BEFORE THE NURSE PRACTITIONERS'
TECHNICAL REVIEW COMMITTEE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATE OF NEBRASKA

IN THE MATTER OF A PUBLIC HEARING REGARDING THE PROPOSED CHANGES TO THE INTEGRATED PRACTICE AGREEMENT REQUIREMENT FOR NURSE PRACTITIONERS	TRANSCRIPT VOLUME I of I (Pages 1 through 126) EXHIBITS 1-2

Nebraska State Office Building
301 Centennial Mall South
Lower Level A
Lincoln, Nebraska

Convened, pursuant to notice, at 1:02 p.m.,

March 2, 2013,

BEFORE:

Janet Coleman, Chairperson.

COMMITTEE MEMBERS PRESENT:

Jeffrey Baldwin, Pharm.D., R.P.
Donald Naiberk, Hospital Administrator
Charlyn Shickell, Ph.D., LIMHP
Marcy Wyrens, R.R.T.
Tom Bassett
Linda Douglas, Ed.D.

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DHHS STAFF PRESENT:

Dave Montgomery, Section Administrator
Ronald Briel, Program Manager

I N D E X

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REPORTER'S CERTIFICATE:

State of Nebraska)
) ss
County of Lancaster)

I, Wendy C. Cutting, reporter for GENERAL REPORTING SERVICE, certify that I reported the proceedings in this matter; that the transcript of testimony is a true, accurate and complete extension of the recording made of those proceedings; further, that the disposition of the exhibits is referenced in the index hereto.

IN TESTIMONY WHEREOF, I have hereunto set my hand at Lincoln, Nebraska, this _____ day of April, 2013.

_____
Reporter

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PROCEEDINGS:

(Exhibits 1 and 2 were marked for identification.)

CHAIRPERSON COLEMAN: I'd like to call to order this public hearing on the scope of practice change that's requested by the nurse practitioners. And I would like to say to you also that no decision has been made by the committee. Most of the committee members still have a lot of questions that we're hoping that as testifiers, both proponents and opponents, that you'll be answering the questions that we've already raised to you that have been distributed. I think it's safe to say that we're going to listen to everything you have to say and be prepared to make a decision, not today, but at the -- begin to make it at the next meeting.

There are lots of questions that haven't been answered. I think we all have some of those questions and we're hoping that you answer them with respect to the amount of education that nurse practitioners have; the amount of laboratory, practical experience that they have before they become licensed; the liability that might exist in states that do have unsupervised practice or states that don't have it; as well as other ways that might solve the problem that nurse practitioners present that don't require a change in the scope of practice.

So those are just some of the questions that we

hope to have you answer today.

And we'll proceed. I think the procedure is not that different from other public hearings. You'll have five minutes and five minutes only to testify. And questions will be asked at the conclusion of each testimony rather than during the testimony. So you'll have your five minutes and then the questions are -- you're not limited in time -- we're not limited in the questions that we answer, and you also, are not particularly limited in the number of minutes you take for testimony in answering a question, except unless it gets unreasonable.

And I will -- Dave, do you have some other things?

MR. MONTGOMERY: Roll call and approval of the agenda.

CHAIRPERSON COLEMAN: Okay. And you're doing the roll call?

MR. MONTGOMERY: Yes.

CHAIRPERSON COLEMAN: Okay, time for roll call.

MR. MONTGOMERY: Dr. Baldwin.

DR. BALDWIN: Here.

MR. MONTGOMERY: Ms. Wyrens.

MS. WYRENS: Yes.

MR. MONTGOMERY: Mr. Naiberk.

MR. NAIBERK: Here.

MR. MONTGOMERY: Ms. Coleman.

CHAIRPERSON COLEMAN: Here.

MR. MONTGOMERY: Dr. Douglas. We expect her to join us shortly.

Mr. Bassett.

MR. BASSETT: Here.

MR. MONTGOMERY: Dr. Shickell.

DR. SHICKELL: Here.

MR. MONTGOMERY: We have a quorum.

The agenda was submitted.

CHAIRPERSON COLEMAN: The agenda was submitted, and is there a motion to approve the agenda?

MR. BASSETT: So move.

CHAIRPERSON COLEMAN: Second?

DR. BALDWIN: Second.

CHAIRPERSON COLEMAN: All in favor say aye.

COMMITTEE MEMBERS: Aye.

CHAIRPERSON COLEMAN: No, the same sign.

(No response.)

The agenda is ready to go.

Do you have some additional information?

MR. MONTGOMERY: Just a couple of extra announcements if you will indulge us for just a moment, please.

These are recording microphones, not amplifying microphones. So those of you who are testifying, please use

your big person voice today --

(Laughter.)

-- so that everybody can have the benefit of your discussion.

When you have one minute remaining on your time, I will say "One minute." And then when your time is expired, I will say "Time." At that time, we do ask you to complete your thought and allow the next person to come on.

The transcript may be purchased from General Reporting Service, and in order to make sure that that transcript is completely accurate, I'm going to ask each of you, even though you have signed in, to state and spell your first and last names at the beginning of your testimony so that we can get everything down right.

Are there any questions about procedure or format before we begin the public hearing?

CHAIRPERSON COLEMAN: Dave, just to clarify, after the initial speech by someone testifying, there is time, then, for us to ask questions.

MR. MONTGOMERY: Yes.

CHAIRPERSON COLEMAN: The questions will come immediately after the testimony.

MR. MONTGOMERY: Immediately following, exactly.

CHAIRPERSON COLEMAN: Okay.

MR. MONTGOMERY: Hearing none, we will open the

hearing with a presentation from Cathy Phillips.

CATHY PHILLIPS

Thank you. Ms. Coleman and members of the Review Committee, I am Cathy, C-a-t-h-y, Phillips, P-h-i-l-l-i-p-s, legislative chair of Nebraska Nurse Practitioners. I'm leading the testimony today in support of our proposal to remove the Integrated Practice Agreement, IPA, requirement with physicians.

We've become aware that the procedural document supporting the purpose of this credentialing review is currently in draft form, and as such, does present some distractions in discussions related to our proposal. As the applicant group, we offer the following clarifications.

A, nurse practitioners are currently fully regulated health professionals.

Scope of practice is currently defined in the Nurse Practitioner Practice Act, statute 38-2310.

The IPA agreement requirement is written in the statute, and our proposal is removal of the IPA agreement requirement already in statute.

We are not seeking a change or expansion in scope of practice.

And in this context, we'd like to suggest for your consideration the following interpretations of the criteria with which we are being evaluated.

Criterion 1, the health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on scope. The IPA agreement does pose limitations on the NP practice, and in this context, Criterion 1 would be interpreted as the health, safety, and welfare of the public are inadequately addressed by the IPA requirement between nurse practitioners and physicians.

Criterion 2 addresses enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public. And we respectfully reiterate that we are not proposing any change in scope of practice. Hence, Criterion 2 would be enactment of the proposal to remove the IPA requirement between nurse practitioners and physicians would benefit the health, safety, or welfare of the public.

Criterion 3, the proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public. And again, we reiterate, we are not proposing any scope of practice change. Hence, Criterion 3 would be interpreted as the proposal to remove the IPA requirement between nurse practitioners and physicians does not create a significant new danger to the health, safety, or welfare of the public.

Criterion 4 addresses education and training for the health profession adequately preparing practitioners to

perform the new skill or service. Again, we reiterate that the health profession nurse practitioners are not requesting any new skill or service. Hence, education and training currently prepares NP graduates for competent practice within scope. Thus, Criterion 4 would be the current education and training for nurse practitioners prepares graduates to practice competently within scope of practice.

Criterion 5 addresses post-professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill or service in a safe manner. NPs are the practitioner and there is no proposal for a new skill or a new service. The intent is to assure the public that NPs are competent to perform services within current scope. Hence, Criterion 5 would be there are appropriate post-professional programs and competence assessment measures available to assure that NPs are competent to perform services within their scope safely.

Criterion 6 addresses measures to assess whether practitioners are competently performing the new skill or service and take appropriate action if they are not. Again, NPs, as those being examined are not proposing a new skill or service. The suggested interpretation is the assessment of competent performance --

MR. MONTGOMERY: One minute.

MS. PHILLIPS: -- and if necessary, that action is taken subsequent to incompetent performance. Hence, Criterion 6, there are adequate measures to assess whether practitioners are competently performing within scope of practice and appropriate action is taken if they are not.

I thank you for your time and I'm happy to answer any questions.

CHAIRPERSON COLEMAN: Are there questions?

(No response.)

MR. MONTGOMERY: Next in testimony is LaDonna Hart.

LADONNA HART

Madam Chair, members of the committee, my name is LaDonna Hart, spelled L-a-D-o-n-n-a, last name, H-a-r-t. I am a family nurse practitioner practicing in Lincoln. I am president-elect of the Nebraska Nurse Practitioners, and I am here on behalf of the NNP to testify in support of our proposal for the elimination of the Integrated Practice Agreement.

I wish to further define and answer questions regarding the scope of practice for nurse practitioners. Essentially, scope of practice is the definition of the rules and the regulations and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may

practice. Such practice is also governed by the requirements for continued education and professional accountability. The scope of practice of a health care profession is the assurance of the safety of the services it provides. The scope of practice of the licenses nurse practitioner is statutorily defined in the Nebraska state law known as the Nurse Practitioner Practice Act. I have included a copy of the Nurse Practitioner Practice Act, although I will not read it for brevity today, but it is included for your reference.

According to the National Council of the State Boards of Nursing, there are certain assumptions that can be made about the scope of practice. One of those assumptions is that the scope of practice is a regulation or -- the purpose of the scope of practices regulation is public protection. Public protection and safety has top priority in the scope of practice decisions. Commitment to consumer safety encompasses the belief that the public should have access to providers who practice competently. There is no evidence that the IPA has afforded patients any measurable benefit on the outcomes of care delivered by nurse practitioners in this or any other state. The IPA requirement, however, has been demonstrated to be a significant barrier to the access of such care for Nebraskans, especially in our rural communities and our

underserved populations.

Changes in professional -- the second assumption, changes in the professional scope of practice and related provisions within the the practice acts are inherent in our current health care system. Health care and its delivery are necessarily evolving. Health care practice acts also need to evolve as the demand and changing capabilities for the delivery of services change. In the context of mandated, rapidly advancing reform, promised innovation in delivery models and more consumers seeking basic services, the IPA is no longer relevant to the role of the nurse practitioner in contemporary health care in this state.

Our third assumption related to scope of practice is that collaboration between health care providers is a professional norm. It is an ethic that is expected of all health care professionals. Inherent in this statement is a concept that competent providers will refer to other providers when faced with issues or situations beyond the original provider's competence or when specialty care is determined as necessary and desirable to improve outcomes for the consumer. Collaboration occurs independently of the IPA.

Our fourth assumption is true collaboration amongst NPs and other health care providers enables a patient to realize the full benefit of diverse but

complementary competencies. Overlap among professionals is necessary. No one profession actually owns a skill or activity in and of itself. One activity does not define a profession, but it's the entirety of the scope of activities within the practice that makes any particular profession unique. Simply because a skill or activity is in one professional skill set does not mean another profession cannot and should not include it in its own scope of practice. Please remember that we are not seeking any new activities to our scope.

Practice acts -- and finally the fifth assumption made with having a scope of practice is that practice acts require licenses to demonstrate that they have the requisite training and competence to function as autonomous health care providers. Nurse practitioners meet initial and ongoing professional licensure requirements in the state of Nebraska. Education, credentialing, and licensure prepare and authorizes nurse practitioners --

MR. MONTGOMERY: One minute.

MS. HART: -- to function autonomously. And by autonomously, we mean with full practice authority, and we'll describe that in a later testifier. But without supervision or orders from any other health care professional.

That concludes my testimony today. I thank you

for the opportunity to be here and I can answer any questions.

CHAIRPERSON COLEMAN: Questions?

(No response.)

Thank you.

MR. MONTGOMERY: Our next testifier is LeAnn Holmes.

LEANN HOLMES

Good afternoon. My name is LeAnn Holmes, spelled L-e-A-n-n, H-o-l-m-e-s. I'm a practicing family nurse practitioner here in Lincoln and I'm here on behalf of the American Academy of Nurse Practitioners as the Nebraska State Representative. I am here today to testify in support of the proposal of the Nebraska Nurse Practitioners to remove the Integrated Practice Agreement.

Removal of the IPA will grant nurse practitioners full practice authority, which you heard LaDonna allude to. Full practice authority may have previously been referred to as autonomous or independent practice; however, I think these terms can be misunderstood to imply lack of interdisiciplinary practice. Nurse practitioners have and will continue to practice in cooperation with all members of the health care team to meet the needs of the patient. The IPA is simply not necessary to ensure that this collaboration occurs. Nurse practitioners have always, and

will continue to collaborate when needed to meet the patient's needs.

Full practice authority reflects the more accurate terminology and refers to the collection of state practice and licensure laws that allow for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, as well as initiate and manage treatments, including prescription medications.

In Nebraska, there is a disconnect between the higher level of care that nurse practitioners are prepared to provide and the level of care that the state practice act with the required collaborative agreement will allow them to deliver. Closing this gap between clinical preparation and regulated practice authority will help end some of the disparities that patients encounter when they seek health care. It will also bring Nebraska more in line with federal recommendations, including those of the Institutes of Medicine and the National Governors Association.

The National Governors Association is quoted as saying, "None of the studies in the NGA's literature review raise concerns about the quality of care offered by NPs. Most studies showed that NP-provided care is comparable to physician-provided care on several process and outcome measures. Moreover, the studies suggest that NPs may provide improved access to care."

The Institutes of Medicine is quoted as saying, "The current conflicts between what APRNs can do based on their education and training and what they may do according to state and federal regulations must be resolved so that they are better able to provide seamless, affordable, and quality care."

One more quote from the Bipartisan Policy Center is that "Physician oversight of work that can be performed autonomously by other professionals can lead to unnecessary repetition of orders, office visits and services, thus increasing total costs without any additional benefit to patients."

Removal of the IPA will increase patient access while team-based care models will further restrict access and efficiency. The nurse practitioner community broadly supports patient-centered care and team-based care for health systems; however, we do not support creating statutory or regulatory requirements that link an individual clinician's ability to obtain state licensure to the formation of care teams with any other discipline. Nor do we support regulations that require the existence of a care team for professional practice. Licensure requirements based on participation in teams interferes with the ability for the profession to be regulated based on the preparation and the evaluation of a professional as a safe and competent

provider of health care.

Health professional licensure is designed to ensure that an individual clinician is safe and competent to provide care to the public. Team-based care is an example of a system of providing care. Tying regulated care teams to licensure impedes transparency, accountability, flexibility, and the efficient use of clinicians. Moreover, requiring nurse practitioners to be part of a physician-led team in order to be licensed will decrease patient access to primary care.

Only one state, Virginia, has passed legislation that links NP practice with the requirement to be part of a physician-led and managed team. The impact of this legislation thus far has been to further restrict NP practice, which, in turn, has led to decreased patient accessibility and choice.

MR. MONTGOMERY: One minute.

MS. HOLMES: With the expended numbers of insured patients in the coming years, increasing the number of primary care providers rather than limiting their practice, is more advisable.

