including advanced practice nurses. This is the best way to get the collaborative, integrative, team-based approach that the applicant groups seems to value.

Committee member Dering-Anderson asked Mr. Schrodt why CRNAs were not included in the letter written by the Medical Association wherein an alternative to the proposal was delineated. Mr. Schrodt responded by stating that provisions pertinent to CRNAs seemed not to be substantially different under the terms of the proposal than they are right now.

Mr. Schrodt asked the applicants how the proposal would improve the lives of the so-called “four percent” if it were to pass. Patti Motel responded that the proposal would make it easier for them to find work in other states. Linda Stones stated that passing the proposal would encourage institutions such as UNMC to expand their training programs for these particular professional groups thereby encouraging more nurses to take their careers in those directions, adding that this kind of progress has already been noticed in states that have already passed a version of this proposal. Mr. Schrodt commented on assertions made earlier in the meeting by an applicant representative, to wit, that executive orders from the Trump Administration lifting certain restrictions for advanced practice nurses have had the effect of improving access to care for underserved populations are misleading, considering that these actions are likely to be reversed once the pandemic is over and thus are not good indicators of what life would be like if the proposal were to pass. Dr. Dering Anderson responded that right now we cannot be so sure that the changes brought about by these orders are going to go away even when the pandemic is over, adding many of these changes might very well become permanent.

Amy Reynoldson commented that NMA would like to see a legislative version of the proposal very soon so that they could formulate a well-thought-out response to the proposal that is more than just a knee-jerk reaction to it.

Comments regarding concerns about transition to practice for recent APRN graduates:

Dear Members of the APRN Credentialing Review Committee,

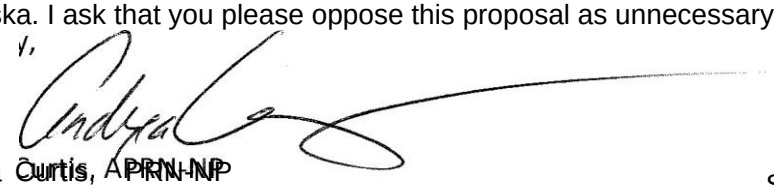
My name is Andrea Curtis, I am an APRN-NP in Hastings, NE, writing to you with concerns about the Board of Nursing's desire to remove the 2,000 hour transition to practice requirement for nurse practitioners and the negative impact that could have on patients.

My concerns center around the lowered admission criteria at schools and the growing lack of experience nurse practitioners possess when graduating from their degree program. It used to be that nurse practitioners previously worked as a registered nurse for several years prior to seeking an advanced nursing degree, and that experience made you a better candidate for admission to graduate school. Upon application to schools offering advanced degrees, students used to go through a personal interview process and the school thoroughly reviewed each applicant prior to approving their admission. It was a very competitive process that yielded top tier students and future practitioners.

However, this has all seemed to change since nurse practitioners gained autonomous practice in 2015, with recent bachelor's degree graduates going straight from obtaining a registered nurse license to entering an advanced degree program. This means that today's nurse practitioners lack valuable real world, hands on experience caring for patients, and that is concerning. I personally gained valuable experience working as a registered nurse in both the ICU and clinical settings. The latter truly assisted in exposing myself to the breadth of patients and the issues they may be facing on a daily basis.

Gaining real world experience like this helps to create a better understanding of the basics, to the point where it becomes a natural reaction and more of your energy can be devoted to complex issues of the patient. Unfortunately, this aspect is something I have found to be deficient with recent graduates whom I have worked with in some capacity in recent years.

In my career, working with a physician has helped me gain the patient assessment skills necessary for effective care, which I believe are skills lacking with newer nurse practitioners. Specifically, I have learned to follow up and address abnormalities the true medical way, which was a skill I did not learn through my education because it was predominately focused on preventative wellness. This is why I believe removing the transition to practice hour requirement would be a mistake and would deteriorate the level of care patients receive in
Nebraska. I ask that you please oppose this proposal as unnecessary and potentially unsafe.



Sincerely,

Andrea Curtis, APRN-NP

Part Six: Committee Discussion and Recommendations

Final General Discussion on the Proposal

The committee members had no comments to make at this time.

Discussion on the Six Statutory Criteria as They Pertain to the Proposal

Criterion one: The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.

Wendy McCarty: Commented that she does see the need for improved access to care in remote rural areas of our state. Dr. McCarty added that she sees the proposal as being forward-looking and that it would make it more likely than under the current situation for remote rural areas to receive better access to care in the future. She added that all four of the nursing groups under review are advanced practice nurses and should be seen as equally competent and well-trained to practice independently.

Sue Eells: Commented that each of the four nursing groups under review are different in significant ways and that this complicates the question inherent in the first criterion.

Denise Logan: Commented that there is a need for improved access to care in our state and that the proposal would be helpful in that regard. Also there is a need for Nebraska to recruit advanced practice nurses and the proposal would be helpful in this way, as well.

Allison Dering-Anderson: Commented that the current piecemeal approach to the regulation of the four advanced practice nursing groups is not efficient given how similar they are to one another. There is a need for greater uniformity in the way these groups are regulated.

