Application
Credentialing Review

Nebraska Nurse Practitioners
December 14, 2012

CONTACTS

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Katherine A Hoebelheinrich
Chairperson
NNP 407 Review Committee

Date

Description of the Applicant Group and its Proposal

1) Provide the following information for the application group(s):

a) name, address, telephone number, email address, and website of the applicant group in Nebraska, and any national parent organization,

Applicant Group

Nebraska Nurse Practitioners (NNP)
1233 Lincoln Mall, Ste. 202
Lincoln, NE 68508
T: 402-438-4960
nnp-407@googlegroup.com
www.nebraskanp.org

National Affiliate Organizations

American Academy of Nurse Practitioners (AANP)
AANP National Administrative Office
PO Box 12846
Austin, TX 78711
T: 512-442-4262
F: 512-442-6469
admin@aanp.org
www.aanp.org

American College of Nurse Practitioners (ACNP)
225 Reinekers Lane, Suite 525
Alexandria, VA 22314
T: 703-740-2529
F: 703-740-2533
ACNP@acnpweb.org
www.acnpweb.org

The AANP will consolidate with the ACNP effective January 1, 2013. The new parent organization for Nebraska Nurse Practitioners will be called the American Association of Nurse Practitioners.

b) composition of the group and approximate number of members in Nebraska,

Membership categories. Nebraska Nurse Practitioners (NNP) has 517 members as of September 30, 2012.

Full members. There are 442 members who are licensed NPs.

Retired members. Retired members may or may not have an active license. Currently, none of the 5 retired members of NNP have an active license.

Student members. There are 70 student members currently enrolled in NP academic programs pursuing graduate degrees either as a Master of Science in Nursing (MSN) or Doctor of Nursing Practice (DNP).

c) relationship of the group to the occupation dealt with in the application.

Nebraska Nurse Practitioners (NNP) is the primary professional organization in the state, with a membership of 48% of the eligible licensed NPs in Nebraska. As of October 1, 2012, 442 of the 1080 licensed NPs in Nebraska are members of NNP.

2) Identify by title, address, telephone number, email address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of any of the following:

a) members of the same occupation or profession as that of the applicant group,

Nurse practitioners (NPs) are one of four groups licensed as Advanced Practice Registered Nurses (APRNs) in the state of Nebraska, regulated by the APRN Board (Advanced Practice Registered Nurse Practice Act, 2008).

This application is made on behalf of NPs in Nebraska. In addition to nurse practitioners, the following numbers of individuals were licensed as APRNs in 2012:

Certified registered nurse anesthetists - 524 licensed in Nebraska
Nebraska Association of Nurse Anesthetists
625 S. 14th St., Suite A
Lincoln, NE 68506
T: 402-436-2168
stheoharis@charter.net
www.hwic.org

Certified nurse midwives - 34 licensed in Nebraska
American College of Nurse Midwives, Nebraska Affiliate
Latrice Martin
822 Bordeaux Ave.
Bellevue, NE 68123
T: 402-292-6433
latrice.martin@midwives.org
www.midwife.org

Clinical nurse specialists - 101 licensed in Nebraska
National Association of Clinical Nurse Specialists
100 N. 20th St., 4th Floor
Philadelphia, PA 19103
T: 215-320-3881
info@nacns.org
www.nacns.org

A comprehensive list of licensed APRNs in Nebraska and their contact information can be made available upon request from the Nebraska Board of Nursing.
Contact person:
Nebraska Advanced Practice Registered Nurse Board
Karen Bowen, MSN, RN, Executive Director
DHHS, Division of Public Health, Licensure Unit
301 Centennial Mall South
Lincoln, NE 68509
T: 402-471-6443
Karen.Bowen@nebraska.gov

b) members of the occupation dealt with in the application,

Though not intended to be inclusive, this category is addressed in Appendix A.

c) employers of the occupation dealt with in the application,

Nurse practitioners work in a wide variety of practice sites. They may be employed by private or public facilities, physicians, for profit or nonprofit organizations, or they may be self-employed. Practice sites of nurse practitioners in Nebraska are listed in Appendix B.

d) practitioners of the occupations similar to or working closely with members of the occupation dealt with in the application,

Though not intended to be inclusive, this category is addressed in Appendix C.

e) educators or trainers of prospective members of the occupation dealt with in the application,

There are 362 NP programs across the United States. The following are accredited NP programs in Nebraska:

Clarkson College
101 S. 42nd St.
Omaha, NE 68131
(402) 552-3100
admiss@clarksoncollege.edu
www.clarksoncollege.edu

Creighton University
School of Nursing, Omaha Campus
2500 California Plaza
Omaha, NE 68178
(402) 280-2700
info@creighton.edu
www.creighton.edu
Campuses in Omaha and Hastings

University of Nebraska Medical Center
College of Nursing
985330 Nebraska Medical Center
4111 Dewey Avenue
Omaha, NE 68198
(402)-559-4000
benjamin.schultz@unmc.edu
http://www.unmc.edu/nursing
Campuses in Omaha, Lincoln, Norfolk, Kearney, and Scottsbluff

f) citizens familiar with or utilizing the services of the occupation dealt with in the application (e.g., advocacy groups, patient rights groups, volunteer agencies for particular diseases or conditions, etc.),

Appendix D identifies advocacy groups, patients rights groups and volunteer agencies that represent citizens familiar with or utilizing the services of NPs.

g) any other group that would have an interest in the application.

Though not intended to be inclusive, this category is addressed in Appendix E.

3) If the profession is currently credentialed in Nebraska, provide the current scope of practice of this occupation as set forth in state statutes. If a change in this scope of practice is being requested, identify that change.

The Nurse Practitioner Practice Act (Appendix F) identifies the following as the scope of practice for NPs:

> **38-2315. Nurse Practitioner; functions; scope.** (1) A nurse practitioner may provide health care services within specialty areas. A nurse practitioner shall function by establishing collaborative, consultative, and referral networks as appropriate with other health care professionals. Patients who require care beyond the scope of practice of a nurse practitioner shall be referred to an appropriate health care provider.
> (2) Nurse practitioner practice means health promotion, health supervision, illness prevention and diagnosis, treatment, and management of common health problems and chronic conditions, including:
>
> (a) Assessing patients, ordering diagnostic tests and therapeutic treatments, synthesizing and analyzing data, and applying advanced nursing principles;
> (b) Dispensing, incident to practice only, sample medications which are provided by the manufacturer and are provided at no charge to the patient; and
> (c) Prescribing therapeutic measures and medications relating to health conditions within the scope of practice. Any limitation on the prescribing authority of the nurse practitioner for controlled substances listed in Schedule II of section 28-405 shall be recorded in the integrated practice agreement established pursuant to section 38-2310.

(3) A nurse practitioner who has proof of a current certification from an approved certification program in a psychiatric or mental health specialty may manage the care of patients committed under the Nebraska Mental Health Commitment Act. Patients who require care beyond the scope of practice of a nurse practitioner who has proof of a current certification from an approved certification program in a psychiatric or mental health specialty shall be referred to an appropriate health care provider.
(4) A nurse practitioner may pronounce death and may complete and sign death certificates and any other forms if such acts are within the scope of practice of the nurse practitioner and are not otherwise prohibited by law (Nurse Practitioner Practice Act, 2012).

Nebraska Nurse Practitioners (NNP) as the Applicant Group is not requesting a change in the NP Scope of Practice.

4) If the profession is not currently credentialed in Nebraska describe the proposed scope of practice, or the functions and procedures of this group.

The profession is currently licensed and credentialed in Nebraska.

5) Describe in detail the functions typically performed by practitioners of this occupation, and identify what if any specific statutory limitations have been placed on these functions, and if possible, explain why the Legislature created these restrictions.

Functions
The American Academy of Nurse Practitioners (AANP) provides the following description of the functions of the NP in their Standards of Practice, identified as *The Process of Care*.