In review, team-based care is not a licensure concept. Individual clinician licensure should not be linked to a team structure. Requirements for membership in care teams for licensure may restrict patient choice and

access to care. The Federal Trade Commission and the Antitrust Division of the Department of Justice have published positions stating, "Recently, the FTC staff urged several states to reject or narrow restrictions that curtail competition among health care providers because they limit patients' access to health care and raise prices. In particular, staff examined APRN scope of practice restrictions that appear to exceed what is necessary to protect consumers."

On behalf of the American Academy of Nurse Practitioners, I thank you for your attention. Can I answer any questions?

CHAIRPERSON COLEMAN: Questions?

MR. BASSETT: Janet, I do have a question.

CHAIRPERSON COLEMAN: Uh-huh.

MR. BASSETT: Towards the first of your testimony, it's on the first page here, "In Nebraska, there's a disconnect between the higher level of care that nurse practitioners are prepared to provide and the level of care that the state practice act with required collaborative agreement will allow them to deliver." Can you give me examples of that? Right now, you know, you go to school, get your licensure, and can do da-di-da-di-da, but because of current agreements that you're forced to have, you can't do it. You're limited. What is that all about?

MS. HOLMES: It's an accessibility issue, essentially, meaning that we could not necessarily go out to western Nebraska and practice, because we would need to find a physician to sign an IPA. So that would restrict our being able to practice at all.

MR. BASSETT: But there aren't individual things that people would come to you and say --

MS. HOLMES: No.

MR. BASSETT: -- I've got a whatever wrong with me and --

MS. HOLMES: No.

MR. BASSETT: -- you say, oh, can't do that because of this agreement.

MS. HOLMES: No. Again, this is not changing our scope of practice.

MR. BASSETT: That's what I understand, yeah.

MS. HOLMES: So the only thing we're doing is getting rid of the collaborative agreement that puts into paper a collaborative effort that already happens without the piece of paper.

MR. BASSETT: Thank you.

CHAIRPERSON COLEMAN: Following along that same line, you said you would seek collaboration when needed. What's the determining factor with that?

MS. HOLMES: You know, it depends and it goes both

ways. I work with a physician colleague who, because I am more of an expert in women's care, will come and seek my opinion on an abnormal pap test, and I will let him know what I would do in that case. And by the same token, I may have a male patient with a testicle problem, which is not my area of expertise, and so I might ask him to, you know, confer with me about the diagnosis.

CHAIRPERSON COLEMAN: But you're working with a physician.

MS. HOLMES: Yes, I do.

CHAIRPERSON COLEMAN: And what was your question?

DR. SHICKELL: I had a question. Are you against the team-based care system approach?

MS. HOLMES: I don't think that team-based care should be linked to licensure. So team-based care is a system of providing care, and yes, we should be providing team-based care. And sometimes that will include a nurse practitioner and a respiratory therapist and a physical therapist. And sometimes that will include a physician and a PA. It depends on what the patient needs.

What I object to is requiring the nurse practitioner to be part of a team in order to achieve a license.

CHAIRPERSON COLEMAN: What is the National Governors Association that you cited?

MS. HOLMES: It's all the governors from each of the 50 states that meet in Washington, D.C., on a regular basis. They did -- I don't know if it was a literature review or a meta-analysis recently on this subject. And that document has been submitted.

CHAIRPERSON COLEMAN: Other questions? You seem to get the questions. Now we've eased up. We'll ask everybody questions from now on.

(Laughter.)

MR. MONTGOMERY: Thank you. Before our next testifier, I would like to remind the audience to please keep your sidebar conversations under control and respect the people who are testifying.

Dr. Julie Sundermeier.

DR. JULIE SUNDERMEIER

Ms. Coleman and members of the Technical Review Committee, my name is Julie Sundermeier, Dr. Julie Sundermeier, and that's spelled J-u-l-i-e, S-u-n-d-e-r-m-e-i-e-r. I'm a nurse practitioner. I'm a member of the Nebraska Nurse Practitioner Applicant Group for the current credentialing review. I support the removal of the Integrated Practice Agreement. Removal of this agreement would not alter nurse practitioners' scope of practice. It would simply allow that practice to be more transparent, more accessible, and more efficient, allowing

nurse practice to the full extent of our education and training. Nursing has, by far, the largest numbers of health care professionals. Quality care hinges on having a well educated nursing workforce and clinical competency as a major component of that in both academic and clinical arenas.

Today I will address nurse practitioner education and training starting with answers to the questions that were brought forward after the last meeting. The first question listed was, when nurse practitioners take online courses, how do we know how much contact they've had with their patients directly? So distance learning or web-based learning is expected to meet the same academic program standards as programs provided in traditional face-to-face formats. Web-based learning is a didactic component of NP education and should not be confused with clinical hours. On-site clinical preceptors supervise the clinical experience of nurse practitioner students.

The second question. How much clinical time does a typical nurse practitioner student receive during their education and training? This question actually has been previously addressed in about four testimonies, but I'll reiterate that national accreditation standards require masters prepared NPs to have at least 500 hours of clinical experience. Doctoral prepared nurse practitioners are

required to have a minimum of 1,000 hours or an additional 500 hours if they already have their masters. Most NP programs require well above this amount. It should be emphasized that these NP hours build on the foundation of undergraduate clinical hours and classroom education obtained with a BSN or a bachelor of nursing. On average, undergraduate nursing students receive 1,000 clinical hours upon degree completion.

It's also important to note that nurse practitioner programs undergo full accreditation by a national accrediting agency. And this accreditation is a rigorous and ongoing review process. This process ensures that the consumer and the nurse practitioner programs meet national standards and benchmarks for preparing to practice within a defined scope.

The third and final question that I'll address that was brought forward does -- how does nurse practitioner curriculum compare with that of other health professions such as physicians, for example? Nurse practitioner curriculum includes the traditional medical components of advanced pathophysiology, advanced pathology, advanced pharmacology, as well as assessment, diagnosis, and treatment. The difference is that these sciences are rooted in a nursing philosophy. This is based on psychosocial aspects of patient, family, and community in providing

holistic care. Another important hallmark of APRN practice is that provision of care is directed at illness prevention, health promotion, and improved patient care outcomes.

Nurse practitioners do not deny that there are differences in education between NPs and physicians. However, the American Academy of Nurse Practitioners states that clinical outcomes really is a far better measure of educational effectiveness. And the following three factors highlight that, these significant differences in education between physicians and NPs.

The first point. NP students have formal academic preparation and licensure as an RN before entering school.

MR. MONTGOMERY: One minute.

DR. SUNDERMEIER: They have a professional degree in nursing at the start. And so their education starts at a higher point than other graduates education programs. NP students determine their population -- patient population at time of entry, thus the focus is defined. NP education is competency-based, not time-based. NP students do not progress without meeting certain competencies.

Comparison of education models side by side is not the appropriate measure of clinical success or patient safety. The appropriate measure is patient outcomes. And after 40 years of research and 100 studies, there is no study that has determined that practitioner care is

ineffective or inferior in any aspect.

It is not NP education and training that limit full practice authority. It is a restrictive state regulation. Evidence-based medicine is the gold standard of ethically sound, quality-driven, and outcome-based patient care. Health policy and regulation should follow these same evidence-based standards. Thank you and I'm happy to respond to any questions.

CHAIRPERSON COLEMAN: Any questions?

DR. SUNDERMEIER: I've also submitted a letter from Dean Howell from Creighton University and there was a previous letter submitted by the dean of the University of Nebraska Medical Center, and they submit these letters on their own behalf.

MR. MONTGOMERY: Thank you.

CHAIRPERSON COLEMAN: No questions?

DR. SHICKELL: I have a question.

CHAIRPERSON COLEMAN: Okay.

DR. SHICKELL: This would be on clinical supervision of a nurse practitioner compared to an RN. The clinical supervision would be more stringent of a nurse practitioner?

DR. SUNDERMEIER: In education?

DR. SHICKELL: In their practice as they're going out in their clinical hours?

DR. SUNDERMEIER: This is in their education process, so that is a clinical preceptor to help guide that student and supervise that student, not out in practice. That was based on the education and training. Does that clarify that question?

DR. SHICKELL: I guess so.

CHAIRPERSON COLEMAN: Are there other questions?

(No response.)

Thank you.

MR. MONTGOMERY: Next testifier is Deb Kozeny. Kozeny?

MS. KOZENY: Kozeny.

MR. MONTGOMERY: Sorry.

MS. KOZENY: That's okay, no problem. My husband's name, so I can't say much about that.

(Laughter.)

DEB KOZENY

Good afternoon, members of the committee. My name is Deb Kozeny, D-e-b, K-o-z-e-n-y. I am a practicing nurse practitioner and co-chair of the practice council for the Nebraska Action Coalition here. I am offering testimony today on belaf of Kelley Hasenauer. Unfortunately, Kelley could not be here today secondary to other commitments, and she is from North Platte, Nebraska.

Kelley is a full-time nurse practitioner and

business owner in North Platte, Nebraska. She supports the removal of the Integrated Practice Agreement requirement with physicians in Nebraska. I am offering testimony on her behalf on the basis of her experience as a clinical preceptor and graduate nursing faculty with the transition of new graduates to practice.

"I have been a licnesed nurse practitioner for almost 12 years. Over that tenure, I have been actively involved in the process of transitioning graduate nurse practitioners to practice. After three years of full-time practice, I began mentoring and training new nurse practitioners as a clinical preceptor, and I have witnessed firsthand their successful transition to practice. I have also been employed as an assistant professor in the Family Nurse Practitioner Program at the University of Nebraska Medical Center. I am currently the APRN representative on the Nebraska State Board of Nursing, although, I must be clear that my testimony is personal today and does not represent the opinion -- necessarily represent the opinion of the Board.

"I would like to address transition to practice for all APRN graduates. I will review the optimal model for ensuring public safety while expanding patient access to APRN-provided health care. I will emphasize the following: All APRNs in Nebraska are educated at the graduate level.

Graduate APRNs are experienced health care clinicians. Graduate APRNs have been trained under the close supervision of experienced clinicians. National certification is required for all APRNs licensed in the state of Nebraska. And, number five, there is no evidence that public safety has been endangered in those states with full practice and prescriptive authority that have no requirement for physician oversight or of new or experienced APRN licensees.

"The National Council of State Boards of Nursing assists state boards of nursing in their quest to protect public health, safety, and welfare. The Board works closely with all national boards of nursing to develop guidelines for licensure and regulation of nursing professionals. In the 2008 report titled, "Consensus Model of APRN Regulation: Licensure, Accreditation, Certification & Education" that has been cited in the application, the Board defines APRN profession and provides a regulatory model for state lawmakers to follow when designing all APRN legislation.

"I would like to focus on the key areas that demonstrate it is safe for all APRNs who have met the requirements for licensure in Nebraska to practice without an IPA. I will refer frequently to the Consensus Model in this discussion, regarded as a flagship for an evidence-based APRN license model. APRN licensure that is in alignment with the Consensus Model for APRN Regulation

ensures public safety by regulating the licensure, accreditation, certification, and education of APRNs. It is important to note that Nebraska licensure requirements, with the exception of the required IPA, already follow or exceed the Consensus Model guidelines. By removing the IPA, we will be in step with these and recommendations by other national authorities, including the Institute of Medicine and the American Association of the Colleges of Nursing that has been cited previously in the course of this application. These organizations collectively recommend that APRNs be allowed to the full scope of their education and ability.

"The following are the key points regarding APRN licensure requirements that ensure that graduates and new licensees are safe to provide care: Only graduates of educational programs that have been nationally accredited and are accepted as -- are accepted as candidates for licensure. National accreditation standards guide the didactic and clinical content of these programs requiring APRN graduate level content in the ares of health assessment, physiology/pathophysiology, and pharmacology. Nation accreditation assures standardization of APRN education, --

MR. MONTGOMERY: One minute.

MS. KOZENY: -- preparing practitioners so they are board eligible. Graduate APRNs are experienced health

care clinicians. They practice as registered nurses prior to completing their graduate education program has been cited previously. APRNs' total clinical time of a new graduate is 2,500 or clinical hours. This includes 800 clinical hours for the BSN-RN graduate, at least three years of RN experience totaling 1,250 to 2,100 hours of patient care, and an additional minimum of 500 hours of clinical time during the APRN program.

"Graduate APRNs have been trained under the close supervision of experienced clinicians who must be currently licensed and in good standing as APRNs or physicians. During these mentorships, APRN students build upon their pre-existing network of collaborative health care colleagues. They learn how to expand their nursing expertise in the advanced clinician role. Once employed, APRNs enter the training or probationary period -- "

MR. MONTGOMERY: Time.

MS. KOZENY: Thank you.

CHAIRPERSON COLEMAN: Any questions?

(No response.)

MR. BASSETT: But we will read the rest of your testimony.

MS. KOZENY: Okay, perfect, thank you. Her testimony.

CHAIRPERSON COLEMAN: No questions?

(No response.)

Okay, thank you.

MR. MONTGOMERY: Next is Dr. Pat Coyle-Rogers.

CATHY PHILLIPS

I'm obviously not Dr. Pat Coyle-Rogers.

(Laughter.)

I am Cathy Phillips. I did previously spell my name. I am presenting testimony on behalf of Dr. Coyle-Rogers who could not be here today. Dr. Coyle-Rogers is in full support of the proposal to remove the Integrated Practice Agreement requirement with physicians. She is the Director of the MSN doctoral of nursing programs at Clarkson College. She is also the past chair of the Commission on Certification, American Nursing Credentialing Center.

This testimony addresses the role of certification/recertification in assuring NP competency. 2008 Consensus Statement affirms the need for continued education of nurse practitioners. The certification/recertification process affirms these outcomes. Competency of NPs, particularly those who may be in solo practice in remote or rural locations is clearly addressed in the existing certification/recertification process.

I will direct your attention to the three-column handout that Dr. Coyle-Rogers provided. It was the second

handout, so that you may take a look at the crosswalk between initial education and certification standards that she clearly spells out.

The third column addresses multiple methods that NPs complete for recertification and maintaining competency, including clinical hours and pharmaco therapeutics.

I want to address -- or Dr. Coyle-Rogers wishes to address the questions posed specifically at the March 1st meeting by Ms. Shickell regarding selection and ongoing support of students. There is information on the handouts as well that addresses excellence in students, both young and seasoned, with respect to admission standards, GPA, experience as an RN, recommendation from employers, the Graduate Record Exam, et cetera, as well as outlining information on nurse practitioner students selection, as well as continued assessment including screening for drug/alcohol/child abuse, commercial drug screen process, et cetera.

Dr. Coyle-Rogers was a bit perplexed by the question, how would NP programs know that the student applicants were either good or perhaps need to screen out disorders such as bipolar or other illness for the competence of NPs entering into the programs. Dr. Coyle-Rogers and the committee also want to assure you that as with all fields, including medicine, there are health

care providers and students suffering with diseases based on chemical imbalances such as diabetes, heart disease, perhaps bipolar disorder, or depression. However, all of these professional schools have admission processes in place that attempt to determine student status with respect to any chemical dependency, mental health, or other general health care issues.