Criterion two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

Wendy McCarty: Commented that the proposal would benefit the public by making it more possible for improved access to care in remote rural areas of our state.

Jeromy Warner: Commented that in his mind opponent information and arguments did not discredit applicant group claims regarding the benefits of the proposal.

Criterion three: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.

Allison Dering-Anderson: Commented that opponent group data and commentary were not convincing regarding the potential of the proposal to cause new harm. Also, opponent arguments regarding how the proposal would weaken team approaches to healthcare are not believable because cooperation between health professions has become a mainstay of healthcare today, and has become such a necessary component of our healthcare system that there can be no doubt that it's here to stay, regardless of what happens vis-a-vis current political controversies between certain health professions.

Su Eells: Commented that her concerns were with the Nurse Midwifery group, and that new harm could arise from a weakening of oversight of these providers under the terms of the proposal.

Jeromy Warner: Commented that he saw no evidence or information that convinced him that any harm would come from the proposal.

<u>Criterion four</u>: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

Allison Dering-Anderson: Commented that there is no new skill or service being proposed in this review, and that it's the circumstances wherein these services would be occurring that in some instances are new, adding that in her judgement the proposal satisfies this criterion.

Wendy McCarty: Commented that all four of the nursing groups under review are well-trained and well-educated and possess comparable skill sets and abilities, and for these reasons should be regulated as one, single, nursing profession.

Jeromy Warner: Commented that the extent of overlap between the four nursing groups in question is not entirely clear and that important differences remain.

Su Eells: Commented that the education and training of CRNAs is impressive and should be an example to other nursing groups.

<u>Criterion five</u>: There are appropriate post-professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill of service in a safe manner.

Wendy McCarty: Commented that the Board of Nursing provides the oversight for all nurses and provides for all post-credentialing education and training and that this should ensure that appropriate standards would be in place for the proposal under review.

Jeromy Warner: Commented that he is not sure about the uniformity of post-professional education and training among the four respective nursing groups, especially as regards CNMs.

Ben Greenfield: Commented that his concern is with the additional prescriptive authority in the proposal and the potential for new harm that this might create given the differences

between the four groups in training and work experience vis-à-vis pharmacology-related services.

Allison Dering-Anderson: Expressed disagreement with Dr. Warner regarding the CNMs and asked, what are CNMs not doing that the other nursing groups are doing vis-à-vis education and training for example? She added that the core education and training of all four of the respective nursing groups is the same.

<u>Criterion six</u>: There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

Wendy McCarty: Commented that the oversight provided by the Board of Nursing should be adequate to provide the public with the necessary protection. She added that the core education and training of these four nursing groups is the same.

Denise Logan: Commented that she has confidence that the Board of Nursing would be able to protect the public under the terms of the proposal, but added that she is not totally sure about the extent of uniformity of testing vis-à-vis pharmaceuticals among the four nursing groups in question.

Allison Dering-Anderson: Commented that she too is not entirely clear about the extent of uniformity of testing vis-à-vis pharmaceuticals among the four nursing groups in question.

Jeromy Warner: Commented that he is not sure of the extent of consistent clinical hours among the four nursing groups under review. This question was asked but he didn't recollect an answer from the applicant group.

Denise Logan: Also commented on the relative lack of information about the extent of consistent clinical hours among the four nursing groups under review.

Formulation of Recommendations on the APRN Proposal

The committee members took the following action on the APRN proposal as a whole via an up/down vote to formulate their recommendations:

Voting to approve the applicants' proposal were the following committee members:

Allison Dering-Anderson
Wendy McCarty
Denise Logan

Voting not to approve the applicants' proposal were the following committee members:

Ben Greenfield
Su Eells
Chairperson Dr. Jeromy Warner abstained from voting.

After the voting was completed the committee members commented on their reasons for voting as they did, as follows:

Allison Dering-Anderson: (Voted yes)

Overall, there is no indication that the proposal would cause any harm and there is reason to believe that it could improve access to care.

Su Eells: (Voted no)

Midwifery safety is a concern in that this group did not seem to possess the necessary background in pharmaceuticals, overall, to be safe.

Ben Greenfield: (Voted no)

Prescriptive authority is a concern and it seemed that at least some of the members of the four nursing groups in question lacked sufficient educational / experiential background to have full prescriptive authority.

Denise Logan: (Voted yes)

Prescriptive authority is a concern but the facts tell us that three of the four nursing groups under review already prescribe extensively. As long as the Board of Nursing enforces high standards in this area of care there should not be a problem with approving this proposal. She added that access to care could be improved by the proposal without creating significant new harm. Additionally, the recruitment of new advanced practice nurses to Nebraska might also be improved by passing this proposal.

Wendy McCarty: (Voted yes)

The preponderance of evidence indicates that the proposal would likely benefit the public without creating significant risk of new harm, adding that information from other states indicates that rural populations have benefited from other versions of this proposal, and that opponent predictions of harm to the public from them have not been borne out by available evidence, therein.