The nurse practitioner utilizes the scientific process and national standards of care as a framework for managing patient care. This process includes:

A. Assessment of health status. The nurse practitioner assesses health status by:
- obtaining a relevant health and medical history
- performing a physical examination based on age and history
- performing or ordering preventative and diagnostic procedures based on the patient's age and history
- identifying health and medical risk factors

B. Diagnosis. The nurse practitioner makes a diagnosis by:
- utilizing critical thinking in the diagnostic process
- synthesizing and analyzing the collected data
- formulating a differential diagnosis based on the history, physical examination, and diagnostic test results
- establishing priorities to meet the health and medical needs of the individual, family, or community

C. Development of a treatment plan. The nurse practitioner, together with the patient and family, establishes an evidence-based, mutually acceptable, cost-awareness plan of care that maximizes health potential.
Formulation of the treatment plan includes:
- ordering and interpreting additional diagnostic tests
- prescribing/ordering appropriate pharmacologic and nonpharmacologic interventions
- developing a patient education plan
- appropriate consultation/referral

D. Implementation of the plan. Interventions are based upon established priorities.
Actions by the nurse practitioner are:
- individualized
- consistent with the appropriate plan of care
- based on scientific principles, theoretical knowledge, and clinical expertise
- consistent with teaching and learning opportunities

Actions include:
- accurately conducting supervising, and interpreting diagnostic tests
- prescribing/ordering pharmacologic agents and nonpharmacologic therapies
- providing relevant patient education
- making appropriate referrals to other health professionals and community agencies

E. Follow-up and evaluation of the patient status. The nurse practitioner maintains a process for systematic follow-up by:
- determining the effectiveness of the treatment plan with documentation of patient care outcomes
- reassessing and modifying the plan with the patient and family as necessary to achieve health and medical goals (AANP, Standards of Practice for Nurse Practitioners, 2010)

The preceding definition is closely aligned with the functions detailed in the Nurse Practitioner Practice Act (Appendix F) scope of practice for NPs (38-2315) with the following distinctions:

> 2b. Dispensing sample medications incident to practice
> 3. Management of the care of patients committed under the Nebraska Mental Health Commitment Act
> 4. Pronouncement of death, completion and signature of death certificates and any other forms (Nurse Practitioner Practice Act, 2012)

Nurse practitioner functions are best understood in context of the development of the role to fulfill the primary care needs of the population that could no longer be met by physicians alone. The establishment of Medicare and Medicaid in 1965 greatly expanded the coverage of health care services. Increased hospital use and the accompanying demand for physician services resulted in a shortage of physicians for primary care services. It became apparent that the role of registered nurses could be expanded with advanced education and clinical training to provide diagnosis and treatment. The first NPs were prepared to provide pediatric primary care services (Dolan, Fitzpatrick & Herrman, 1983).

State boards of nursing began to license APRNs in the early 1970s (Dorsey, 2007). Scope of practice regulations for advanced practice nurses were carved out of the definitions of medical practice within the states (Safriet, 2011). Nurse practitioners were performing functions that had once been exclusive to the practice domain of physicians. Historically, physicians had been the first group of healthcare professionals to obtain legislative recognition of and protection for practice authority. Their practice was defined in broad and undifferentiated terms to include all aspects of care (Milstead, 2008).

In the mid-1990's, the persistent drift of physicians to specialty practice propelled an ever widening gap in primary health care services. "The explosion of evidence within health care, the rapidly changing healthcare environment, and economic incentives created pressure for physicians to specialize and to further specialize within specialties" (Stevens, Hansen & Ryan, 2010, p. 5). Nurse practitioners had established themselves as qualified primary care providers and moved to fill the void, most often to facilities offering care for the underserved in inner city and rural areas (Kalisch & Kalisch 1995).

Statutory Limitations

The change sought in this Credentialing Application is removal of the Integrated Practice Agreement pursuant to section 38-2310 of the Nurse Practitioner Practice Act (Appendix F).

As healthcare has become increasing complex, overlap of the functions of health care providers is an inherently natural evolution. The continuing challenge to provide comprehensive care to all individuals can only be met by optimizing resources and supporting the practice of all healthcare providers to the fullest extent of their education and preparation. Physician supervision restricts practice and ignores the ability of NPs to function autonomously within a defined scope of practice. Restriction of practice is a barrier to the access of much needed services. State regulations for an Integrated Practice Agreement with provisions for physician supervision are no longer relevant to the role of the NP in contemporary health care in this state.

> **38-2310. Integrated practice agreement, defined.**
> (1) Integrated practice agreement means a written agreement between a nurse practitioner and a collaborating physician in which the nurse practitioner and the collaborating physician provide for the delivery of health care through an integrated practice. The integrated practice agreement shall provide that the nurse practitioner and the collaborating physician will practice collaboratively within the framework of their respective scopes of practice. Each provider shall be responsible for his or her individual decisions in managing the health care of patients. Integrated practice includes consultation, collaboration, and referral.
> (2) The nurse practitioner and the collaborating physician shall have joint responsibility for patient care, based upon the scope of practice of each practitioner. The collaborating physician shall be responsible for supervision of the nurse practitioner to ensure the quality of health care [sic] provided to patients.
> (3) For purposes of this section:
>
> (a) 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; and
>
> (b) 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. (Nurse Practitioner Practice Act, 2012)

Legislative History

The current regulatory system governing scope of practice in this state has evolved from and remains tightly linked to the history of professional licensure. When other healthcare professionals seek legislative recognition, they are perceived as attempting to claim the ability to do tasks that were once included in the universal and implicitly exclusive authority of the practice of medicine. "This dynamic has fostered an enduring, conceptually faulty, and potentially detrimental legislative view of the scope of practice" (Stevens et al., 2010, p. 5).

In 1984, Legislative Bill (LB) 724 authorized the practice of NPs in Nebraska with provisions that were unquestionably characteristic of the understanding of the relationship of the role to the practice physicians at the time. The functions of the NP were described as "specific medical functions" (p. 8736) to be specifically enumerated in a practice agreement with a collaborating physician. The NP could practice only under the supervision of a collaborating physician. Practice agreements were subject to approval by the Board of Nursing and the Board of Examiners in Medicine & Surgery (Nebraska State Legislature, 1984).

Discussion regarding physician supervision as a barrier to practice in Nebraska began with the introduction of LB 414 to the Health and Human Services Committee in 1995. The compelling tenant for the bill in its original form was independent practice for NPs that would "bring the standards of professional requirements and practice opportunities in line with neighboring states" (Introducer's Statement of Intent). There was evidence that Nebraska was losing qualified graduates to other states where "working conditions were more favorable and less restrictive" (Introducer's Statement of Intent). There was also testimony regarding the difficulties that NPs were having securing a practice agreement. Opponents did not cite any evidence in the hearing that physician supervision was associated with a measurable benefit on the provision of services by NPs (Nebraska State Legislature, 1995).

LB 414 changed descriptors in the scope of practice that had previously defined activities of the nurse practitioner as delegated medical acts to shift liability from the physician to the NP. It also mandated that NPs maintain liability insurance (Nebraska State Legislature, 1995).

The bill was given priority designation in the Legislature in January 1996. Independent practice had been dropped in negotiations between Nursing and Medicine for concessions that required graduate education for NPs, the creation of an advanced practice registered nurse regulatory board, and a "bypass arrangement for extraordinary circumstances" in which the nurse practitioner was unable to obtain a "physician cooperative agreement," (Nebraska State Legislature, 1996, p. 9580). The latter eventually became the APRN Board (38:2322) and Waiver Process (38:2306) in the Nurse Practitioner Practice Act (Appendix F, 2012).

The last remaining issue was the definition of supervision in the practice agreement, "the ready availability of the collaborating physician for consultation and direction of activities" (Nebraska State Legislature, 1996, p. 9580) of the NP. Senator Witham and co-sponsor, Senator Wesley, offered an amendment, AM2750, to strike the words "direction of" and

insert the words "advice on" (p. 9580) the activities of the NP with the intent of resolving the disagreement between nursing and medicine.