All policy and procedures for professional schools attempt to identify these students, remove them from the clinical site, and also assist them in securing any needed treatment and/or counseling. The State of Nebraska has in place a process for RNs, as well as LPNs and other health care providers to obtain any assistance needed. And Dr. Coyle-Rogers reminds the committee that NP students and graduates are already licensed RNs.

She had also asked to address questions posted online by the committee members, such as those previously answered, so I will not address that. The first question was in regards to NPs taking online courses. That was just addressed by Dr. Julie Sundermeier. I'm simply reiterating that accreditation processes and quality of education evaluation standards are already in place.

The question that I don't believe had been answered yet that Dr. Coyle-Rogers had been asked to be addressed was, could schools hire a physician to supervise

first- and second-year NPs in their practices. Dr. Sundermeier did address the nursing model with components incorporated of the medical model, such as diagnosis and treatment.

MR. MONTGOMERY: One minute.

MS. PHILLIPS: With respect to NP education, national standards are currently in place for certification exams requiring at least 50 percent of clinical time be spent with a nurse practitioner preceptor and require that NP faculty teach the course. Director of programs that are not nurse practitioners must have in place a nurse practitioner clinical coordinator overseeing the curriculum. So the answer would be that a licensed physician does not meet those requirements.

I am appreciative of your time to present this testimony on behalf of Dr. Coyle-Rogers and would certainly attempt to answer your questions on her behalf, but I would most likely defer to the other educators that are in the room.

CHAIRPERSON COLEMAN: Are there any questions?

(No response.)

Thank you.

MR. MONTGOMERY: Thank you.

Dr. Linda Lazure.

Ms. Coleman, members of the Technical Review Committee. I am Dr. Linda Lazure, L-i-n-d-a, L-a-z-u-r-e, former chair of the Nebraska Board of Health, former president of the Nebraska Nurses Association when the 1996 LB 414 was passed, and currently Executive Committee member of the Nebraska Action Coalition. I speak today from the perspective of a former Board of Health member. I served from '97 to 2009, who worked for many years on the Credentialing Reform 2000 committee with several folks in this room, actually, and the subsequent development of the Uniform Credentialing Act enacted in 2008, which combined the common statutory areas from all the health-related professions. There is still unfinished work by the Department of Health and Human Services, including review of some of those professions' specific statutes and regulations. I know the Board of Nursing still needs to review the nursing regulations and completing this review work was one of the reasons that I sought my position on the Board of Nursing currently.

According to the UCA, "The purpose of each board is to protect the health, safety, and welfare of the public." And having said that, the Board of Health members' duties include reviewing and approving regulations emanating from the statutes. In the nursing statutes and regulations, references to consumer health and public safety are

prominent. Nurses involved in framing these statutes and regulations were basing the language on foundational nursing documents and national standards. The Nursing's Social Policy Statement, for example, was initially published in 1980 and defined scope of practice in 2010 when it was published again. Quote, "Although a single scope of professional nursing practice exists, the depth and breadth to which individual nurses engage in the total scope of professional nursing practice are dependent on their educational preparation and self development, their experience, their role, the setting, and the nature of the population they serve."

Like the Social Policy Statement, The Code of Ethics, another foundational document, has undergone changes with the times to reflect contemporary societal needs and practice advancements. For example, "Interpretive Statement 7.2: Advancing the Profession by Developing, Maintaining, and Implementing Professional Standards in Clinical, Administrative, and Educational Practice" has evolved since the initial Code for Professional Nurses was published in 1950 to include self-management and regulation as a hallmark of professionalism. Quote, "Allowing others to mandate the requirements or to establish the boundaries of professional practice does not serve nurses or the patients who benefit from nursing care. Nurses must be the primary architects of

the standards that define professional practice."

Nursing as a profession takes these foundational documents and multiple standards of practice that flow from them very seriously. When I hear continued questions about NP preparation and continued competency, I cringe. Nurse educators have based rigorous content requirements on the sound principles of these foundational documents to assure the public that nurses are educationally qualified and that national evidence-based standards are utilized to assure initial and continued competency to practice. Other testifiers today have spoken to those standards.

I can personally assure you that the 1996 insertion of the IPA into LB 414, the original statute, was not predicated on evidence-based practice, nor was it a validated factor to assure safe care to Nebraska citizens. I did think at the time, however, that the IPA could open the long-closed door to collaborative practice by providing a mere affidavit that the nurse practitioner could identify at least one physician colleague for "consultation, collaboration, and referral."

Within the IPA definition, the nurse practitioner statute defines "collaborating physician" and "supervision." Here's from the statute. "The nurse practitioner and the collaborating physician shall have joint responsibility for patient care, based on the scope of practice of each

practitioner. The collaborating physician shall be responsible for supervision of the nurse practitioner to ensure quality of health care provided to patients. For purposes of this section, collaborating physician means a physician or osteopathic physician licensed in Nebraska and practicing in the same geographic area and practice specialty, related specialty, or field of practice as the nurse practitioner."

MR. MONTGOMERY: One minute.

DR. LAZURE: And "supervision means the ready availability of the collaborating physician for consultation and direction of the activities of the nurse practitioner within the nurse practitioner's defined scope of practice."

This definition of supervision, embedded in the politically expedient inclusion of the IPA, has undergone some unexpected and unfortunate interpretations throughout the years. A primary reason may be that the statutory definitions of IPA and supervision were not included in the APRN Regulations' list of definitions, as they should have been. Instead, both key terms are only tangentially mentioned on page 10 of the APRN Regulations section. I've included that for you, but I will not read that whole thing. You have to go clear down to item E on the third page here to identify that collaborating physician is responsible for supervision through ready availability, et cetera.

I contend that the IPA has undergone misinterpretation from the inception of the rules and regs emanating from LB 414. Because of the lack of precision in leaving the prominent statutory definitions of IPA and supervision out of the definitions, individual physicians and administrative entities have most likely used their own personal definition of supervision to interpret the IPA.

MR. MONTGOMERY: Time.

CHAIRPERSON COLEMAN: Any questions? No questions?

(No response.)

Thanks.

MR. MONTGOMERY: Next is Dr. Mary Cramer.

DR. MARY CRAMER

Ms. Coleman and members of the Review Committee, I'm testifying on behalf of Dr. Kathy Morris today. My name is Mary Cramer, M-a-r-y, C-r-a-m-e-r, and I'm professor at the University of Nebraska Medical Center, College of Nursing and College of Public Health.

"At the March meeting of the Technical Committee meeting, there were questions about nurse practitioner practices and collaborations in rural areas, as well as questions about the competency of NPs who are practicing in rural areas. I regret that I am unable to attend the session today, but I have been asked -- I've asked my former

Department Chair, Mary Cramer, from UNMC College of Nursing to read my testimony in response to the committee's concerns.

"I am a family nurse practitioner. I've been practicing in rural, critical access hospitals since 2004 in Nebraska and Iowa. Specifically, I've practiced in critical access hospitals in Clarinda, Iowa, Hamburg, Iowa, and Shenandoah, Iowa. I have also practiced in the critical access hospital in Falls City, Nebraska. Currently, I practice in five emergency rooms in the metro Omaha/Council Bluffs areas through the Alegent/Creighton Health System. I would ask the Technical Review Committee to note that because of my multiple practices in Nebraska, I am required to have an Integrated Practice Agreement for each of those five sites, an example of the barriers created by the current Nebraska statutes for NP practice and which do not exist in Iowa.

"I am also assistant professor at the University of Nebraska Medical Center, College of Nursing, and serve as the area coordinator for the UNMC Family Nurse Practitioner Program which is the largest of our NP programs with over 100 students enrolled. I'm a fellow in the American Academy of Nurse Practitioners and I have served on the Academy's national board. In my role on the Academy board, I participated in a multidisciplinary task force of

providers, including emergency room physicians and together we developed and approved the competencies for NP entry level to practice as regard their work in the emergency room. The American Nurses' Credentialing Center, our national certifying body, will develop the new certification exam for our emergency NPs, which will validate their competency in this area."

For time, I'm going to skip to another paragraph to avoid redundancy.

"I'd like to specifically address the committee's concern regarding ongoing and continuing competency of NPs. All of the sites that I practice in, rural and metro, follow strict standards for required competency demonstrations and/or successful completion of courses. As a practicing NP, I'm also required, as part of maintaining my national board certification, to engage in continuing education in my specialty and as offered by national organizations that are specific to my specialty as a family nurse practitioner in emergency care. These educational requirements are established by our national accrediting and certification bodies and benchmarked against competency standards.

"I'd like to specifically address the committee's concerns about NP collaborations as relates to my rural practice in critical access hospitals. I have admitting privileges at both city critical access hospitals. When I

staff the ER, it is a hospital and Medicare requirement that I communicate with my physician backup whenever I admit or transfer a patient. Like all health care providers today, NPs are educated to work on teams and we believe collaboration with physicians and other providers is an essential component of all quality health care. And new technologies are providing even more opportunities for interprofessional collaborations in rural areas. For example, the trauma camera, which is becoming more common in critical access hospitals, can be used not only during trauma, but for stroke evaluation. And we even have the burn center evaluate a burn and recommend treatment. I have used these technologies many times to collaborate on such cases with specialists in hospitals in Omaha and Lincoln."

MR. MONTGOMERY: One minute.

DR. CRAMER: "This may include the cardiologist, neurologist, or emergency physician.

"Interprofessional collaborations, physician-to-physician, nurse practitioner-to-physician, produce positive outcomes for patients and that should be everybody's top priority.

"I would ask you to consider that it is not my integrated practice agreement with a physician that tells me what to do. Rather it is because I am educated to practice

my specialty, I have passed national board certifications to ensure my competency, and I practice under my own license and within my proscribed scope of practice. Thus, I know the appropriate action to take and when to refer or consult just as my collaborating physicians in rural practices know when they, too, should refer or consult with specialists."

And her testimony says that I will answer questions, but I probably will not.

(Laughter.)

CHAIRPERSON COLEMAN: I just have a question just for clarification.

DR. CRAMER: Yes.

CHAIRPERSON COLEMAN: Did you indicate that Medicare requires you to have a collaborative arrangement in a hospital?

DR. CRAMER: Her testimony says, and I am not a nurse practitioner, her testimony says, "When I staff the ER, it is a hospital and Medicare requirement that I communicate with my physician backup whenever I admit or transfer a patient." It's communication.

CHAIRPERSON COLEMAN: I thought that's what you said. I did not know that about Medicare, but I don't deny it's probably true.

MR. NAIBERK: Can I ask a question of clarification, and whoever can answer can answer. She

referred to the fact she had to have multiple IPAs because she had multiple practice sites.

DR. CRAMER: Yes, she does. In Nebraska.

MR. NAIBERK: In Nebraska. So, I guess my question is, doesn't it say geographically in the -- what's the definition of having an IPA with a physician geographically to their practice site, because if she's in Falls City, and she's also practicing in Omaha, and what's the guideline on that? It's just out of curiosity, because I've worked with nurse practitioners before and we've gone through that, and I just kind of want to know what the current thought process is as far as licensure goes.

MS. HOEBELHEINRICH: I think I understand what you're asking.

MR. MONTGOMERY: Please identify yourself.

MS. HOEBELHEINRICH: One of the issues with the Integrated Practice Agreement is -- and the language is readily available. It also says, within a reasonable proximity. But the miles that you are from your collaborating physician are highly variable. I'm thinking there are 70 miles -- there are nurse practitioners -- we have -- and you'll hear later from someone in the group here who is -- lives in Scottsbluff and is being asked to consider an Integrated Practice Agreement with an Omaha psychiatrist, so there are -- there's tremendous variability

in that. As to why she may have five is that collaborating physician may only be willing to cover her practice in one ER.

MR. NAIBERK: That's what I wanted to -- thank you.

DR. CRAMER: And the highlight was that she practices in Iowa, as well, where she is not required to do that.

MR. NAIBERK: Right, thank you.

CHAIRPERSON COLEMAN: Other questions?

(No response.)

Thank you.

MR. MONTGOMERY: Next is Ginger Brasuell.

GINGER BRASUELL

Ms. Coleman and members of the Technical Review Committee, my name is Ginger Brasuell, G-i-n-g-e-r, B-r-a-s-u-e-l-l. I am a psychiatric mental health nurse practitioner and I am obviously here today in support of doing away with the IPA requirement to practice as a nurse practitioner in this state.

I am a practice owner in Scottsbluff, Nebraska, for the past four years. I have been in practice in since 2001 with no revocations, limits, restrictions, or suspensions on my license. I'd like to talk to you a little bit about my practice and kind of talk to you about how

these arrangements work, or do not work in my case, in a rural area. My caseload consists of severely and disabled mentally ill people. I believe if we still had state hospitals, a big share of my patients would be living in those hospitals, so I am trying to take care of these people in the community, which is what we did with our sweeping legislation here a decade or two ago.

Probably three fourths of my patients have Medicare or Medicaid. Up to 25 percent of my patients I see on a pro bono basis. They have no payer source. They have tried to get disability, maybe are still trying to get disability. Some have been turned down so many times that they've given up. So they have no means of getting the mental health care.

I worked at a community mental health center up until 2009. I have had different collaborative agreements. The gentleman I collaborated with at that time, when I would ask him a question, he would say, "You know what you're doing. Keep on doing it." So that was the course of the collaboration there. When he left the mental health center, the care of 600 patients fell to me. I don't know if you have the expression "scarcer than hen's teeth" out here in Lincoln, but that's what psychiatrists are in the Panhandle. At that time, there were two that worked for Regional West Medical Center and there was another gentleman who was in

private practice. The gentleman in private practice agreed to take me on and do a collaborative agreement with me. His approach was considerably different, because he wanted me to bring in charts and then tell me how to prescribe medications for the patients. So his idea of supervision, I think is more like the lady talked about, it was like a clinical setting. And, I don't know, we didn't understand each other too well on that. When he retired, I sought an agreement with the physicians at Regional West. Their policy is if you don't work for Regional West, they won't collaborate with you.

During this time, I was fortunate enough to meet a psychiatrist from Fort Collins, Colorado, who is -- specializes in affective disorders. He's also an assistant clinical professor of psychiatry at George Washington University School of Medicine and a recognized authority in the treatment of affective disorders. So I had an unofficial collaboration with him. He was always available to me for questions and would even take my referrals --

MR. MONTGOMERY: One minute.

MS. BRASUELL: -- for a nominal fee.

Fort Collins is 150 miles from where I live. Unfortunately, he's not licensed in Nebraska. Dr. Kelly is not, so he won't qualify for a collaborating physician. I am currently in the process of trying to get him licensed in

the state of Nebraska. By the time we do the license and all the transcripts, it's going to cost about $500. But I've worked on several waivers and I know the Board is running out of patience with me on the waivers, so that seemed to be the next best thing to do.

The rest is here for you to look at at your leisure. I appreciate your time, and I'll answer any questions if I can.

CHAIRPERSON COLEMAN: Are there some questions?

MR. BASSETT: Isn't there anyone this side of Colorado or Wyoming, Bridgeport or Ainsworth or Alliance?

MS. BRASUELL: A psychiatrist. I have to have a psychiatrist. It has to be in my specialty.

MR. BASSETT: And there aren't any out there?

MS. BRASUELL: There are -- well, now three. Three psychiatrists work at Regional West. I think someone is going to give you the statistics on what the actual percentages are in -- throughout the state. And it shocked me. I knew it was bad, but I had no idea that bad.

The other thing, I'm 32 miles from Wyoming, Torrington, Wyoming. I could drive 32 miles and practice there without a practice agreement. That's not going to help the people in the Panhandle. Also, I could travel to Fort Collins and work for Dr. Kelly, but that also won't help the people in the Panhandle. So I'm just going to try

to make it work.

CHAIRPERSON COLEMAN: Other questions?

DR. SHICKELL: Just a comment. I want to say that's a wonderful thing you're doing to see them pro bono.

CHAIRPERSON COLEMAN: It's hard to live on pro bono, though.

DR. SHICKELL: Are there a lot of homeless out there, too?

MS. BRASUELL: Yes. You'll notice in my notes, I have people that live at the KOA campgrounds. That's homeless, as far as I'm concerned. And then I have a couple that got housing for the homeless through some block grants, so yeah, it -- the ones that aren't incarcerated, and we've got those, too.

CHAIRPERSON COLEMAN: Other questions, comments?

(No response.)

Thank you.

MS. BRASUELL: Thank you for your time.

MR. MONTGOMERY: Next is Cindy Matson.

CYNTHIA MATSON

Good morning Ms. Coleman and members of the Technical Review Committee. My name is Cynthia Matson, C-y-n-t-h-i-a, M-a-t-s-o-n. I have dual certification as a family and psychiatric mental health nurse practitioner. I am employed by the University of Nebraska at Kearney as the

Associate Director of Student Health.

I support the proposal by the Nebraska Nurse Practitioners to remove the Integrated Practice Agreement requirement with physicians. I am offering testimony today on the basis of my personal experience as a nurse practitioner with the IPA, not as a representative of UNK. As a family nurse practitioner, I would like to respond to concerns voiced by the Technical Review Committee regarding the initial and ongoing competency of nurse practitioners, as well as our ability to develop effective relationships with other providers and health care professionals for consultation and referral outside hospital-based networks. Most recently, the IPA has posed a significant barrier to my entry into practice as a newly certified psychiatric mental health nurse practitioner.

As a graduate family NP six years ago, I was employed at Ravenna Medical Clinic, a hospital-owned family practice clinic in a rural setting. My collaborating physician there was a wonderful, collegial man with over 20 years of emergency room experience. He was in the clinic two days a week, so the remaining time, I was the only provider on site to care for patients. Hospital billing staff periodically reviewed our clinical records for compliance with billing and coding protocols. No one audited my charts or monitored my practice decisions, nor

was there an established process or protocol to do so that I was aware of. If I had questions, I called the collaborating physician. I also called upon and made referrals to other physicians and specialists that I had developed working relationships with as a registered nurse in my previous 12 years of practice. At the same time, my IPA physician would come to me with questions for areas that were outside of his usual practice or comfort zone, such as women's health and routine pediatric care. We had a truly collaborative working relationship, not because it was mandated in statute by an IPA, but because we respected each other as clinicians.

I am currently responsible for the daily operations of the Student Health Clinic on campus that serves approximately 2,700 students and we see over 10,000 patients every year. My IPA for the family practice over the past four years is with a physician who has contracted with the University as the Medical Director for Student Health. He is employed in a nearby private clinic practice and has no on-site clinical responsibilities at the college. He does not review my charts, nor does he provide any oversight regarding my practice decisions. My IPA has no impact on my ability to make competent decisions in the daily course of my clinical patient care.

In 2009, after our consulting psychiatrist

resigned from the University, I was asked to consider additional graduate education and certification as a psychiatric mental health nurse practitioner by my University. Last year, after completing a post-masters certificate, I began the process of searching for a psychiatrist to enter into an IPA. I contacted six psychiatrists across the state and was denied by all but one individual who wanted $6,000 annually to perform that service. I subsequently sought a practice waiver from the APRN Board and was denied on the basis of not having demonstrated due diligence in my attempts to locate a collaborating physician. I made additional contacts with psychiatrists at the University of Nebraska Medical Center and Creighton University, and was again denied an IPA. In December of 2012, I successfully appealed to the APRN Board and was granted a one-year practice waiver.

I work with a student population that is high risk for mental health problems within an underserved area in the state. Many, if not most, of our students do not have the financial resources to access off-campus care. Most do not have any idea how to navigate the health care system outside of the student health services of the University. We also do not have budgeted funds for a consulting psychiatrist, as we had in the past or to pay fees associated with an IPA.

Psychiatrists at a local hospital will not enter

into a practice agreement with outside providers citing a no-compete agreement. They will, however, accept patient referrals if the acuity is beyond what I determine can be safely managed on an outpatient basis.

MR. MONTGOMERY: One minute.

MS. MATSON: I have also developed excellent working relationships with other experienced psych NPs who are available to me for consultation. It needs to be understood that as a family NP, every medication or treatment decision that I would be making as a psych NP falls under my scope of practice as a family NP. This has been a very frustrating experience over the past year and consumes time and resources that would be better spent caring for my patients.

Throughout my years of experience as an RN and then as a nurse practitioner, I have developed an extensive network for referral and consultation, including physicians and other health care professionals, all of whom I work with closely to make sure that my patients receive the best possible care. At the same time, other providers request consultation and make referrals to me on the basis of the clinical services and expertise that I offer. I thank you for hearing my testimony and would be happy to answer any questions that you have.

CHAIRPERSON COLEMAN: Questions?

(No response.)

Thank you.

MR. MONTGOMERY: Next is Connie Benjamin.

CONNIE BENJAMIN

Good afternoon, Chairperson Coleman and members of the Nurse Practitioner's Technical Review Board. I am Connie Benjamin, C-o-n-n-i-e, Benjamin, B-e-n-j-a-m-i-n. I am State Director for AARP in Nebraska. And if you can't tell, I have a sore throat and a cold and I sound a little bit like a frog, so bear with me, please.

I am pleased to have this opportunity to be here today to provide comments. My comments, in part, were prepared by staff at our national office for AARP in Washington, D.C., where we have the center to champion nursing in America.

AARP is a non-profit, non-partisan membership organization for people aged 50 and older. We have 202,000 members in Nebraska. We are committed to advocating for access to affordable, high quality health care for all generations.

AARP strongly supports the removal of the Integrated Practice Agreements between physicians and advanced practice nurses. Doing so will increase consumers' access to health care by supporting and allowing utilization of NPs.

I'm going to skip a paragraph and come back to it later.

A recent report from the National Governors Association, *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care,* recommends that states consider easing their scope of practice restrictions on nurse practitioners emphasizing their role and the growing demand for primary care. This recommendation supports the 2011 Institute of Medicine evidence-based report, *The Future of Nursing: Leading Change, Advancing Health,* which calls for changes at the state and federal levels to help increase consumers' access to care by enabling nurse practitioners to practice to the full extent of their education and training.

The current mandatory supervision required between physicians and nurse practitioners can often delay care to consumers, especially in rural and urban underserved areas where there is a lack of available physicians with whom the nurses can collaborate. In rural Nebraska people age 65 comprise a significant percent of the population. For example, I grew up in Garfield, Nebraska, which has 27 percent of its population aged 65 and older. Based on surveys and anecdotally, we know that older adults want to receive their health care in their community. According to a 2008 AARP Nebraska survey, 84 percent of members surveyed

felt it was extremely important or very important to be able to have services that would enable them or the family member to stay at home as long as possible. This desire to age in place requires that there be access to health care locally, and nurse practitioners can greatly help to meet this need.

Many of Nebraska's health care consumers get the following services from nurse practitioners: assessment and diagnosis of conditions, prescriptions, and referrals to specialists. AARP Nebraska supports the removal of IPAs, because it will improve consumers' access to care by reducing the waiting time for such care. Decades of evidence demonstrates that NPs provide a high quality health care to consumers, as do physicians. This high quality of care is evident whether or not the NPs are supervised or have written IPAs with a physician. As you've heard, there are surrounding states, such as Colorado, Iowa, and Wyoming who have provided care for years without mandatory physician supervision.

AARP Nebraska is deeply appreciative of the primary care and chronic care management provided by all clinicians. We need to be certain, however, that our members and all health care consumers can access a primary care provider when and where they need one. Removal of IPAs would ensure such access to such care.

Thank you for the opportunity to be here today and

provide these comments. Are there any questions?

CHAIRPERSON COLEMAN: Questions?

How many AARP members in Nebraska do utilize a nurse practitioner?

MS. BENJAMIN: I do not have that data. That would be a good question for a next survey, but I'm guessing that we're going to see more and more need for that in the future with the aging population, boomers aging. The huge waiting lists that we're beginning to see in some of the larger areas for people on Medicare to find a primary doc, I think that's going to become a bigger need in the future for sure. But that would be a good survey question for us in the future.

CHAIRPERSON COLEMAN: Other questions?

(No response.)

MS. BENJAMIN: Thank you.

MR. MONTGOMERY: Next is Kristi Eggers.

KRISTI EGGERS

Good afternoon, Ms. Coleman and members of the Nurse Practitioner Technical Review Committee. My name is Kristi Eggers, K-r-i-s-t-i, E-g-g-e-r-s, and I'm a family nurse practitioner in Sutton, Nebraska. I am here today to offer support of the proposal by the Nebraska Nurse Practitioners to remove the Integrated Practice Agreement requirement with physicians. My testimony is based on my

experience as a rural nurse practitioner practice owner.

I was recruited to work in a hospital-owned rural health clinic in Sutton in 2005 as a new nurse practitioner graduate. I was initially interviewed by the hospital and then subsequently by the community. A community economic development group had taken an active approach to attracting a primary health care provider to the community and they were looking for a good fit. The clinic building had been purchased and abandoned several times in the previous years. In 2005, the Economic Development Corporation insisted on being involved in the selection of the provider. They negotiated with the hospital insisting that the provider would live in Sutton rather than commuting in from another community.

When I arrived in Sutton, there was a rural clinic with a part-time provider and a nursing home. There was no other health care resources. Today, there is a pharmacy, a physical therapy office, chiropractic office, optometry, massage therapy, and a fitness center, which have all evolved in the last five years. These businesses are all locally owned and operated.

In October 2012, I resigned my position with the hospital. The community advocated for me to stay in Sutton. Many letters and calls of support poured out from the people in the community. There was concern from individuals as

well as business owners who were concerned that if I left the community, the other health care resources in town would be affected. The Economic Development Corporation terminated their lease with the hospital and offered the lease to me if I would consider going into private practice and staying in Sutton. I knew that I wanted to remain in the community, but owning a private practice was a lot of risk. My primary concern was being able to obtain an IPA. Previously, I'd had my agreement with hospital-employed physicians, and that was now no longer an option. I was able to obtain an IPA from a retired physician on a temporary basis with the understanding that he was going to be leaving the state. It was quite concerning to consider taking on the risk of a new practice without the long-term IPA in place. After many discussions with community members, I decided to proceed. The community was anxious to support me in maintaining a practice. There was a concern that those who had established care over the last eight years would go to another community for their medical needs, in turn for their medications and also their therapy. They would be more likely to patronize other businesses than those in our local community.

I applied for a small business loan and grant through the LB 840 funds. The LB 840 committee met and reviewed my business plan, pro forma, and recommended to the

city council that I receive $50,000 low interest loan in addition to a $40,000 grant. The city council voted unanimously in favor. The local bank got involved and provided additional loan funds as needed. The Economic Development Corporation offered me low rent and also provided much needed construction and remodeling for the building.

I hired a consulting firm to help me with the startup of the practice, specifically with the legal and technical components of starting a practice. I spoke with other private practice NPs to find out that many were paying for the IPA agreement. One was paying a percentage of her practice revenue, another $3,000 per month. The consultant group recommended that I budget for $1,000 to $2,000 per month to fill this requirement. I knew that I would have my current IPA in place until the end of January, but after that, I was unsure if I would be able to find someone to do the agreement or if I would be able to afford it. I contacted a physician that had previously lived in a nearby rural community. I explained that I was going to open a practice and inquired about his interest in carrying the IPA --

MR. MONTGOMERY: One minute.

MS. EGGERS: -- as well as supervision for the PA that was also in our practice. He was interested in coming

back to a rural community. I hired him on an hourly basis. We opened the practice December 10th and he is my collaborating physician fulfilling my IPA as well as the supervisory agreement needed for the PA. He has since moved to Sutton. We are available to each other by clinic or by phone. We have started preliminary discussion about becoming true business partners and owning the practice together. I believe it's important for health care providers to have a personal interest and feel connected in a rural community.

Having adequate consultation and referral sources was a concern for me when starting a practice; however, it has been a very positive experience. I utilize several area health care facilities and specialists. I've developed relationships with a number of specialty physicians.

MR. MONTGOMERY: Time.

CHAIRPERSON COLEMAN: Any questions?

(No response.)

MS. EGGERS: I didn't give you a copy, did I?

MR. MONTGOMERY: No.

MS. EGGERS: How about after the fact?

CHAIRPERSON COLEMAN: Thank you.

MR. MONTGOMERY: Thank you very much.

Sharon Gossman. Please forgive me if I fracture these names.

SHARON GOSSMAN

MS. GOSSMAN: Good afternoon, Madam Chairman and members of the committee. I am Sharon Gossman, S-h-a-r-o-n, G-o-s-s-m-a-n. I am the president of Nebraska Nurse Practitioners. I want to acknowledge those that have made significant adjustments in their work schedules and taken the time to prepare testimony on behalf of Nebraska Nurse Practitioners in support of the proposal. I'm also very appreciative of the time that the Technical Review Committee has voluntarily offered in this credentialing review process.

I want to briefly comment regarding those nurse practitioner colleagues that declined to offer testimony today on the basis of their fear of repercussions such as the loss of patient referrals or the risk of the solvency of their IPAs. I respectfully ask the Technical Review Committee to consider the responsibility that we as the applicant group have undertaken in this credentialing review endeavor. Fear of change should never motivate reluctance to speak or to pursue needed change, but for some, it has.

With that in mind, my testimony today is in response to the question raised by Mr. Bassett, specifically, if we had a crystal ball, do we anticipate more changes in rural than urban clinical practice? The short answer to that is, probably not. The more accurate

response is that change in all practice locations is the more certain inevitability as we prepare for our state's share of the estimated 38 million newly insured Americans. We anticipate the progressive demise of fee for service to patient-centered, interdisciplinary team models that reward providers and their patients with clinical outcomes and not just services.

For the record of this hearing, I would like to submit the following comments from letters that we have received that offer a sampling of how nurse practitioners are and will be utilized in various models of care in the state. Those are attached. I will just summarize some statements from them.

The first is from Christie Hinrichs, president and CEO of Tabitha Health Services. She describes their experience with nurse practitioners as "overwhelmingly positive including treatment plans in hospice, palliative care, long-term care, post-acute rehabilitations, memory care, and assisted living."

Rhonda Herrick from Franklin County Memorial Hospital and Rural Health Clinics, Board of Directors, says, "As a member of the board, we know that without this group of outstanding medical providers," referring to the NPs that they employ, "we would not be able to keep our doors open."

Carrie Jensen Budd, Gentiva Home Health, writes

that NPs "manage the patients care and coordinate care. They provide follow up after discharge from the hospital or facility in a timely fashion, and often are able to keep the patients out of the hospital."