Transcripts of the debate in the legislature describe the senators' perception that physician supervision implied liability for the activities of the NP, and that liability afforded the patient a higher standard of care (pp. 9598-9599). Amendment AM2750 failed on the basis of the conclusion by the senators that *to advise* was inconsistent with supervision. A subsequent vote approved LB 414 with the inclusion of the IPA and retained the definition of supervision as physician *direction of* the activities of the NP (Nebraska State Legislature, 1996).

Following LB 414, there have been two additional bills submitted to the Health and Human Services Committee requesting removal of the Integrated Practice Agreement, LB 753 (2008) and LB 230 (2009). Opponents again failed to cite any evidence in those hearings that physician supervision afforded patients any measurable benefit on the outcomes of care delivered by NPs in this, or any other states.

6. Identify other occupations that perform some of the same functions or similar functions.

Nurse practitioners, physicians, osteopathic physicians and physician assistants all function as health care providers. A health care provider is defined in the Code of Federal Regulation as a "provider of medical or health services, and other person or organization who furnishes, bills, or is paid for health care in the normal course of business" (Title 45 - Public Welfare, 2002).

7. What functions are unique to this occupation? What distinguishes this occupation from those identified in question 6?

The functions of the NP—assessment, diagnosis, development and implementation of a plan of care and evaluation of the outcome—although, not unique to NPs as health care providers, are uniquely distinguished by the nursing philosophy of care. "The concern of nursing is with man in his entirety, his wholeness. Nursing's body of scientific knowledge seeks to describe, explain, and predict about human beings" (Rogers, 1970, p. 83).

Nurse practitioners differ from other healthcare providers, including physicians, osteopathic physicians and physician assistants, in that their functions are defined in a scope of practice. Nurse practitioners and other healthcare providers also differ in their respective models of care and role authority.

Scope of practice. Nurse practitioners function within a defined Scope of Practice (38:2310) within the Nurse Practitioner Practice Act (Appendix F, 2012). Scope of practice is the "definition of the rules, 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 requirements for continuing education and professional accountability" (Pew Health Profession Commission, 1995, p. ix). The scope of practice of a healthcare profession is the assurance of the safety of the services it provides (Pohl, Hanson, Newland & Cronenwett, 2010).

Conversely, the Statutes Relating to the Medicine and Surgery Practice Acts (Appendix G, 2012) define the practice of medicine, surgery (38-2024), osteopathic physicians (38-2029), and physician assistants (38-2014). Medical practice acts are generally regarded as all-inclusive, giving physicians full plenary authority to diagnose and treat all conditions.

Models of care. Nurse practitioners, by the nature of their education, experience and emphasis on caring for the individual, emphasize a holistic approach to medical care. The basic tenets of the NP educational curricula, which includes the traditional medical components of pathophysiology, pathology, pharmacology, diagnosis, and treatment are rooted in a nursing philosophy that emphasizes the psychosocial aspects of patient, family, and community in providing care. The nursing model has also long emphasized prevention and continuity of care as a priority, in contrast to the more traditional episodic medical model of care that responds after illness has occurred (Pender, Murdaugh, Parsons, 2001). Nursing is patient-centered, as opposed to disease-focused. Nurse practitioners view patients and families as active participants in their care and incorporate education as a necessary and important element of patient care (AANP Standards of Practice for Nurse Practitioners, 2010).

Role authority. The NP functions under statutory provisions in the Nurse Practitioner Practice Act (2012) that includes physician and osteopathic physician supervision (38-2315). The statutes (Appendix F) also define Collaboration (38-2308), Consultation (38-2309) and Referral (38-2314) with other healthcare professionals.

Comparatively, the Statutes Relating to the Medicine and Surgery Practice Act (Appendix G) define the Physician Assistant (38-2047) as performing "medical services that (a) are delegated and provided under the supervision of a licensed physician" (2012). Historically, the role of the physician assistant was developed as an *extension* of physician practice and as such, is defined in physician practice acts (Dolan et al., 1983).

Nurse practitioners are educated and prepared to function in an *expanded* nursing role (Dolan, 1983). Loretta Ford, who founded the role of the NP with Henry Silver, MD in

1965, recalls, "The [NP] was not a substitute for the physician; their relationship was envisioned as collaborative and collegial" (Ford, 1997 pp. 87-91). While the health care provider roles and functions of NPs and physician providers overlap in many ways, they are not the same, nor does one subsume the others by the very nature of their respective science, education, and preparation. Nurse practitioners have never regarded physician collaboration to mean physician supervision of their practice (Kalisch & Kalisch, 1995).

8. Identify other occupations whose members regularly supervise members of this occupation, as well as other occupations whose members are regularly supervised by this occupation. Describe the nature of the supervision that occurs in each of these practice situations.

Physician supervision of NPs. According to the Nurse Practitioner Practice Act, (Appendix F), the Integrated Practice Agreement (38-2310), physician supervision of the NP is defined as follows:

> 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 (Nurse Practitioner Practice Act, 2012).

The interpretation of supervision as *ready availability* varies significantly between physicians and NPs that have entered into IPAs in Nebraska. It is widely accepted that the physician may or may not be on the same practice site as the NP, and is available by telephone, text, fax, or email.

The physician entering into a practice agreement with the NP does not necessarily practice at the same site, or share the same employer as the NP. There may be a contractual agreement requiring a specified number of minimum monthly practice hours by the physician at the practice site, and the physician does not necessarily fulfill that commitment when the NP is on site. Practice agreements may be arranged by employers, so that the NP may not have met the physician prior to beginning practice (NNP membership survey, November 2012, in progress).

In practice, *availability of the collaborating physician for consultation and direction,* as stated in the statutory definition, may be interpreted by both parties as including some agreed upon frequency for either a shared or independent review of a sample of patient medical records by the physician. There may or may not be any written criteria specifying the number of records that will be reviewed, what action will be taken or what the expected outcome of the review will be.

Practices for physician signature, or increasingly, electronically-formatted documentation, vary widely and may in part depend on medical staff or health care facility policies. In some practice agreements, there is no demonstrable physician oversight of the activities of the NP (NNP membership survey, November 2012, in progress).

Nurse practitioner supervision of other occupations. Nurse practitioners may be required to supervise licensed and unlicensed staff in clinics, hospitals, and any other setting where healthcare is provided. Supervisory roles in the practice are defined according to practice ownership, contractual agreement, and/or facility policies and procedures.

For example, the NP as a practice owner would have a supervisory role over a phlebotomist that he/she employed, but not with the phlebotomist that is employed and trained by the hospital where he/she makes patient rounds. The NP, as the highest credentialed staff member in attendance, may have the authority to direct emergency or critical care personnel in procedures such as cardiopulmonary resuscitation or trauma interventions, but may not have a supervisory relationship with the same staff. Likewise, a NP, as the most knowledgeable and qualified staff member, may have an employer-defined role to train staff nurses in a new procedure, but not necessarily a supervisory role.

9. What actions, judgments, and procedures of this occupation can typically be carried out without supervision or orders? To what extent is this occupation, or portions of its practice, autonomous?

Nurse practitioners in Nebraska function within the Scope of Practice (38-2310) in the Nurse Practitioner Practice Act (Appendix F, 2012). Nurse practitioners are educated, credentialed and licensed to function autonomously without supervision or orders from any other health care professional. The degree of NP autonomy varies across the United States due to state based regulatory requirements.

Autonomy is the hallmark of professionalism:

> Nursing can no longer be viewed as a subsidiary function of medicine that is prescribed by doctors' orders; nursing care now reflects a patient-centered approach based on nursing theory and shaped by a nursing process of reasoning. Current legal and professional regulations legitimate this nurse-driven process of practice. The body of statutory and case law that governs nursing practice hold nurses accountable to a definition of practice that recognizes and codifies practice in accordance with current nursing knowledge and clinical practice standards. Accountability is inherent to autonomy. (Wolf, 2009)

Autonomous practitioners have direct lines of access to clients. They are responsible for their own practice decisions and are accountable to clients, peers, and professional organizations, as well as to the courts (Marram, Schlegel, & Bevis, 1974). Nurse practitioners are also responsible for seeking education to acquire new and maintain existing knowledge, skill sets and competencies.