Cathy Clark, NP, says that 75 percent of emergency room coverage in Bassett, Nebraska, is provided by NPs. Bassett is 48 miles from the nearest hospital that provides delivery services, and they rely heavily on NPs for prenatal and postpartum care. She states that "It would be a severe hardship and expense for these young mothers to commute for prenatal and postpartum visits."

Bill Brush, rural employer and president of the Loup Basin Public Health Department for nine counties states that "for many years, I have attempted, without success, to organize a rural community health plan. Residents of this state need to have the option of receiving primary care from nurse practitioners that are not required to be affiliated with a hospital or physician system."

Jon Bailey, Director of Rural Research and Analysis Program Center for Rural Affairs cites the unique care needs of rural residents in the state and the emerging, consistent support for a broad, holistic approach to care coordination, including health care homes that utilize a team of health care providers. He says, "Nurse practitioners are excellent choices to lead rural health

care homes."

In closing, I would like to reference the American Hospital Association report that was released this past month. Mr. Naiberk, I'm sure that you're familiar with that report. It's entitled *Ensuring a Healthier Tomorrow: Actions to Strengthen our Health Care System and our Nation's Finances.*

MR. MONTGOMERY: One minute.

MS. GOSSMAN: The AHA points out that new delivery models hold the promise to improve care; whether that will be medical homes, combining hospital, physician and/or post-acute services reimbursement into a bundled payment; or forming accountable care organizations or some other variant of team-based care. New and innovative models cannot be implemented and thrive without removing legal and regulatory barriers that stand in the way of allowing hospitals, doctors, and other providers to work together.

The AHA joins the Institute of Medicine and the National Governors Association with specific recommendations to "Permit non-physician providers -- practitioners, excuse me, or NPPs, to practice to the full extent of their training." The implication for NPs in the State is clearly the removal the IPA.

The team approach in health care falls short of patient-centeredness as long as the discussion is just about

spreading the workload or who is in charge of the care that is being provided. Patient-centered care is ensuring that the consumer has access to the provider that is most qualified and in the best position to provide care at the time needed.

That concludes my remarks and I will entertain any questions.

CHAIRPERSON COLEMAN: Questions?

(No response.)

Thank you.

MR. MONTGOMERY: Next is Nancy Gondringer.

SANDRA BORDEN

Good afternoon. My name is actually Sandra Borden. S-a-n-d-r-a, B-o-r-d-e-n. I'm reading the testimony of Sara Theoharis, certified registered nurse anesthetist. She is president of the Nebraska Association of Nurse Anesthetists.

"I truly regret not giving this testimony in person, as this is such a critical day for our fellow advance practice registered nurses, the nurse practitioners.

"In my hometown of Hastings, our medical facilities draw from a large area of Nebraska, Benkelman to Fairbury, even down into northern Kansas. Many of these small communities have no physicians. Without nurse practitioners, access to care would be extremely limited.

This is easily visible to me as I periodically travel to these one-operating-room hospitals that sporadically need anesthesia care. Every hospital and surgery center requires each patient to have a history and physical prior to having any procedure done. More than half of these preoperative evaluations are completed by nurse practitioners. The small townspeople surrounding Hastings and so much of Nebraska rely on these nurse practitioners for their health care and wellness education.

"Nurse practitioners across the country have difficulty getting a physician to supervise them, thus limiting their work and the primary care needed by so many Americans, especially in rural settings. We would not have a Convenient Care Center in Hastings if it were not for nurse practitioners. They took the initiative to open it, which has been a blessing, not only for our overcrowded emergency room, but also to our community. As busy as the urgent care center is, it has had plenty of problems staying open as physicians have minimal incentives or aren't even willing to take the additional time to cover the nurse practitioners that work there.

"The certified registered nurse anesthetists of Nebraska have been granted independent practice as well as the supervision opt-out. Approximately 360 CRNAs in Nebraska work in 99 percent of the hospitals and surgery

centers across the state. Of the 93 counties in Nebraska, 83 rely solely on CRNAs for anesthesia service. In 2010, *Health Affairs* provided research showing that anesthesia care by a CRNA alone is equal in quality to all other anesthesia practice models. The researchers studied Medicare data from 1999 through 2005, which found 'no evidence that opting out of the oversight requirement resulted in increased inpatient deaths or complications.' In June 2012, the *Nursing Economics* journal published research stating the most cost-effective anesthesia care model is a CRNA. Historically, nurse anesthetist programs have continued to graduate nurse anesthetists ready to provide high quality anesthesia services in any practice situation, especially in rural settings. I believe the nurse practitioner programs have followed suit. I agree with the Institute of Medicine's recommendations and strongly support nurse practitioners and all nurses in using their full potential and practicing at their peak scope of practice."

Thank you for your time.

CHAIRPERSON COLEMAN: Any questions?

(No response.)

MR. MONTGOMERY: Kathy Hoebelheinrich.

KATHY HOEBELHEINRICH

Ms. Coleman, members of the Technical Review

Committee, as you know, I am the chair of this group. My name, K-a-t-h-y, H-o-e-b-e-l-h-e-i-n-r-i-c-h. And like everyone before me, I support the proposal at hand. I'm here to respond to specific questions about evidence and risk of malpractice insurance claims for both nurse practitioners and physicians in practice agreement relationships.

Two specific questions. Ms. Coleman, you asked regarding the implications for malpractice liability.

Mr. Bassett, your inquiry was the evidence of claims in those states that have independent practice, or as we prefer to call it, full practice authority for nurse practitioners. And specifically you asked, "What is the experience, is there a problem in those states?"

There were several written questions on the website that were -- also echo these concerns. And of those, the last asked regarding insurance rates, and I've inserted malpractice in front of that, because I assume that was the question.

I have four points regarding malpractice risk. Growth in the frequency and severity of claims against nurse practitioners is attributed to increased risk exposure parallel to legislative trends and advancing standards for independent practice.

Two, data collected from nurse practitioners named

in claims is not state specific, but rather identifies overall liability patterns and trends for the development of risk management strategies.

Demographic profiles and workplace attributes for nurse practitioners experiencing claims are nearly identical to those who do not.

Mandated collaborative relationships with physicians, such as the IPA, increase the risk of claims against physicians, and do not offer the consumer of any assurance of greater safety or competency from nurse practitioners.

As previously detailed in the application, and we've provided you there with evidence of lower rates of malpractice claims for nurse practitioners in states that do not require physician supervision. There's a second study cited there as well.

In a recent Nurses Service Organization publication, one of the nation's largest professional liability insurance programs for nurse practitioners and their underwriting partner, CNA commented on the rising rates of malpractice insurance for all health care professionals. They note that the rising number of reported claims against nurse practitioners drives up expenses related to defending insureds. And according to them, almost every nurse practitioner has felt this impact by

seeing their individual premiums go up, and that would be the response to the question regarding the increase in malpractice rates.

In the CNA/NSO report, and that was just released last October, the average paid indemnity, those monies that are paid on behalf of an insured practitioner in the settlement or judgment of a claim, had increased by 19 percent since the last study in 2009. And that 2009 report is the one that we cite in our application. NSO notes that these changes parallel legislative trends and advancing standards for independent practice, which has particularly accelerated over the past 10 years. NPs have experienced increased collaboration and autonomy. They have less direct supervision. Prescriptive authority has increased, and more insurance providers are recognizing and reimbursing NPs as primary providers.

CNA/NSO concludes the increase in demand for services and the advancement of the ability of NPs to practice to the full extent of their scope, there is no question that they will face more malpractice risk.

Regarding the patterns and trends, and again the data conducted in the study is not particular to any particular state. The intent is that nurse practitioners use that data to examine their practices carefully and direct their risk control efforts towards the areas that are

statistically -- demonstrate error and loss in that study.

They look at three areas. Nurse practitioner specialty and location. As you would expect, the numbers named, 75.5 percent are in adult and family practice settings, and that parallels those nurse practitioners that are not involved in suits.

Allegations. And I'm not going to read this on a blow-by-blow basis, but 96 percent of the closed claims are diagnosis, treatment and care management, and medication prescription. Scope of practice claims did not make the top five. Those were at 0.5 percent and fall outside, as I had mentioned.

Similarly, I did survey, by email and phone call, boards of nursing in surrounding states and one of the questions was, is there any comparison for states that are rural, like Nebraska, and I went to those around us, Colorado, Wyoming, Montana, North Dakota, and Iowa, report no change in disciplinary rates related to malpractice or scope of practice complaints.

Injuries are reported. It should be no surprise that the most common injury that results in litigation is death.

MR. MONTGOMERY: One minute.

MS. HOEBELHEINRICH: Risk management recommendations. Rate action along is a short-term

solution. CNA/NSO offers substantial categorized recommendations, and in going with this, I think the best summary of how the nurse practitioner integrates that in her practice, and I've submitted a letter from Janell Grant in Alliance, Nebraska. And Janell does a wonderful job of articulating and describing her population.

Third, demographic profile and workplace attributes. Of those that they looked at, the most significant -- and you'll be able to read this. I won't get through all of it. But the most significant finding of the four is that 73 percent of respondents who had experienced claims had practiced for more than 11 years.

And I've got Topic 2 regarding demographics practice profile. And again, I list those there for your reference.

The last point that I want to make -- and this is based on the case law analysis that Carolyn Buppert submitted to us, and it's posted on the website. Three points. It is advantageous for collaborating physicians to avoid being involved in the care of patients being evaluated and managed by NPs. Collaboration/consultation does not appear to shield NPs from litigation or being found liable. If there is no mandate for collaboration, NPs may be more likely to utilized a formal referral process to physicians, which is the safest for all concerned.

And then finally --

MR. MONTGOMERY: Time.

MS. HOEBELHEINRICH: -- is a reiteration of the four point. I'll end here. And are there any questions?

CHAIRPERSON COLEMAN: Any questions?

(No response.)

Okay, thank you, Kathy.

MR. MONTGOMERY: Tara Whitmire.

TARA WHITMIRE

Ms. Coleman and members of the Technical Review Committee, good afternoon. My name is Tara Whitmire, T-a-r-a, W-h-i-t-m-i-r-e. I am a nurse practitioner and the public relations chair for Nebraska Nurse Practitioners. I am offering support for our proposal.

I will specifically address the questions posed by Dr. Shickell regarding the legislative initiatives that NNP sees as the fallout of our proposal to remove the Integrated Practice Agreement. Again, I wish to clarify that we are not seeking any change or expansion in our current scope of practice. We do not anticipate any legislative initiative subsequent to this credentialing review to change the scope of practice as it is written in the Nebraska Nurse Practice Act. Our intent with the removal of the IPA is full practice authority as explained previously by my colleague, LeAnn Holmes.

As noted by Kelley Hasenauer's testimony, our pursuit of full practice authority is consistent with recommendations by the Consensus Model for APRN Regulation endorsed by the National Council of the State Boards of Nursing. We will always strive for alignment at the state level with the evidence-based national models like the NCSBN Consensus Model as the best assurance of public safety and practice.

At the present time, we have identified several legislative and regulatory priorities that must be addressed, at least incrementally, many at the federal level, if we are to realize full practice authority in this state. The following pose additional barriers to practice:

No. 1, Medicaid restrictions for full prescriptive privilege for durable medical equipment, such as walkers and canes, supplies like gauze and wound supplies, and services like physical therapy.

No. 2, the failure of Medicare to define nurse practitioners as primary providers in accountable care organizations. Medicare also does not authorize NPs to order home health services and hospice care.

No. 3, Medicare reimbursement parity with physicians for equivalent services.

And No. 4, definitions of physician services by private insurance carriers that fail to include NPs as

providers of reimbursable services.

To explain these barriers further, at the February 1st meeting, Cathy Phillips, NNP legislative chair, noted that we are actively addressing the regulatory barrier imposed by Medicaid related to nurse practitioners having full prescriptive privileges for ordering durable medical equipment, as I said, like walkers, canes, wound vacs, supplies and therapies. We reached out to Vivienne Chaumont, the director of Nebraska Medicaid, for clarification and discussion related to Nebraska's interpretation of Medicaid regulations. The full text of that discussion, entitled, "February 1st, 2013, Cathy Phillips Letter," is available on the Credentialing 407 Review website.

At this time, it appears that the substance of the issue is related to the state's interpretation of Medicare restrictions related to home health services.

At the federal level, there are several issues that are being addressed by our parent organization, the American Association of Nurse Practitioners and their legislative team. Our role is participatory and we will follow their lead for educating and informing our congressmen at critical junctures. These issues, again, are related to the accountable care organizations and home health and hospice services. A bill will be introduced in

the near future into the 113th U.S. Congress to allow nurse practitioners to order and document home health care and hospice services.

Also, Medicare reimbursement parity with physicians has been previously addressed in the credentialing application. All providers are caught in the uncertainty surrounding sustained reimbursement fee-for-service rates. Glenn Hackbarth, the chairman of the Medicare Payment Advisory Commission, the independent commission that advises Congress on Medicare policies told a House subcommittee on March 15, 2013, that "nurse practitioners are a necessary part of dealing with our primary care issues. We have not taken full advantage of their capabilities" of NPs and other providers, "and frankly I think we're going to have to." Hackbarth went on to --

MR. MONTGOMERY: One minute.

MS. WHITMIRE: -- tell legislators it may be possible for Congress to increase payment for primary care services as part of reform legislation.

That concludes my remarks. I want to acknowledge the service of the Technical Review Committee in this credentialing review, and I'm happy to respond to any questions.

CHAIRPERSON COLEMAN: Questions?

MR. BASSETT: Tara, where are you from?

MS. WHITMIRE: Omaha.

MR. BASSETT: That was a tough question, wasn't it?

(Laughter.)

MS. WHITMIRE: I'm used to patients always asking me, so I always have to say I'm from Storm Lake, Iowa, but I live in Omaha right now.

MR. BASSETT: Okay, I didn't see that here.

CHAIRPERSON COLEMAN: Other questions?

(No response.)

Thank you.

MR. MONTGOMERY: Kathy Havlicek

KATHY HAVLICEK

Ms. Coleman and members of the Technical Review Committee, my name is Kathy Havlicek, K-a-t-h-y, H-a-v, as in Victor, l-i-c-e-k, and I am a nurse practitioner. I was in the first class of nurse practitioners to graduate from the University of Nebraska Medical Center's dual-certification program in 2006. I essentially completed two NP tracks at the same time. One track was in family practice, the other one was in psychiatry/mental health. This new curriculum was developed and initiated through a federal grant, the philosophy of which was to integrate patients' medical and mental health needs where nurse practitioners would be able to manage the patient's overall

health care concerns, both primary care and mental health.

I am from Lincoln and have my own private practice office. There is no one else with me in my office. I function as the provider and the office nurse all in one. I love my practice model and so do my patients. I manage over 600 patients and a year ago was asked by a psychiatrist who was leaving town to take over her patients, as she felt that my practice style was most closely aligned with hers rather than her MD colleagues.