10. Approximately how many people are performing the functions of this occupation in Nebraska, or are presenting themselves as members of this occupation? To what extent are these people credentialed in Nebraska?

There are 1080 licensed nurse practitioners in Nebraska as of November 2, 2012. Appendix H shows the coverage of NPs according to county in the state of Nebraska (Nebraska Center for Nursing, 2012a). A map of physician coverage in Nebraska is included in Appendix I (Nebraska Center for Nursing, 2012b). These maps illustrate the lack of providers in several counties.

All NPs are credentialed, providing health care services within the specialty areas for which they are educationally prepared and certified. All individuals applying for licensure in Nebraska as a NP must have:

1. Successfully completed a graduate-level program in a clinical specialty area of NP practice; education is the formal preparation of the NP.
2. Verification of having passed a national certifying examination; certification is the formal recognition of the knowledge, skills and experience demonstrated by the achievement of standards identified by the profession.
3. Verification of having passed a national Licensing & Regulatory Affairs examination.

Requirements prior to commencing practice in Nebraska are:

1. Licensure as APRN;
2. An Integrated Practice Agreement(s);
3. Proof of Liability Insurance; and
4. Jointly Approved Protocols WHEN the applicant:
   A. has not completed 2000 hours of advanced nursing practice under the supervision of a physician.
   B. cannot demonstrate separate course work from an approved program in pharmacotherapeutics, advanced health assessment, and pathophysiology or psychopathology to include 45 advanced academic contact hours each; or
   C. does not have a master's or doctorate degree. (Regulation and Licensure, 2004)

Specialty areas recognized by the APRN Board for certification and licensure in Nebraska are adult, family, gerontology, pediatric, acute pediatric, psych/mental health, adult psych/mental health, child and adolescent psych/mental health, acute care, women's health, and neonatal (Regulation and Licensure, 2004). If a NP wishes to expand practice into an additional specialty area, he/she must have the educational training and be certified in that specialty.

Certification is offered by the following professional organizations:

American Academy of Nurse Practitioners (AANP)
PO Box 12926,
Austin, TX 78711
T: 512-442-5202
www.aanp.org
AANP offers NP certification in the following areas: Adult NP, Gerontologic, Adult-Gerontology, and Family NP

American Nurses Association – American Nurses Credentialing Center (ANCC)
8515 Georgia Avenue, Suite 400,
Silver Spring, MD 20910
T: 800-284-2378
www.nursecredentialing.org
ANCC offers NP certification in the following areas: Acute Care NP, Adult NP, Adult Psychiatric and Mental Health NP, Family NP, Gerontological NP, Pediatric NP, and Family Psychiatric and Mental Health NP

Pediatric Nursing Certification Board (PNCB)
800 S. Frederick Avenue, Suite 204,
Gaithersburg, MD 20877
T: 888-641-2767
www.pnpcert.org
PNCB offers NP certification in the following areas: Pediatric NP and Acute Care Pediatric NP

National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC)
PO Box 11082, Chicago, IL 60611-0082
1-800-367-5613
http://nccnet.org
NCC offers NP certification in the following areas: Women's Health NP and Neonatal NP

American Association of Critical-Care Nurses (AACN)
101 Columbia
Aliso Viejo, CA 92656-4109
1-800-899-2226
http://aacn.org
AACN offers NP certification in the following area: Acute Care NP

11. Describe the general level of education and training possessed by practitioners of this occupation, including any supervised internship or fieldwork required for credentialing. Typically, how is this education and training acquired?

A Bachelor of Science in Nursing (BSN) degree is a requirement for application to a NP program. Nurse practitioners graduate with a Master of Science in Nursing (MSN) or Doctorate of Nursing Practice (DNP). There are two types of doctoral programs in nursing: a research-based doctorate (PhD) and a practice-based doctorate (DNP). DNP curricula build on traditional master's programs by providing education in evidence-based practice, quality improvement, and systems leadership, among other key areas. The American Association of Colleges of Nursing has endorsed transitioning the current level of preparation necessary for advanced nursing practice from the master's degree to the doctorate-level by the year 2015 (American Association of Colleges of Nursing, 2012).

National consensus-based evaluation standards for NP programs have been developed and endorsed by all major NP organizations and NP program accreditation bodies (National Task Force on Quality Nurse Practitioner Education, 2012). There are two national accrediting bodies for NP schools: the National League for Nursing Accreditation Commission (NLNAC) and the Commission on Collegiate Nursing Education (CCNE). The faculty member who provides direct oversight must be nationally certified in the same population-focused area of practice. Nurse practitioner students complete their clinical experience based on preceding or concurrent didactic coursework, with an emphasis in the APRN core competencies: advanced pharmacology, advanced health assessment, and advanced physiology and pathophysiology. There are nine NP core competencies defined by the National Organization of Nurse Practitioner Faculties (NONFP), listed as follows:

1) **Scientific Foundation Competencies**
    - Critically analyzes data and evidence for improving advanced nursing practice.
    - Integrates knowledge from the humanities and sciences within the context of nursing science.

- Translates research and other forms of knowledge to improve practice processes and outcomes.
- Develops new practice approaches based on the integration of research, theory, and practice knowledge.

2) Leadership Competencies

- Assumes complex and advanced leadership roles to initiate and guide change.
- Provides leadership to foster collaboration with multiple stakeholders (e.g. patients, community, integrated health care teams, and policy makers) to improve health care.
- Demonstrates leadership that uses critical and reflective thinking.
- Advocates for improved access, quality and cost effective health care.
- Advances practice through the development and implementation of innovations incorporating principles of change.
- Communicates practice knowledge effectively both orally and in writing.
- Participates in professional organizations and activities that influence advanced practice nursing and/or health outcomes of a population focus.

3) Quality Competencies

- Uses best available evidence to continuously improve quality of clinical practice.
- Evaluates the relationships among access, cost, quality, and safety and their influence on health care.
- Evaluates how organizational structure, care processes, financing, marketing and policy decisions impact the quality of health care.
- Applies skills in peer review to promote a culture of excellence.
- Anticipates variations in practice and is proactive in implementing interventions to ensure quality.

4) Practice Inquiry Competencies

- Provides leadership in the translation of new knowledge into practice.
- Generates knowledge from clinical practice to improve practice and patient outcomes.
- Applies clinical investigative skills to improve health outcomes.
- Leads practice inquiry, individually or in partnership with others.
-
- Disseminates evidence from inquiry to diverse audiences using multiple modalities.
- Analyzes clinical guidelines for individualized application into practice.

5) Technology and Information Literacy Competencies

- Integrates appropriate technologies for knowledge management to improve health care.

- Translates technical and scientific health information appropriate for various users' needs.
    a) Assesses the patient's and caregiver's educational needs to provide effective, personalized health care.
    b) Coaches the patient and caregiver for positive behavioral change.
- Demonstrates information literacy skills in complex decision making.
- Contributes to the design of clinical information systems that promote safe, quality and cost effective care.
- Uses technology systems that capture data on variables for the evaluation of nursing care.

6) Policy Competencies

- Demonstrates an understanding of the interdependence of policy and practice.
- Advocates for ethical policies that promote access, equity, quality, and cost.
- Analyzes ethical, legal, and social factors influencing policy development.
- Contributes in the development of health policy.
- Analyzes the implications of health policy across disciplines.
- Evaluates the impact of globalization on health care policy development.

7) Health Delivery System Competencies

- Applies knowledge of organizational practices and complex systems to improve health care delivery.
- Effects health care change using broad based skills including negotiating, consensus-building, and partnering.
- Minimizes risk to patients and providers at the individual and systems level.
- Facilitates the development of health care systems that address the needs of culturally diverse populations, providers, and other stakeholders.
- Evaluates the impact of health care delivery on patients, providers, other stakeholders, and the environment.
- Analyzes organizational structure, functions and resources to improve the delivery of care.
- Collaborates in planning for transitions across the continuum of care.

8) Ethics Competencies

- Integrates ethical principles in decision making.
- Evaluates the ethical consequences of decisions.
- Applies ethically sound solutions to complex issues related to individuals, populations and systems of care.

9) Practice Competencies

- Functions as a licensed independent practitioner.
- Demonstrates the highest level of accountability for professional practice.

- Practices independently managing previously diagnosed and undiagnosed patients.
    a) Provides the full spectrum of health care services to include health promotion, disease prevention, health protection, anticipatory guidance, counseling, disease management, palliative, and end of life care.
    b) Uses advanced health assessment skills to differentiate between normal, variations of normal and abnormal findings.
    c) Employs screening and diagnostic strategies in the development of diagnoses.
    d) Prescribes medications within scope of practice.
    e) Manages the health/illness status of patients and families over time.
- Provides patient-centered care recognizing cultural diversity and the patient or designee as a full partner in decision-making.
    a) Works to establish a relationship with the patient characterized by mutual respect, empathy, and collaboration.
    b) Creates a climate of patient-centered care to include confidentiality, privacy, comfort, emotional support, mutual trust, and respect.
    c) Incorporates the patient's cultural and spiritual preferences, values, and beliefs into health care.
    d) Preserves the patient's control over decision making by negotiating a mutually acceptable plan of care. (NONPF, 2012)

12. Identify the work settings typical of this occupation (e.g., hospitals, private physicians, offices, clinics, etc.) and identify the predominant practice situations of practitioners, including typical employers for practitioners not self-employed (e.g., private physician, dentist, optometrist, etc.).

Work settings for NPs are described according to licensure renewal survey data collected in 2010 (J. Ramirez, personal communication, October 7, 2012). Note that the majority of NPs are employed by hospitals, followed by physicians' offices or health clinics.

There are 3.1%, or approximately 30 NPs, that listed themselves as self-employed in 2010. This would include NPs in solo and combined practices with other NPs, physicians, osteopathic physicians and/or physician assistants.

Hospital	45.5%
Physician's Office/Health Clinic	23.8%

Ambulatory Care	.8%
Nursing Education	6.9%
Other	5.0%
Self Employed	3.1%
Public/Community/Home Health	2.3%
Nursing Home	1.4%
Dialysis Center	0.9%
Student Health/School	0.9%
Agency Staff (temporary or scheduler)	0.5%
Alcohol/Detox/Halfway House	0.2%
Hospice	0.2%
Occupational Health	0.2%
Assisted Living	0.1%
Parish Nursing	0.1%
Forensic Nursing	0.1%
Insurance Company/HMO	0.1%

13. Do practitioners routinely serve members of the general population? Are services frequently restricted to certain segments of the population (e.g., senior citizens, pregnant women, etc.)? If so, please specify the type of population served.

Nurse practitioners are often the provider of choice with health promotion and disease prevention services, and may be the only health care provider for rural and underserved populations. Nurse practitioners work with patients across the lifespan and serve all members of the population in all areas of healthcare, working within specific specialties defined by their area of certification.

The APRN Board provides the following description of specialty practice areas:

- Adult - 18 years and older
- Family- covers the life span
- Pediatric- birth through 21 years
- Gerontology- aging adult (55 years and older)
- Acute- acutely ill, critically or chronically ill adult patients
- Women's health- women across the life cycle with emphasis on conditions unique to women
- Neonatology- birth to 2 years
- Adult Psych/Mental Health- provide a full range of psychiatric and primary mental health care to adults

- Psych/Mental Health- provide primary mental health care to individuals of all ages and families
- Child and Adolescent-provide primary mental health care to children and Psych/Mental Health adolescents through 21 years of age. (Guidelines for Nurse Practitioner Specialties, 2009)

14. Identify the typical reasons a person would have for using the services of a practitioner. Are there specific illnesses, conditions or situations that would be likely to require the services of a practitioner? If so, please specify.

Nurse practitioners practice within their scope of practice as defined by their education, and by the standards and guidelines established by their national certifying body. The definition of *typical* reasons that an individual would require the services of a NP is entirely dependent on the NP's clinical practice specialty and the work setting.

A **Family Nurse Practitioner (FNP)** provides healthcare to patients and families at all stages of life in primary care settings. An **Adult Nurse Practitioner (ANP)** provides primary care services to adults. The individual presenting to a NP for primary care services might require a well-child, student athlete, or preoperative exam. They may also present for diagnosis and treatment of short-term, acute illnesses like an upper respiratory infection or musculoskeletal pain. Adult nurse practitioners also monitor and treat relatively stable chronic disease, like hypertension or diabetes. They would encounter patients in private practice, as well as, rural health, public health and community health centers. In a rural clinic practice, the role of the NP may be expanded to hospital and nursing home rounds, and after-hours calls, including emergency room care with additional training for established patients in the practice.

Children would see a **Pediatric Nurse Practitioner (PNP)** for primary care services, including well-child exams and immunizations, until the age of 21. PNPs might practice in private primary care pediatric practices, or hospital-based specialty clinics for children with chronic disease like hemophilia or diabetes. Acute care PNPs would care for critically ill, hospitalized children.

The **Geriatric Nurse Practitioner (GNP)** provides primary care, treatment, and counseling for the older adult most often in residential care settings. The focus is on chronic disease and the impact of developmental changes such as those that occur with vision, hearing, and mobility. The GNP is concerned with the maintenance of self-management skills like medication administration, meal preparation, household chores and motor vehicle safety for those elders living independently. The GNP might refer a patient for physical therapy or

other rehabilitative-restorative therapies after injury, or following surgery for degenerative joint disease. Patients may present to the GNP for medication renewal or adjustments, as well as for monitoring chronic, labile health conditions between appointments with specialty providers, e.g, heart failure or chronic lung disease. Family members are included in consultation, education and planning for entry into and ongoing long-term care services.

Women's Health Nurse Practitioners (WHNPs) provide primary care exclusively to women of childbearing age and beyond. The focus is on prevention, diagnosis and treatment of diseases specific to women. Prenatal care, postpartum care, guidance for menopause, gynecologic health maintenance that includes pelvic and breast examinations, treatment for sexually transmitted diseases, and contraceptive services are just some of the services a WHNP might offer in a private practice or other setting that offers women's health services.

N**eonatal Nurse Practitioner (NNPs)** care for preterm infants, newborns and children under the age of two. NNPs often attend high risk deliveries and may stabilize or resuscitate critically ill newborns. Most NNPs practice in hospital intensive care nurseries and work closely with an interdisciplinary team and families. They may also see patients in clinics following hospital discharge.

Psychiatric/Mental Health Nurse Practitioners (PMH-NPs) assess, diagnose, and treat individuals and families of all ages with psychiatric and mental health conditions, ranging from anxiety reactions to substance abuse to psychiatric disorders. PMH-NPs rely on therapeutic skills that include the prescription of psychotropic medications and administration of psychotherapy. Patients may encounter PMH-NPs in private practices, hospitals, or inpatient treatment programs.

Patients across the lifespan may present to **Emergency Department Nurse Practitioners** with urgent primary care needs e.g., pneumonia; acute and critical illnesses that require stabilization, e.g., exacerbation of asthma or heart failure; accidental injuries, e.g., repair of laceration or limb fracture; trauma or catastrophic illness requiring life support and/or preparation for emergency diagnostic procedures or surgery.

Adult patients encounter **Acute Care Nurse Practitioners** in general and critical care hospital units in specialty practice roles with physicians like Cardiologists, Gastroenterologists and Pulmonologists. Responsibilities include admission and daily orders for nursing and ancillary staff, daily patient visits, review of laboratory and other diagnostic tests, medication management and consultation with other health care providers and staff nurses. Acute care NPs develop and coordinate patient care discharge plans with post-hospital providers and services.