I am testifying today in support of the removal of the Integrated Practice Act (sic), the IPA , as it has been and continues to be a significant barrier to Nebraska nurse practitioners including myself. While the IPA hasn't been an insurmountable barrier to me on the primary care side, it is a very different picture when I put on my psychiatric hat. I need two separate IPAs, one for each practice area. The psychiatrist I have an IPA with is nearing retirement. If the current IPA requirement is still in effect, in place at that time when he retires, I will also be forced to quit my practice at that time as well, as I do not expect to find a supportive psychiatrist replacement, even in Lincoln. I have over 600 patients that this would affect. I'm not sure where they would go for replacement care if I were no longer able to practice as I have safely and competently done with excellent patient outcomes achieved for nearly seven years.

I also want to tell you that I'm also employed in a hospital Employee Health Department which functions as an internal primary care or urgent care clinic for their employees. I've never even met my collaborating physician from the hospital's ER, nor have I needed to contact him.

Ms. Coleman, you and others are concerned about the NP practice barriers that exist in Nebraska. So am I. In my private practice, I have encountered many practice barriers besides the IPA. In fact, I am just now completing my second doctorate degree and have done my entire doctorate research project, a white paper, on the practice barriers that exist for Nebraska NPs, barriers that don't exist for my NP colleagues in neighboring states like Iowa, Colorado, and Wyoming. From my perspective as a practice owner, these are some of the barriers I have encountered.

One, Pharmacists and Pharmacy Systems. Pharmacy systems often will not fill my prescriptions without also listing my collaborating physician's name on the prescription, or they just use the physician's name rather than mine, and I am completely unaware this has been happening or this has been done. This creates confusion for my patients and for me, as future prescription refills are then incorrectly sent to my collaborating physician and not to me. Since I don't practice in the same office as my collaborating physician, the patient my not get the refill

in a timely manner if at all, and I don't even realize that a problem exists, since I didn't get the refill request from the pharmacy in the first place.

Two, Hospitals, nursing homes, and other agencies or health care institutions. I am often not recognized by hospitals and other agencies that I work with. For example, when I order lab work and radiology tests, the hospital also wants my collaborating physician's name, and I can't often order anything without giving it. Again, confusion is created when laboratory, --

MR. MONTGOMERY: One minute.

MS. HAVLICEK: -- radiology and other test results are not received in a timely manner, because the reports go to the physician's office, not to me. This happens despite the fact that I write on my orders to fax the results to me. The consumer is confused and sees some strange physician's name as the provider -- ordering provider, not me. This also leads to insurance confusion and problems, my next point.

Three, I now have an independent panel with several commercial insurance plans that I work with, but this is a very -- was a very big initial practice barrier for me, because of having a private practice office separate and apart from my collaborating physician's. Also, while there is a critical need to see Medicare (sic) patients in

my practice, especially for mental health concerns, and I am very willing to work with these patients, the multiple problems I've encountered with Medicare, Medicaid, and other insurance companies has been such an extreme barrier to me that I no longer accept any Medicaid patients. Yet many times, these are the ones who have limited resources and options and could most benefit from my services.

I have a packet of information I'll leave with you. It contains a letter of support from a psychiatrist and several of my patients. Thank you, committee members for your time, attention, and service to this very important matter. Again, I respectfully ask the Technical Review Committee for your support in removing the IPA barrier. It is a significant practice barrier to the citizens in Nebraska and to myself.

CHAIRPERSON COLEMAN: Are there questions?

Once again, I've heard Medicare mentioned as a problem. Does Medicare require that nurse practitioners be listed?

MS. HAVLICEK: Medicare and Medicaid both, yes, very frequently.

CHAIRPERSON COLEMAN: They both require that you list the collaborating as well as the -- yourself.

MS. HAVLICEK: Not for prescription medications, but we've talked before about the durable medical goods,

even a gauze band, you know, any of those sort of things.

CHAIRPERSON COLEMAN: But not for just general care.

MS. HAVLICEK: Correct.

MR. BASSETT: Janet, I have a questions.

CHAIRPERSON COLEMAN: Yes.

MR. BASSETT: If this scope of practice does change, what changes for you as far as acceptance of Medicare or Medicaid patients? Anything?

MS. HAVLICEK: It would be significant for me. I would be able to take many -- all of those patients.

MR. BASSETT: Because of --

MS. HAVLICEK: Right now there's such a barrier with, as Ms. Coleman just said, with Medicare and Medicaid. Sometimes it doesn't have an effect. Other places it does. And for me, where I don't have a physician that I collaborate right in the same office, the real concern I have is I need a co-signature.

MR. BASSETT: A lot of confusion, then?

MS. HAVLICEK: A lot of confusion, faxing forms back, nothing's done in a timely, concise manner. It's fragmented care. And for those reasons and a lot of time and resource constraints, I've tried until last year and I just -- I'm done playing the game. It's too much of a barrier in my practice. I don't accept Medicare or Medicaid

patients. And I would --

CHAIRPERSON COLEMAN: The assumption is that if the IPA was -- if that was removed, that you would be able to do both Medicare and Medicaid without any problem.

MS. HAVLICEK: Medicaid -- the state follows the federal, so for me, it would be an easier arena, less barriers on the state level to negotiate here in Nebraska with Medicaid patients. It would be a significant improvement and they would have access that right now they call and say, sorry, I don't have that insurance.

CHAIRPERSON COLEMAN: Pharmacy issue is a different issue. I guess I don't know what's -- that would depend on the pharmacy, probably.

MS. HAVLICEK: Right. A lot of times it'll be a collaborating physician that might be popped in instead of my name on the profile. Then what happens, I write the prescription. When they call in a refill, it goes -- and sometimes I don't even know that and I don't understand the internal pharmacy system, but it often goes to the collaborating physician, not my name.

CHAIRPERSON COLEMAN: I'd blame computers for that.

MS. HAVLICEK: But it's a barrier, and it's something that happens continually today for me.

MR. NAIBERK: And you feel the elimination of the

IPA would solve the pharmacy issue as well?

MS. HAVLICEK: Right, because then I wouldn't have to list that person, the other person's name, Dr. Smith, Dr. Jones. It would just be my name.

CHAIRPERSON COLEMAN: I guess -- and you're getting this because you're in Lincoln, probably, but is the sense that there would be other -- there would be more nurse practitioners in a private practice if this were passed, like in Lincoln and Omaha. Mostly we've heard about rural areas.

MS. HAVLICEK: You know, to be honest, I think the biggest bulk of our concern in Nebraska, and again, I have my entire dissertation research is written on barriers that exist in Nebraska that don't in our neighboring states. I think the biggest impact with this -- I don't see people would run out and open up all kinds of shops in Lincoln and Omaha. I think what it would do, as we've heard testimony already is it would remove some of those problems for western Nebraska.

I think Dr. Ba- -- or Mr. Bassett, you made the comment about, well, Bridgeport. There's not a psychiatrist there, and that gets to be a real gray area, again, based on the interpretation of whoever is interpreting at the time for the State. Somebody may say, no, I need somebody, you know, 200 mile radius. The problem is, there's just not

enough psychiatry and mental health. If I were talking in my primary care role, I've got several IPAs. That's not so much of a concern for me. My IPA barrier is really on the mental health side and I have a -- in my dissertation work, I have a map showing that outside of Sarpy County, Douglas County, and Lancaster County, the rest of Nebraska is listed as a critical shortage -- federally designated critical shortage area for mental health. Primary care's not too far behind.

CHAIRPERSON COLEMAN: I understand that it makes a difference more than in the rural areas, but I guess I was just curious as to whether you would see more private practice being opened in those three counties that you listed, Sarpy, Douglas, and Lancaster, if there would be more private -- nurse practitioners in private practice.

MS. HAVLICEK: I don't know the answer to that, but I think it would help the people in Sutton, Nebraska, and people like me, because when my current IPA collaborating psychiatrist physician retires, even in Lincoln, I don't think I'm going to have support as the current environment is for someone to sign that.

CHAIRPERSON COLEMAN: Other questions?

(No response.)

I think we have reached the point at which we might at least take enough of a break to stand up and shake

a little bit, take about --

MR. MONTGOMERY: Could I quickly ask, is there anyone else who wishes to testify in support of the application at this time?

I see no one. I'm sorry, is -- yes. There is another person who wishes to testify. I understand your previous testimony was to read the letter from another individual, so if you would like to testify on your own now, please come forward. And state your name again for the record, please.

DR. MARY CRAMER

Mary Cramer, M-a-r-y, C-r-a-m-e-r, professor at the University of Nebraska Medical Center, College of Nursing and the College of Public Health. I'm a former department chair and the Psychiatric Mental Health program and Family Nurse Practitioner program was in my area. And we did a study -- you have this information, but I want to highlight on the heels of this other, that we, at 90 percent of the counties in Nebraska are mental health shortage areas. And UNMC has a program for psychiatric nurse practitioners. We looked at where our graduates went and 70 to 80 percent of them have left the state of Nebraska. That's significant. They go elsewhere. They go to Iowa, Wyoming, Colorado and so forth to practice. And yet, we continue to have this shortage. So I just wanted to

highlight that point for you.

CHAIRPERSON COLEMAN: Any questions?

(No response.)

Thank you.

MR. MONTGOMERY: Thank you.

CHAIRPERSON COLEMAN: Okay, about seven and a half minutes.

(Off the record from 2:55 p.m. until 3:07 p.m.)

CHAIRPERSON COLEMAN: Okay, I think we're ready to go. We have some opponents, I assume they're opponents.

MR. MONTGOMERY: Yes. We have --

CHAIRPERSON COLEMAN: We have four other people or five other people.

MR. MONTGOMERY: Four other individuals have signed in as offering opposing testimony at this time. First is Dr. Bob Wergin. Again, forgive me if I'm massacring the names here.

DR. ROBERT WERGIN

Good afternoon. Thank you for the opportunity to give my perspective as a practicing family physician. I am a -- my name is Robert Wergin, R-o-b-e-r-t, Wergin, W-e-r-g-i-n. I'm an MD. I practice in Milford, Nebraska. I'm a comprehensive family physician, doing the full scope of family medicine. It's a town of 2,000 about 25 miles west of here. I also serve on the board of directors

nationally, the American Academy of Family Physicians who represent 105,000 practicing physicians across the United States.

Another hat I wear is I was honored to be selected to the Governor's Task Force for the Patient-centered Medical Home Concept of Care pilot project in our state, which was -- we chose Kearney and Lexington as part of that, and part of that was implementing a team-based, physician-led type of practice, patient-centered medical home in both those communities. And I'm happy to report, it's just come to conclusion this February, and you'll be happy to see the preliminary results of that. The final results have not been vetted as of yet, but very positive. They showed an increase in quality markers and a decrease in cost, which hire quality, lower cost usually get legislators' attention generally.

I practice in a rural health clinic in Milford, Nebraska, and by Medicare regulatory requirements, I'm required to work with a physician assistant or nurse practitioner, and I'm very happy to do that. Helps me immensely. And I want to tell a story about -- just happened a couple of weeks ago as they asked me to come testify. And I came out of a room after seeing a patient and my physician assistant, Kim, was there and said, "Gee, Dr. Wergin, down in Room 5, I have a person with acute

problem that's complicated, abdominal pain, shortness of breath, Mrs. Smith" -- that's not her name. I can't say that, but -- "and I'm not sure what to do. She has these other diseases, diabetes, heart disease, renal failure, long list of medications." I said, "That's fine. I'll go down and see her." So I went down, talked to Mrs. Smith, did her exam, reviewed her meds and diagnoses, and we set up a -- some diagnostic studies and a preliminary treatment plan and she'll be following up with me. And during that 40 minutes that it took me to do that, my -- Kim and my physician assistant had gone into another room and saw three patients, actually, in that time, two acute infectious disease patients she was very comfortable treating and one with a chronic stable medical condition. And I just highlight that to point out that I believe that's a good team approach to medicine. And we at the American Academy of Family Physicians often say the mantra, "The right provider, the right care, at the right time." And I think that happened in that case. We often, after board meetings, come out and talk about health care delivery in this country and the expanded numbers. And we think the team -- newly insured patients, we think the team approach to care is going to provide for those individuals. We often say the statement, "Fragmentation bad, team approach good." And of course, we say, family medicine foundational to our health

care delivery system in this country. You might expand that to even say primary care team-based care is foundational.

We at the American Academy of Family Physicians feel that further fragmenting care by creating another class of providers and care that may be less comprehensive, and we think that's key in health care delivery only fragments care further, which I think has arrived us at our current situation. So we feel that team-based care is most important. As I leave the meeting today, I'm going to go and be on call in my facility --

MR. MONTGOMERY: One minute.

DR. WERGIN: -- in Seward, Nebraska, and I would say that we take very seriously the appropriate provider and the appropriate care in those situations, and whether you're fully prepared to see all undifferentiated patients. We think physicians are in the best position to do that.

I want to thank the committee again to let me share my perspective of this issue, scope of practice of nurse practitioners with you, and I'd be glad to answer questions or defer the remaining of my time to my colleagues.

CHAIRPERSON COLEMAN: Questions?

MS. WYRENS: I have a question for you and this is probably more from your Academy of Family Practice world, but, you know, team-based, which I think we all agree is an

awesome thing, but how do you plan to develop those teams with the current shortage of family practice physicians, especially in our rural world? What's the process or what are the thoughts on that?

DR. WERGIN: We've taken a multi-prong approach nationally by expanding the primary care pool. Now, as you know, my son's a second-year med student and has a ways to go before he's out, but we need to expand the graduate medical education funding and alter that and prioritize what the citizen of this country needs. My academy represents 105,000 family physicians across the country and we think there may be a shortage by 2020 of as many as 35- or 40,000 family physicians or primary care. We think that team approach to care will help fill those gaps in having physicians do that. So expansion of workforce is important in the team approach would help. And we're very cognizant of that, actually trying to improve student interest in family medicine.

In our state -- I think Dr. Rauner mentioned that loan repayment -- my son will be $200,000 in debt by the time he's done, and we need to alleve that, so they leave the state for better debt repayment programs. So we're focused on expanding that physician workforce and that. Also if you look at other states, I actually only had five copies. I didn't bring it. I brought California's map of

Washington, Arizona, and Utah -- Oregon, I'm sorry. And where nurse practitioners that independently practice, practice. And it's not rural, at least other states by definition, if you can track them at all.

MS. WYRENS: Thank you.

CHAIRPERSON COLEMAN: Other questions?

I think Marcy's probably sharing the great concern that many of us have is that, yeah, teamwork is wonderful, if we only had it. I don't know how you guarantee that. Of course, you don't probably know how to guarantee it either, but I think that's a concern is that we'd all be in favor of teamwork except it doesn't always work that way in parts of the -- more rural Nebraska. At least that's what we've heard.

DR. WERGIN: I'm committed -- here's one person committed to that teamwork and I live it.

CHAIRPERSON COLEMAN: Okay. You know, I believe you do. I don't have any question about that. I know some others that do, too, but there are those places that -- we have to do something about them, too, I think.

DR. WERGIN: We do.

CHAIRPERSON COLEMAN: Other questions?

(No response.)

DR. WERGIN: Thank you for your time.

CHAIRPERSON COLEMAN: Thank you.

MR. MONTGOMERY: Dr. Carol Lacroix.

DR. CAROL LACROIX

Thank you for saying Carol Lacroix. It's actually pronounced Lacroix.

(Laughter.)

MR. MONTGOMERY: My high school French came back on me.