Adult Specialty Practice. Patients with health conditions that require specialty physician consultation may encounter a NP for very focused services like insulin management in an Endocrinologist office, medication adjustment in a heart failure clinic in a Cardiology Hospital, or transplantation follow-up in a hospital-based transplant clinic. Some specialists employ NPs for a relatively broader scope of patient encounters, e.g., the NP in a general surgeon's office may see patients throughout the trajectory of a surgical experience, from preoperative education to hospitalization to a final office visit for suture removal. Nurse practitioners may also offer home health visits for those who are homebound, or manage the care and medications of patients enrolled in hospice or palliative care services.

15. Identify typical referral patterns to and from members of this occupational group. What are the most common reasons for referral?

Referral Patterns to the NP. Referral patterns vary from one practice setting to another and are dependent on other provider availability in the setting, location of the practice, type of specialty practice, and patient preferences. The NP in a private primary care clinic with no physician on site would accept patient referrals from other providers and manage the patients independently. In a practice with a physician on site, new patient referrals would most likely be made to the physician with follow-up or agreed-upon interval appointments with the NP. This is especially true when the collaborating physician is in specialty practice and accepts patients for consultation from other providers. The NP would follow specific patients for management and adjustment of a regimen prescribed by the physician.

Patient preferences regarding appointments with a medical or nursing provider would be accommodated assuming availability and equivalency of services. The NP would most likely see established patients for new onset, acute illness, e.g., upper respiratory infection. The patient with multiple complicating morbidities and/or requesting a physician appointment would likely be directed to the physician provider.

The NP working in an acute care hospital setting would follow patients who had been accepted by a collaborating physician for defined services during the trajectory of care (e.g., daily evaluation and written orders). Medical staff policies or regulatory requirements might require collaborating physician review and co-signature of the plan of care and orders written by the NP. Referrals to the NP in a hospital might also be made on the basis of a specialty service provided by a NP following discharge (e.g., cardiac rehabilitation).

Reasons for Referral to Another Provider. Patients requiring more complex or specialty care are referred by the NP to a physician in specialty practice. For example, the patient

presenting with back pain and a suspicious spinal mass identified by the radiologist would be referred to a neurosurgeon.

The NP would request consultation and treatment by a specialty physician provider for a patient presenting with an urgent or emergent condition. For example, the patient with diabetes, a non-healing foot wound, and lower extremity cellulitis would be sent to the emergency department for evaluation, anticipating the need for surgical consultation and debridement. In a rural area, a NP with hospital privileges might admit the same patient to the local hospital with orders for intravenous antibiotics and insulin, and surgical consultation arranged with a visiting surgeon.

16. Is a prescription or order from a practitioner of another health occupation necessary in order for services to be provided?

Other health care provider referral orders are customary and usual practice, driven by payer requirements for many of the specialty services provided by NPs as self-employed practitioners e.g., mental health, or employees of another entity e.g., wound care. Any provider offering specialty consultation or services would be subject to the same payer requirements for a referral order e.g., home health and hospice agencies can only accept physician orders for those services for Medicare patients (Brassard, 2012).

17. How is continuing competence of credentialed practitioners evaluated?

Ongoing education and practice is vital to growth and maintenance of clinical skills, knowledge, and evidence-based practice. Continuing competence of nurse practitioners relies in part on mandatory continuing education requirements that must be met for licensure and certification renewal. In the state of Nebraska, 40 continuing education contact hours are required for relicensure every 2 years, with 10 of these hours in pharmacology. Nebraska also has a minimum practice requirement for 2080 hours of practice as a NP within the previous 5 years immediately preceding renewal. At least 500 of the 2080 hours of practice must be in a clinical role in which there is direct nurse/patient relationship (Regulation and Licensure, 2004).

Certification renewal is mandatory in Nebraska. Certification requirements vary according to specialty and include specifications for continuing education, including pharmacology hours and specialty practice hours. National certification requirements for continuing education generally extend well beyond those required by the state for relicensure; the renewal period ranges from three to five years, depending on the NP specialty area.

Site-based evaluation of competence and skill sets of NPs is based primarily on requirements within the practice environment. For example, NPs with hospital privileges undergo medical staff requirements for credentialing, and apply for core and advanced practice privileges or skill sets related to their specialty. The credentialing process ensures that the provision of healthcare services is quality, driven by safe and competent providers. It also provides an additional level of scrutiny by a peer review credentialing committee. Providers are generally required to undergo a review process for hospital reappointments at two-year intervals.

Nurse practitioners rely on advanced training to learn and maintain procedural skills that exceed basic credentialing requirements. For example, Advanced Trauma Life Support for Surgeons certification and renewal courses are offered to NPs who provide emergency and/or trauma care in their workplace. A Family NP who shares emergency department call with a collaborating physician in rural Nebraska must necessarily possess skills like chest tube insertion. That same NP will also be required to learn procedural skills that support collaborative practice in the primary care clinic like joint injections, cardiac stress tests, cast applications, or layered suturing.

An experienced NP may teach new skills, mentor a less experienced NP to assist with learning new skills or procedures, or demonstrate competency of established skills according to hospital and/or medical staff policies. All clinical inpatient and outpatient settings typically employ an annual evaluation system that may include peer reviews, self-evaluation, and input from physician and other nursing colleagues. Employers typically require basic and/or advanced lifesaving certification. There may also be additional certification or credentialing requirements specific to specialty.

18. **What requirements must the practitioner meet before his or her credentials may be renewed**?

The continued competence requirements for APRNs to qualify for licensure or relicensure are as follows:

- Current national certification/recertification;
- Documentation of a minimum of 2080 hours of practice as an APRN within the previous five years immediately preceding renewal AND documentation of 40 contact hours of continuing education in the clinical specialty area within the previous two years, 10 hours of which shall be in pharmacotherapeutics;
- At least 500 of the 2080 hours of practice must be in a clinical role in which there is a direct nurse/patient relationship;

- Applicants who have not been licensed in Nebraska or authorized by any other jurisdiction for a minimum of two years shall not be required to meet the continuing education or practice requirement for license renewal;
- Applicants who have not been licensed in Nebraska or authorized by any other jurisdiction for a minimum of five years shall not be required to meet the practice requirement for license renewal (Regulation and Licensure, 2004).

19. Identify other jurisdictions (states, territories, possessions, or the District of Columbia) wherein this occupation is currently regulated by the government, and the scopes of practice typical for this occupation in these jurisdictions.

Currently, 18 states and the District of Columbia allow independent practice or full plenary authority for NP practice, meaning NPs practice within their required education and training under their own license and are accountable for the care they deliver. Appendix J contains a map that illustrates scope of practice regulations for NPs according to state (Pearson, 2012). Regulations related to scope of practice vary between states and are qualified as including practice authority, oversight requirements for practice regulation, prescriptive authority and grounds for disciplinary action (Klein & Kaplan, 2010; Watson & Hillman, 2010).

The removal of scope of practice barriers is a primary recommendation of the Institute of Medicine (IOM) landmark report, *The Future of Nursing*. This report notes that state regulatory barriers are problematic and many states have not kept up with the evolution of the healthcare system, despite decades of NP outcomes research. The report discusses four key messages and makes eight recommendations for change that are focused on the potential for the nursing profession to meet current and projected health needs of the population. The first message states, "Nurses should practice to the full extent of their education and training" (IOM, 2010, p. 4). Restrictions related to scope of practice within the states prevent NPs from practicing to the full extent of their competency.

An APRN regulatory model, called the Consensus Model for APRN Regulation, was developed in 2008 to establish national standard requirements for licensure, accreditation, certification, and education for uniformity across all states. It is expected that the Consensus Model will be universally implemented by 2015. The model calls for laws that enable NPs to practice independently and be accountable "for recognizing limits of knowledge and experience, planning for the management of situations beyond [their] expertise; for consulting with or referring patients to other health care providers as appropriate" (Consensus Model, 2008).

Additional Questions an Applicant Group Must Answer about their Proposal

1) What is the problem created by not regulating the health professional group under review, or by not changing the scope of practice of the professional group under review?

The change sought in this credentialing application is removal of the Integrated Practice Agreement, section 38-2310 of the Nurse Practitioner Practice Act (Appendix F, 2012). The Integrated Practice Agreement poses the following problems:

A. Integrated Practice Agreements are difficult to acquire and maintain.
Integrated Practice Agreements are difficult to acquire in communities where there are either no or few practicing physicians. Rural counties suffer disproportionately in this aspect. In communities where there are relatively more physicians, there are physicians who are simply unwilling to enter into a practice agreement with a NP. The difficulties that NPs have encountered acquiring practice agreements in this state can be readily retrieved in testimony in Health and Human Services Committee hearings (Nebraska State Legislature, 1996; 2008; 2009).

The problems persist. Physicians can and do withdraw from practice agreements without notice and/or leave patients without services until a new collaborating physician can be located. As recently as November 2012, a NP with offices in York and Fillmore county was forced to suspend all activity within both agency and private mental practices for a week until she was able to locate another psychiatrist who was willing to enter into a practice agreement (Personal communication, November 17, 2012).

B. The terms of Integrated Practice Agreements are subject to multiple inconsistencies in interpretation and administration.

Proximity of the collaborating physician and physician. The Integrated Practice Agreement calls for the collaborating physician to practice "in the same geographic area" as the NP (Appendix F, Nurse Practitioner Practice Act, 2012). However, geographic area is not defined in specific terms.

Testimony from a NP on behalf of LB 753 in 2008 cited a collaborating physician as living 200 miles from her rural private primary care practice (Nebraska State Legislature, p. 70). Nurse practitioners in the state continue to report wide variances in the proximity of collaborating physicians to their practice locations (NNP membership survey, November 2012, in progress).

Physician related specialty practice. The Integrated Practice Agreement also calls for the collaborating physician to practice in the same "practice specialty, related specialty, or field of practice as the nurse practitioner" (Appendix F, Nurse Practitioner Practice Act, 2012).

A NP in a rural primary care practice testified before the Health and Human Services Committee in 2009 that she had consulted with the APRN board and had approval to enter into a practice agreement with a pathologist until she was able to locate another collaborating physician (Nebraska State Legislature, LB 230, p. 43).

Another NP testified at the same hearing that part of her difficulty securing a practice agreement was on the basis of physician's interpretation that his practice was unrelated to the skill set of the NP (p. 41).

Physician supervision. The reader is directed to Question 8 of this application which details the multiple interpretations and varying practices regarding physician supervision in practice agreements in this state.

Physician Liability. The interpretation that the practice agreement requirement implies physician liability for the actions of the NP was established in debate in the legislature for LB 414 in 1996 (Nebraska State Legislature, pp. 9598-9599). Concerns regarding liability by both physicians and their practice owners were cited as a deterrent to entering in practice agreements in testimony for LB 230 in 2009 (pp. 41, 46-47). Malpractice insurance for collaborating physicians in practice agreements with NPs can be higher if they are expected by law to be accountable for NP practice (Christian, Dower & O'Neil, 2009).

C. The implementation of the waiver option (38-2333) imposes additional restrictions on NPs who are unable to acquire an Integrated Practice Agreement.

The waiver option (38-2322) exempts NPs from the IPA requirement when they will practice in a geographic area where there is a shortage of health care services and they have made a diligent effort to find a collaborating physician (Appendix F, Nurse Practitioner Practice Act, 2012). However, this poses limitations on NPs seeking a practice agreement in an area where there is not an overall shortage of physician providers or services, but where there is a shortage of providers with specialty skills, such as mental health (Nayar, Nguyen, Apenteng & Shaw-Sutherland, 2011).

Waivers are denied. A NP in rural Nebraska testified before the Health and Human Services Committee in 2008 that she had been denied a waiver by the APRN board on the basis of conditions related to a formal referral system with other health care providers and personal

ownership of the practice. These are circumstances that do not have to be substantiated in practice agreements and that did not change when she eventually acquired a practice agreement (Nebraska State Legislature, 2008, LB 753, pp.73-74).

Another NP in rural Nebraska described the following experience regarding the waiver option: "When starting this clinic I talked to the state about obtaining a waiver because we struggled to find a physician who would be our collaborator. They told us that we had to answer a lot of questions and prove that we had tried to get a collaborating physician and that even if we were granted a waiver we would be required at frequent intervals to prove that we had been working on finding a collaborating physician (Personal communication, July 2011).

The Board of Advanced Practice Registered Nurses (APRN Board) minutes reveal that the waiver option is infrequently utilized. Two waivers have been requested since July 2011. The waivers varied in duration from two to 12 months for an initial request, and six months for an extension for a NP actively seeking a collaborating physician (2012, July 17, pp. 1-2; 2012, July 27, pp. 2-3).

Reasonably, a six to 12 month renewal and/or no assurance that an extension will be granted poses a significant risk to anyone who has resources invested in a new or existing practice, notwithstanding the uncertainty for staff and patients who may be left without an employer and provider, respectively, on short notice. A NP testified before the Health and Human Services Committee in 2008 regarding her reluctance to open a primary care practice in her community on a waiver option.

> "Our physician retired and moved away ten years ago. Our pharmacy closed its doors when an overpass was put in. We have no medical community. We have no medical services....I found a suitable building, I developed plans needed for renovations, I made arrangements with a nearby pharmacy to deliver prescriptions on a daily basis, I arranged for laboratory pickups of samples. My husband and I were ready to invest $100,000 to renovate, staff, and equip a clinic. We knew there wouldn't be much return, but we were willing to do it. It's my town. The project came to an end when I was unable to find a physician anywhere who would sign a collaborative arrangement. I contacted every primary care physician in a 75-mile radius and was refused by all....I'll be real honest--I wasn't to [sic] invest $100,000 on a yearly renewable contract" (Nebraska State Legislature, 2008, LB 753, pp. 70-71).

D. The Integrated Practice Agreement is a barrier to the ability of NPs to offer high quality, cost effective healthcare to underserved populations.

The difficulties associated with the acquisition and maintenance of a practice agreement creates barriers for NPs to (a) practice in areas of the state that would benefit most from their services as primary care providers and (b) fill voids in health care services, particularly mental health care services, in the state.

A recent summary of demographic data suggests a growing and disproportionately high number of individuals over the age of 65 residing in rural areas who have concomitant markers for chronic disease and disability (Cramer, Lazure, K.J. Morris, Valerio & R. Morris, in press, 2012). Forty-two percent of the state's population resides in rural areas with comparatively lower percentages of primary health care providers. A total of 51 counties in Nebraska are designated Primary Care Health Professional Shortage Areas (HPSAs); 15 of the 38 frontier counties have no primary health care providers (Mueller, Nayar, Shaw-Sutherland, Nguyen, Xu, Vanosdel, & Hummel, 2009).

The Health and Resources Services Administration (HRSA) designates localities with ratios of population to primary care practitioners (physicians and osteopathic physicians) greater than 2000:1 as Primary Care HPSAs (HRSA, Health Professions, 2012). Nebraska's health workforce data includes NPs and physician assistants in the definition of primary provider, recognizing their significant role in providing primary care in the rural areas of the state, especially rural health clinics (Mueller et al., 2009). Rural communities also require primary care coverage for their local nursing homes, which can be provided by NPs (Cramer et al., 2012).

Only 20 Nebraska counties have a NP-to-population ratio higher than the 2004 national average ratio of 42 to 100,000 population. Twenty-eight of Nebraska's 93 counties do not have any NPs (Appendix H). NPs are qualified to provide the basic primary healthcare services that consumers need. Basic health care services increase the quality of life for individuals, can mitigate the utilization of more expensive secondary and tertiary health care interventions and keep employees in the workplace, which in turn improves productivity and economic security for communities (AARP Public Policy Institute, 2010).