DR. LACROIX: Exactly. It's been Americanized. So it's C-a-r-o-l, L-a-c-r-o-i-x. I've been a faculty member of the Department of Family Medicine at UNMC for the past 18 years, and during that time, I've had the opportunity to help train at least 15, probably 20 nurse practitioner students, some of them from UNMC, some from Creighton, and some from the Clarkson School of Nursing. For me, precepting means that the students come in and they go with me into a room to see the patient or I send them in ahead of time and let them get their feeling about what's going on and then we talk about it and decide after that what we're going to do with management and treatment. Generally, the student comes to my office for 12 hours a week, if the rotation's for 10 weeks, or sometimes 24 hours a week if the rotation lasts just five weeks. The rotation's usually are 10-week rotations.

I've noticed over the years that the first students who came tended to be older women, 40 or older, who

had already been in nursing and kind of wanted to do something different, so they had a lot of nursing experience. Since 2008 when the requirements went that the APRN should have a bachelor's -- or a master's degree, excuse me, I'm now seeing more students who are coming straight from nursing school to this program, and that concerns me, because I don't think they have nearly as much experience as the other students did. They don't have the clinical experience. So then they come to the program and it's a two-year program for their master's, and out of that, they're getting somewhere between 400 and 600 clinical hours total. You take a family physician, they start their clinical training in medical school. Their first two years are office, the second two years are clinical, and that's all clinical. And then for the three years of family medicine residency, they're also doing clinical the whole time. During the residency, each week they spend at least three half-days, if not five, seeing their own family practice patients, and the rest of the time they're seeing clinical situations, other specialties. So I feel like, if you figure the minimum, if you are in -- work 40 hours a week, 50 weeks a year, that comes out to 2,000 hours of experience. So a medical -- a family medicine student, physician, has has two years in medical school and three years in residency. That's about 10,000 hours of exposure

to patients as opposed to 500 for the family practice nurse.

I really welcome the family nurse -- the nurse practitioners as part of the health care team. I do think health care team is an important concept and I think we can make it work better if we talk with each other instead of against each other.

I especially feel like the nurse practitioners are very well trained in educating patients and in chronic disease management. I do not feel like they have as much skill and training in the acute care stuff. And that's what really worries me in rural Nebraska.

Any questions?

CHAIRPERSON COLEMAN: Questions?

(No response.)

So, if there aren't doctors in rural Nebraska, and there are only nurse practitioners, what do they do?

DR. LACROIX: Then they need to have a phone communication. And that's why I think these collaboration agreements are very important because you're committed to each other to back each other up.

MR. BASSETT: Do you happen to know another state, such as, let's say Iowa, that has the independent practice, if there are any other regulations -- wrong word, stipulations that to get in the nurse practitioners' program you have to have had X number of years of experience before

you can get in or is that just, again, like you are saying, you go from one degree to the next?

DR. LACROIX: I believe it's just going from one degree to the next.

CHAIRPERSON COLEMAN: Other questions?

(No response.)

Thank you.

DR. LACROIX: Thank you.

MR. MONTGOMERY: Dr. Rick Blatny.

DR. RICHARD BLATNY

My name is Rick Blatny, I'm a family physician in Fairbury, Nebraska. That's Richard Blatny, R-i-c-h-a-r-d, Blatny, B-l-a-t-n-y.

My discussion today involves mainly Criterion, I believe, 5 and 6. I served on the original 407 Committee which I recall was around 20 years ago. And that's when we went through all of these things. And at the time there was a great concern about maintaining safety and supervision of nurse practitioners to basically protect the citizens of Nebraska. I do not recall that the IPA was considered a door to eventual independent practice. That really -- I do not recollect that at all. At any rate, we settled on a collaborative agreement and I think it's been discussed today what the collaborative agreement entails. It certainly does put upon the physician, the supervising

physician, the duty that he must perform that. Now, I have no doubt like any -- probably anything else regulated, there may be instances where the supervising physician isn't doing his duty, he's not performing it. The fact, however, that that type of practice continues doesn't mean that you would do that for everyone. You know, you -- eventually, looking at the difference of training of a nurse practitioner and a physician, there's bound to be more errors made. There's no other way to look at it.

At any rate, at the time, we set up a -- the nurses also wanted a -- nurse practice wanted a -- their own board. They didn't want to fall under the Board of Medicine and Surgery. They wanted their own. And they said, well, they would grant privileges based on principles of nursing, et cetera. And so you know the composition of that original board was five physicians, five nurse practitioners. I believe there were three lay persons, a pharmacist. In about 2007, they changed that, and such that now the Board has four nurse practitioners. Actually there's a nurse midwife, a clinical nurse specialist, nurse anesthetist, I believe, and a nurse practitioner, and three physicians, and one lay person. Well, we can see where the -- there could be two lay persons. There may be two. And you can see where the vote can change here. And, of course, everything that was granted at the time was done on the basis that,

well, the one controlling factor that you have out there to maintain good care is the collaborative agreement. This year we find, the nurse practitioners want to handle acute care. We've heard some testimony here that a nurse practitioner, if you come in with an acute myocardial infarction, can take care of you for the weekend. I believe I heard that in one of our meetings. Legally, they can't do that in Nebraska. They can't take care of them themselves. They have to have supervision. And I believe right now, they're only licensed to take care of chronic conditions. And acute myocardial infarction is not a chronic condition. And, you know, in my and most physician's views, you need to have somebody better trained to be doing that.

At any rate, the Nebraska Medical Association is not opposing this year, their bill, which again it says, a possibility for acute care.

MR. MONTGOMERY: One minute.

DR. BLATNY: Okay. But that is based on the fact that there'd be a supervisory agreement. And, of course, we're looking here now at taking that away, and so basically, it opens the door. It allows people with 500 hours of training to basically act as physicians in an area where compared to physicians who have 12- to 14,000.

I just want to mention that in rural Nebraska, because I practice in rural Nebraska, I'm in Fairbury. I

have four physicians and three PAs. We work together. And it is the way to go. Every day I'll have a nurse practitioner -- or excuse me, a PA come to me at least a couple times a day asking about a patient, also, and -- that's more complex. And we're glad to help them out. We're right there. That's a great way to be.

The nurse practitioners out in rural Nebraska, if they are granted the privilege we're considering here, they're going to be on their own. They're not going to be able just to get on the phone and call up somebody every half hour. I mean, I don't really know who's going to be available to just handle their problems if they don't have some sort of an arrangement made.

MR. MONTGOMERY: Time.

DR. BLATNY: Okay. The hospital in rural areas, I'll just sum this up. The hospital in rural areas can limit it by virtue of the fact that they make rules and they only grant the privileges dependent upon a supervising physician and that is the way it's done in our state.

I guess, finally, I just wanted to mention that the nurse anesthetists are -- have a very specialized field. I think they do an excellent job. And Fairbury does have physicians. We heard the testimony here that they may not, but we do. I just want to point out that when they are practicing out there and we're performing a procedure, the

physician is the one that is in charge. We have to co-sign for that nurse anesthetist. If something really goes wrong in that procedure, we're the ones in charge.

I think to take away this collaborative agreement really allows nurse practitioners to practice out rural area. You have no way to know what's going on in those clinics.

MR. MONTGOMERY: One minute over.

DR. BLATNY: Okay. Well, that's it, thank you.

CHAIRPERSON COLEMAN: Are there some questions?

(No response.)

One of the things -- and we have heard -- through the times that we've met, we've heard a lot about nurse practitioners in a rural area who find it very difficult to find a physician who's willing to be -- to collaborate with them. And that's been a problem. So, what -- how do we solve that?

DR. BLATNY: Okay, I really think the way to solve it is again, through a group practice, nurse practitioners, PAs, and physicians, and more satellite offices. Fairbury, in the past, has had satellite office. I went to one for 25 years. But we also have our PA go out there. And there are very few areas in our state that can't be satisfied by a group practice in a slightly larger city that can afford to have a practice having a satellite office out there and

having a nurse practitioner there, having a PA there, having at times a physician there. And I really think if you look at what's happening, that is occurring today and I think it just needs to be expanded. And I believe there's a demand for PAs and nurse practitioners, and that way, everyone is properly supervised.

CHAIRPERSON COLEMAN: I don't think probably there's much disagreement with what you've just said. I just think that it's very difficult to have that happen at this point. It seems like it's very difficult. It's a good idea to have that teamwork kind of thing, but it doesn't seem to be happening in some of the -- I always have trouble thinking of Fairbury as a rural area, but I suppose --

DR. BLATNY: Well, we went -- for instance, we went to Deshler. Deshler is a community of 1,000. Deshler many years ago, about 30 years ago, had a physician. He retired and died. So now that city is being taken care of by a satellite office. Chester is another one. There are a whole batch of these cities out there or these towns that are small, 1,000 or less. And they are being served by satellite offices. I'm not sure if you look on the map showing the distribution of physicians and PAs and nurse practitioners if it shows those satellite offices. I think -- Dave, do you know? I think it often just shows them located in the main office, not their satellite offices

that can be 30-40 miles further.

CHAIRPERSON COLEMAN: I just think the evidence does seem to show that there is some difficulty in getting those collaborative relationships. We heard someone talk today about having to go to somewhere in Colorado to get a psychiatrist.

DR. BLATNY: I think in our state, psychiatric care is at a shortage everywhere. It's in Omaha, it's in Lincoln, it's in Fairbury, everywhere there's a problem there. But we're short psychiatrists also.

DR. SHICKELL: Is there a model or could the Med Center and Creighton and the training schools that work together with nurse practitioners, medical students, could they set up a model? I mean, how can this come about so that they will know when they graduate there is a satellite in Timbuktu and they can go there? Why isn't more being done?

DR. BLATNY: I guess I don't have all the answers to that, but I mean, anything can be done if you work at it hard enough, it would seem. If you have an area, a community that has enough patient population to be able to produce enough income for someone to be out there -- you know, you can't just send people out in the middle of a barren area and say, "Here I am." You know, if there's only a few people they're possibly going to do, they're not going

to make it. They're going to be there for a short time, invest a bunch of money, and leave. So, again, I think that there needs to be more work done to do that. And I don't see any reason why there couldn't be. It's -- I think also we have to still remember that it often takes a patient, maybe 40 minutes or 45 minutes to get across town to get to their provider in Omaha or Lincoln, and out in rural Nebraska, they can get quite a distance in 45 minutes.

So, but I think that is being done. I think it's being worked at. I don't have any numbers for you.

MS. WYRENS: I have a question for you, because, I love the team model because I think it's great, but how would we do that with our mental health and our psychiatry component based on -- I mean, I know I'm asking kind of your thoughts outside of your norm, but how would we do that, because you were right. We struggle with patients with just, you know, the basic site from the physician component. We're hearing, you know, from our nurse practitioners that that's a huge process. And I don't know how I would see that as that team component when it comes to mental health especially.

DR. BLATNY: For mental health.

MS. WYRENS: Yeah, I don't know that I -- I'm having trouble putting my head around the --

DR. BLATNY: I don't know if more could be done

with telecommunication, but then you have to think that there has to be someone sitting on the other end. So that now I've got two people occupying that same period of time to take care of one person. It's a tremendous problem. I agree with you. You know, we feel very fortunate in Fairbury. We have a resident psychologist and we have a couple social workers that come over. We do not have a psychiatrist. We used to have a consultant psychiatrist, we don't. So what we find ourselves doing is referring more of those patients, you know, elsewhere.

I don't know if anyone's been able to solve the psychiatric dilemma in our state or --

MS. WYRENS: I just, you know, using the team model, you know, that was kind of -- I didn't know if you had any thoughts on that piece or not from the mental health perspective.

DR. BLATNY: You know, you'd obviously have to get a group to work together to try to do that. And I don't have the answer for that, I'm sorry.

MS. WYRENS: I just thought maybe I could pick a corner of your brain on that one, so thank you.

DR. BLATNY: That one's empty.

(Laughter.)

CHAIRPERSON COLEMAN: Any other questions?

(No response.)

MR. MONTGOMERY: Dr. Bob Rauner.

DR. ROBERT RAUNER

Dr. Bob Rauner, R-a-u-n-e-r. I'm a -- background is family medicine and public health. First, as a followup of one of your questions earlier, that's a map of the current distribution of family physicians, PAs, and nurse practitioners. You'll see the distribution for all is pretty close, although the widest distribution is for family physicians.

Also I'd like to point out Deuel County, which is near Cheyenne, there's this misleading statistic about X number of counties not being served, which is actually flat out wrong. It's because of how we describe where people are. I used to go to that clinic in Chappell every day, I mean, every week. It is currently served Monday through Friday by a physician or a mid-level every day, even though it lists zero on there, because of their satellite. Their main clinic is in Sidney, not in Chappell. And I believe Big Springs, which is also in Deuel County, has someone coming from Ogallala, so that map is extremely misleading.

The other thing that the death of family medicine is greatly exaggerated. The age distribution of rural family physicians is the same as the age distribution of urban family physicians, so they're not going away. They're not going to disappear. There won't be no family doctors in

Nebraska, I mean, so you have to keep in mind that some of these statistics are exaggerated for different gains, I guess you might say.

Another issue I think you raised in your questions after the last testimony is, is there a comparable certification/recertification? The answer is no. A family nurse practitioner, it may be a couple weeks of training during that 12 to 16 weeks of clinicals they get. For family medicines, it's three years of training in family medicine. If you do the math, the individual disciplines in 12 weeks, they're going to get maybe a week of cardiology, a week of pediatrics. In family medicine, you may get three to six months of cardiology, three to six months of, you know, obstetrics, and so there's a huge difference in the training to start off with. And then is there a similar recertification process? No. To be a family -- board-certified family physician, you have to complete three years, you have to pass your boards. You then have to every year do 50 hours of continuing education, including a self-assessment module where they focus on high impact conditions like diabetes. They want everybody to do it this way. There are quality improvement projects you have to do within your own clinic using your patients' charts. You have to recertify and take that exam again at least every 10 years. There's nothing comparable for a family nurse

practitioner like that.

We talk about team-based care. We had someone actually come up here and say that team-based care prevents access, which is surprising, because I gave you a peer review article last time I was here saying that that is actually one of the policy interventions to promote access is to do team-based care. The article I -- and I can probably find that for you again, if it's been lost, but it was a Kaiser Permanente study where they focused on the fact that if you move from a solo practitioner approach to -- in their approach, they used two family physicians per nurse practitioner, you had a -- I can't remember if it was 20 or 30 percent increase in access, because you can handle the surge capacity between those. The biggest problem actually is this attempt to be solo silo people. There's a reason that there are so few solo practitioners anymore. Part of it is the fact that it's really nice to be able to walk down the hall and say, "Hey, let me bounce this patient off of you."

In our practice, honestly, when we see someone practicing solo, I'm trying to think of the tactful way of putting this, but sometimes they're solo because they can't work and play well with others, so maybe there's a reason they can't find a practice agreement.

The other thing that worries me is that, you know,

I used this last time, as well, the Wayne Gretzky hockey puck analogy. Are we going to where the puck has been for the last 10 years or are we going to where it's going? The puck is going toward accountable care and medical home. It's all around collaboration and communication, and when you sever relationships, you are not improving collaboration and communication.

One of my hats is I am a medical director for an accountable care organization in Nebraska. We have clinics all the way from McCook, Nebraska, to Broken Bow, over to Bellevue. Every one of our clinics has nurse practitioners or PAs. Several of them are recruiting more of those nurse practitioners and PAs to improve access. And we're recruiting family physicians to improve access. It's all about team-based care. We're trying to move from the just random provider of the day to where people literally are in teams. One of our best clinics that has the best outcomes, Joe works hand in hand with his PA. They don't have separate schedules. They combine. They start out from the beginning of the day. They look at who's coming in and they divide and conquer based on that. And based on what they're seeing, they may hand off and go back and forth. You know, "I don't really need to see this, this is just a followup." "No, this is really intense. Joe, I need your help with this." That's the way to really improve quality.

MR. MONTGOMERY: One minute.

DR. RAUNER: The other assertion was that the Virginia-based (sic) care team model was already hampering access. I don't know how you can even make that assertion. It just went into effect two months ago, so how can it already have made that effect? I do think the Virginia care-based team is the way to go. It was compromise between the physicians and the nurse practitioners in Virginia, and to me that makes the most sense is to turn it away from these agreements to actually making people in -- get away from their silo approach.

I guess, the other thing I'd like to say is that the Malcolm Gladwell 10,000-hour rule, you need 10,000 hours to get really good at stuff. Five hundred hours versus 10,000, there isn't a shortcut. I don't know if you know, but UNMC tried to shorten medical school to three years twice in its history. Both times, within a couple years, they said, this ain't working. There's a reason you need a certain amount of training.

And with that I think I finished on time?

CHAIRPERSON COLEMAN: Are there some questions?

MR. NAIBERK: Dr. Rauner, you're going to get a question that's probably directed more towards all of your colleagues that presented today from me, and so if any of them want to speak up, they can. I guess, the most

troubling part for me on the IPA probably goes back to testimony that we've heard in regards to difficulty finding it. And then the other part of it is, is that in practice, I'm not sure it ever truly existed the way people thought it was going to back in, you know, when they implemented it. And I can talk from personal experience that I don't think that was necessarily the case in one facility that I was at. And we heard testimony today. I guess, my question is, is if we're going to leave the IPA in place, it's not probably working very well 100 percent of the time or maybe even all the time -- or a majority of the time. What needs to be done or what can we do to fix that issue or what rationale is there to say, well, we'll leave it in place and we won't -- we're going to continue to let physicians charge $3,000 to, you know, to have that agreement in place. Because I don't think that was really ever the intention.

DR. RAUNER: No.

MR. NAIBERK: The intention was to create this collaboration. So I guess that's kind of --

DR. RAUNER: I mean, actually, I think that's one of the reasons why that Virginia care-based -- it's the way to reset it and try to make it happen like it was supposed to happen. I'd actually say that most of the time it is working the way it's supposed to be, because they're in the same group. So, actually, my wife, Lisa, is a family

physician. She is the supervising physician for one of the family nurse practitioners who just testified actually. I think that's a good relationship. They're not having problems. I would say 95 percent of the time, there is no issue. There are five percent of the times where there is an issue. The question is why. Is it just because these are a bunch of greedy doctors or is there something else? And I think there's probably both, honestly.

Now, should there be a cost? Well, yeah. You're taking on a lot of liability. I mean, you shouldn't do that for free. I mean, no lawyer's going to give me advice for free. I mean, you have to pay for things. If I have an IT consultant come in, it's going to cost some money. Now, what -- now, should it be $5,000 a month? Probably not. Maybe $500 is more reasonable. So I think there might be -- could be some gouging.

Sometimes they're using the wrong people. I know someone who happens -- I guess I won't describe it, because you might figure out who he is. I think it's a disreputable physician who supervises one of the clinics around here. He'll just sign his name to anything for money. We have situations like that.

We have another "free clinic" supervised by a retired cardiologist, who's supposedly providing with no primary care background supervising primary care NPs.

We have another town I know of where the supervising physician is a surgeon, yet he's supervising people taking care of diabetes and asthma. That makes no sense to me.

I know another one where it's a I think it's -- it's either a radiologist or a pathologist an hour away, "supervising" another. That's not appropriate.

If we're going to have practice agreements, they should be real practice agreements, not just in name only. There are a lot of loopholes. You could drive a truck through them. I honestly think we should open up and start looking at the Virginia model where I think it truly is what it was supposed to be, because I don't think -- I think 95 percent of the time, it's like my wife and LaDonna's practice. It's the way it's supposed to be. But five percent of the time, it's kind of abused, misused, whoever will pay. Sometimes it's gouging. Sometimes it's like -- you mentioned the psychiatric -- there's psychiatric access everywhere. It's not just because the NPs don't have scope of practice, because there's not enough psychiatrists, not enough psychologists. Why? Because we just underfunded for, like, what, 49th out of 50th in how we fund psychology services. Scope of practice isn't going to fix that. You guys just got to pay for it. I mean, that's the real reason we have no psychology access in the state. It's not --

DR. ROBERT WERGIN

I have a comment just briefly. It's the rural health clinic model works that way. I sign off on all my PAs by requirement, a Medicare requirement. And I actually -- the way our clinic works -- I'm sure there's model that abuse it, but every two weeks, we pull the chart and review it. When Ms. Shickell mentioned models, the rural health clinic model works on that premise, is I have to sign every one of my physician assistants' charts or nurse practitioner. And it's an opportunity, too, every two weeks to pull a chart, look at it, say how could we approach this differently. And even chronic disease models, which she helps me with greatly, we look at them. Have we met our milestones? Gee, on this chart we missed this. How can we do better? And the two of us work collaboratively in that environment.

But I don't doubt that there's even rural health clinics where the physician doesn't do that. And I -- unless there's some other more regulatory environment. Under Medicare models, I know they do come -- the rural health people come out, pull my charts. They better be signed and they better show a certain standard of care.

You mentioned other role models. They do rotate -- my son comes out to rural practices as a med student to get them exposed and it's an eye-opening

experience for someone from Omaha to come out and see what I do. They say, "Gee, I thought you just saw sore throats and colds," and they say, "Wow. I'm in your ER with you. You're doing trauma, you're doing that." They used to say, "You're an RD, a real doctor." That's what they used to call me there. So, I'd say the rural health clinic model might work better in that.

CHAIRPERSON COLEMAN: Any questions?

MR. MONTGOMERY: We've reached the conclusion of those who had signed in as wishing to testify in opposition to the proposal. Is there anyone else who wishes to offer testimony in opposition to the proposal today?

(No response.)

Seeing none, is there anyone who wishes to offer neutral testimony?

(No response.)

Hearing none, at this point we have an opportunity for the proponents and the opponents to take five minutes as a group to summarize and respond to any comments that have been made in today's testimony or to re-emphasize points that you would like to leave the committee with.

CHAIRPERSON COLEMAN: And hopefully the whole group is not going to talk at once, right?

(Laughter.)

MR. MONTGOMERY: However they want to, but they

have five minutes. So, I see Ms. Hoebelheinrich is coming forward for proponents. Will you be offering that summary?

KATHY HOEBELHEINRICH

Yes, I will. And I certainly -- I have prepared remarks and I will -- I've been taking notes madly. That's the risk of being extemporaneous. And I will try to insert comments, and I certainly would -- to my prepared remarks, but I'd certainly appreciate if I haven't covered something in terms of that has been spoken prior, please ask, because I've been listening.

Again, Kathy Hoebelheinrich, K-a-t-h-y, H-o-e-b-e-l-h-e-i-n-r-i-c-h. And you don't know how many times I've spelled that name in my married life.

(Laughter.)

I want to respond in terms of what we see as our interpretation of the criterion, and I'm not going to read those in a blow-by-blow, because you have those on the paper in front of you. And we do believe that while we recognize that there's generic verbiage, but it has created some confusion about the scope of practice.

So Criterion 1, with respect to the public -- their needs being adequately addressed by the current IPA requirement, we want to make it clear that many practice agreements in this state -- and it's hard to define "many." I would personally disagree with the five percent number

that I heard. No measurable -- that there is no measurable oversight and it's up to the parties entering in the agreement to define supervision. And I've had several practice agreements and that has always been the case. That physician and I define how that supervision will look.

The IPA by itself offers the consumer no assurance that the nurse practitioner is safe and competent. And you've heard a great deal of testimony today regarding our education, our preparation, licensure, credentialing.

The IPA poses a significant barrier to health care. I appreciate the comment of the death of the primary provider, versus provider shortage. And again, we've submitted ample documentation from UNMC, the studies that have been done there regarding the provider health care shortages in the state. And any way you slice or dice it, they're simply not there in those communities.

Janell Grant, I submitted her written letter, she's the only pediatric provider within a 60-mile radius of her community in Alliance, and folks travel 60 -- I believe she said 60 to 90 miles to see her.

Second criterion, enactment of the proposal of the IPA would benefit the public. The evidence for that is, nurse practitioners, we're highly qualified, competent providers, and we believe that in the evidence of the outcome studies that we've cited and over four decades of

those, we believe in matching the provider to the patient to the care delivery model. And I would contend that you do not need a physician in all settings. For myself, diabetes management, there was no physician on site in my prior employment. When somebody went down on the treadmill because they were hypoglycemic, and I was subsequently called and sought a referral from the physician to manage the insulin, those were things that did require physician oversight. So there's no one-size-fits-all model here. And I believe what's being described to you in Milford and many communities, and even my colleagues behind me, work very, very well with physicians. And we're not saying there's a one-size-fits-all model or that we intend to replace any of those. It's a very specific, very, very specific.

The -- I'm not sure that there is any evidence and I find the comment regarding -- the data regarding errors made by clinicians. Again, I'm not sure of that. We've not been able to locate that.

New and innovative models cannot thrive, and specifically as nurse practitioners, we support patient-centered team-based care. And from the recent American Hospital Association document, they call for the removal of the barriers --

MR. MONTGOMERY: One minute.

MS. HOEBELHEINRICH: -- to the implementation of

those.

The Virginia model which you've heard a lot about today, the Virginia model was not intended to be applied as a national model of care. That was specifically designed for those states that had physician-imposed relationships on the basis of licensure and statute.

A bit more about -- I'm going to move on to three. Malpractice claims, much of the information there I've waded through. My personal insurer told me that their expectation was that any practice agreement, a nurse practitioner in their -- that they were covering, that we specifically approach a physician, and they cited a cost of $2,500 for an additional rider, which they said most physician malpractice claims don't have. So the question of should a fee be charged --

MR. MONTGOMERY: Time.

MS. HOEBELHEINRICH: Thank you.

CHAIRPERSON COLEMAN: Do we have a wrap-up from the opponent?

MS. HOEBELHEINRICH: Questions? Were there questions?

CHAIRPERSON COLEMAN: Oh, are there questions? I'm sorry.

(No response.)

Sorry about that.

MS. HOEBELHEINRICH: Thank you.

CHAIRPERSON COLEMAN: Now, is there wrap-up from the --

MR. MONTGOMERY: Dr. Rauner is coming forward.

DR. ROBERT RAUNER

R-a-u-n-e-r. I guess I'd hit three things. One is the post-training assurance of scope of practice. We actually, to be quite honest, you have pretty big loopholes even for physicians right now. For example, you don't have to be board-certified in anything really in Nebraska. And there are people who get one year of training and then open esthetic practices. I think that's a little sketchy, to be honest with you. But you have the same issue with nurse practitioners. Say someone gets training in -- what is the official certification for family nurse practitioner versus geriatric versus pediatric? And what's out there to have someone who got most of their focus in geriatrics suddenly switching to esthetics? What's the mechanism? And I think there needs to be some mechanism of following that to make sure that what they're doing is in fact. And if you're on your own, there's nobody in there looking unless you drive out there and take a look.

There is one legal issue that hasn't come up yet, and that's our malpractice cap. And to my knowledge what is in the malpractice cap does not specifically list nurse

practitioners. So if they do become independent or not under a physician, are they then under the malpractice cap or not? We'll have to figure that out at some point.

The other thing is, I would encourage you to focus what you listen to based on its strength of evidence. Most of what you've heard, to be quite honest, on both sides, because I know there's not a lot of decent evidence on this, is policy papers put out by -- well, if it's put out by the American Academy of Family Physicians, let's be honest, it'll be a little biased. If it's put out by the Academy of Nurse Practitioners, it'll be a little biased, too. So to put higher weight toward things that are independent peer reviewed evidence, like some of the *Health Affairs* articles I dropped off last time, because they're actually people who had to say, I am asserting this, but you three have to actually look at it and say, yeah, it still flies. Most of what is out there is, honestly, panels of people who were picked to say what they wanted to say. And quite honest on both sides. So to focus on the stuff that is out there. There is a Cochrane Collaborative Report. It's a little dated now, from '09 or 2010, I can't remember. It essentially says there's not enough evidence, unfortunately. So we haven't had too much come. We're having some things coming out in the last year or two essentially looking at the overall cost issue, for example the *Health Affairs*

article I dropped off last time, saying that there was a difference, meaning the ratio of nurse prac- -- of mid-levels. It didn't differentiate nurse practitioner versus PA, did affect cost and quality. And as the ratio got higher, the cost and quality -- the cost went up and the quality did go down and the admissions did increase.

I've actually corresponded with the author of that article and said, "Why didn't you guys talk more in the article?" Well, because they're saving it for the next publication, which hopefully will come out soon. My suspicion is that it's actually a U shape, that if there's zero nurse practitioners, it's worse. If it's 100 percent nurse practitioners, it's worse. That the best -- it's probably a U shape where you have a mix like the Kaiser article I cited where it's a mix of both physicians and nurse practitioners, PAs, that team-based approach. So I'd encourage you to look at the evidence, but unfortunately there's a dearth of it right now.

CHAIRPERSON COLEMAN: Any questions?

DR. SHICKELL: I have a question. Is there any way that you can monitor what doctors are charging for the supervision? Is there any way you can set a standard?

DR. RAUNER: Not that I'm aware of. It's probably secret contracts just like my contract with Blue Cross/Blue Shield. That's not disclosed either. So, you know,

unfortunately, we have zero price transparency in this state. Actually, there was a recent report on giving Nebraska an F on price transparency. So if you want to know what it's going to cost to get X done at this hospital or the other, good luck. There's zero in Nebraska on price transparency for just about everything. Which is part of our problem in health care in general, but that's a whole another can of worms.

CHAIRPERSON COLEMAN: We'll deal with that later.

DR. RAUNER: Yeah. On to next week's topic.

CHAIRPERSON COLEMAN: Any other questions?

(No response.)

Thank you.

MR. MONTGOMERY: We have a question from the audience? This is a public hearing and not a public forum, so at this point, I'm going to rule that we need not accept questions from the public at this time.`

CHAIRPERSON COLEMAN: And we are going on to just a general business session briefly, with all of you and we need to approve the minutes of the last meeting.

MR. MONTGOMERY: At this point, then, are we ready to conclude the public hearing?

CHAIRPERSON COLEMAN: Yes, we are, I'm sorry.

MR. MONTGOMERY: So, with the conclusion of the public hearing, the committee does have a public business

meeting that it will be conducting here in just a couple of minutes. We will take a couple of minutes to allow the room to clear and you certainly are all welcome to stay, if you wish.

(Whereupon, at 3:57 p.m. on March 22, 2013, the proceedings were concluded.)

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