Shortages in the mental health care provider workforce in Nebraska are significantly higher than primary care. There are federally designated HPSAs in 88 counties and 37 counties with no behavioral health professionals (Mueller et al., 2009). A pending gap analysis, The Journey to Barrier-Free APRN Practice in Nebraska (Havlicek-Cook, K. Manuscript in preparation), will investigate the barriers to mental health NP practice in Nebraska. The thesis statement "What would a barrier-free NP practice look like in Nebraska?" methodically investigates 22 barriers to NPs as mental health providers in the state. The

author identifies state regulations related to independent practice for NPs, followed by physician availability for practice agreements, as the two leading issues in the analysis that preclude qualified mental health NPs from practicing in the state (Personal Communication, November 4, 2012).

E. The frank difficulties surrounding the acquisition and maintenance of an Integrated Practice Agreement stifle new and innovative practice models.

An early Institute of Medicine (IOM) report, *Crossing the Quality Chasm,* (2001), pointed to state practice acts that impose unnecessary restrictions on non-physician providers as a barrier to the development of innovative health care models for patients across settings and over time. The report recommended that regulators create an infrastructure to support evidence-based practice, facilitate the use of information technology, align payment incentives with quality initiatives, and prepare the workforce to better serve patients. Innovation is necessary to support the development of a 21st-century healthcare system to meet the needs of the population. Innovation cannot occur in an environment of unnecessary regulation and physician oversight.

The implementation of new primary care delivery models, such as medical homes and accountable care organizations, can provide highly effective chronic disease management and transitional care from one setting to another. These models rely on the establishment of interdisciplinary teams that include NPs. Demonstration projects have been shown to improve quality of care and patient satisfaction, as well as reduce costs at the Veterans Administration Health System, Geisinger Health System and Kaiser Permanente (IOM, 2010).

The Veterans Administration Home Based Primary Care (HBPC) Program is a highly successful home-care model run entirely by NPs. Interdisciplinary teams travel to veterans' homes to provide services (Washington, DC VA Medical Center, 2009). In one study, the program reduced hospital stays from 14.8 days to 5.6 days and kept participants out of more costly retirement facilities by helping them live independently (Chang, Jackson, Bullman, & Cobbs, 2009).

The Programs of All-Inclusive Care for the Elderly (PACE) model offers a similar model of care that enables frail elders to remain in their residences. PACE is scheduled to open a facility in north Omaha early in 2013 (Appendix K). Nurse practitioners are primary care providers in PACE programs. Immanuel Communities (S. Hess, personal communication, October 27, 2012) notes a Centers for Medicaid & Medicare (CMS) waiver that enables NPs to conduct services in PACE programs.

Another progressive patient care model in the state that relies on NPs as care providers has recently announced expansion of their program. In October 2012, the Alegent-Creighton Health Nursing Home Network Team was awarded one of seven Centers for Medicaid & Medicare (CMS) national grants for their "Initiative to Reduce Avoidable Hospitalizations among Nursing Home Residents." Primary responsibilities for NPs in the program will be working with an interdisciplinary team to provide high quality comprehensive health care services to residents/families in select long term care facilities (B.Bergman-Evans, personal communication, October 27, 2012).

F. Nebraska loses qualified NPs to other states where there are no Integrated Practice Agreement requirements.

Studies demonstrate that states with more restrictive practice requirements lose potential practicing NPs to those that have more supportive practice acts, rules, and regulations governing NP practice (Christian et al., 2009; Lugo, O'Grady, Hodnicki & Hanson, 2007; Wing, O'Grady & Langelier, 2005). Favorable practice and regulatory environments are associated with greater numbers of, and thus access to, nurse practitioners (Lugo et al., 2007; Sekscenski, E., Sansom, S., Bazell, C., Salmon, M.E. & Mullan, F., 1994). Credentialing and payment are also linked to state regulations. More restrictive states are less likely to credential NPs as providers than states allowing independent practice (Eibner, Hussey, Ridgely & McGlynn, 2009; Wing et al., 2005).

In this state, there is compelling data regarding the loss of psychiatric-mental health NPs to other states. Nearly 70% of those trained at UNMC College of Nursing have moved from Nebraska after graduation (Rice, 2012), many citing difficulties related to securing a practice agreement. Federally designated HPSAs in the state for mental health professionals have been cited in Section D of this question.

Nurse practitioners offer candid statements regarding the circumstances that prompt their elopement to other states to practice. As early as 1995, a written statement from a NP was read before the Health and Human Services Committee stating that she had relocated because of the "archaic Nurse Practice Act related to advanced practice licensure" (Nebraska State Legislature, LB 414, 1995, p. 60). In October 2012, a NNP member from Boyd county explained, "due to practice restrictions and rural practice predicaments I am moving to another state. I will continue to maintain my Nebraska license, because I really like this state, and maybe change will occur sooner than later. Yet, for now, I am one of the 'brain drain' occurring because of practice issues and lack of support for rural NP practice" (Personal communication, October 20, 2012). Neighboring states, like Colorado and Iowa that do not have practice agreement requirements have been cited by NPs as easy relocation choices due their relatively less restrictive practice environments.

G. Fees paid to physicians in association with Integrated Practice Agreements offer no measurable return to the consumer in terms of the services provided by NPs.

There are no statutory provisions for physician fees in association with practice agreements (Appendix F, Nurse Practitioner Practice Act, 2012). Physician fees (a) are an unnecessary and burdensome expenditure, and (b) have no market precedent regarding what is reasonable and customary, raising legitimate questions regarding the motives of those making the requests for compensation.

Unnecessary and Burdensome Expenditures. Nurse practitioners have testified before Health and Human Services regarding the fees that have been requested by physicians in exchange for practice agreements (Nebraska State Legislature, LB 753, 2008, p. 70; LB 230, 2009, p. 35). There has also been testimony regarding the delays incurred in offering psychiatric services when fees with physicians could not be negotiated (LB 753, 2008, p. 64, 67).

Compensation varies widely, and may include an exchange of services. There are practice owners that have and continue to pay as much as five-figure annual fees to physicians in association with practice agreements. The terms of the agreement may or may not include any measurable oversight, aside from the signature on the practice agreement document itself (NNP membership survey, November 2012, in progress). In those practice agreements where there is a contracted physician fee, the additional costs logically must be absorbed by either the owner or an employer in the practice. The latter is in the face of a third party payer system that is already challenged to adequately reimburse providers for their costs.

Motives. The motives behind fees requested by physicians are questionable.

In 2008, following testimony from NPs regarding the difficulties that had been encountered with fees being paid to physicians, Senator Erdman described fees as "potential payment for...evident 'nonservices'... in oversight" (Nebraska State Legislature, LB 753, p. 70). He described the practice agreement as an "opportunity for extortion" (p. 79). He asked if signing a practice agreement in exchange for a paid fee was "an ethical issue" (p. 80), and if a NP requested a waiver on the basis of reluctance or inability to pay a fee that had been requested, would that be regarded as "acceptable for the waiver" (p. 80).

There was testimony from a NP at the same hearing that her practice owner had located a local physician willing to sign a practice agreement, but eventually withdrew from negotiations on the basis of the proposed conditions that the agreement be kept secret from the physician's medical colleagues if "there were no actual consultations, no involvement with clinic operations, no medical services" (p. 70).

The following year, an Integrated Practice Agreement was withdrawn within a week by a collaborating physician without explanation following the testimony of a NP before the Health and Human Services Committee that a fee was being paid by her employer to a physician in association with a practice agreement. That individual was the only one of five to six NPs in the practice that lost the practice agreement from that physician (Personal communication, December 5, 2012).

H. The Integrated Practice Agreement is one of a succession of interrelated barriers to practice that impedes the ability of NPs, as highly qualified and knowledgeable health care providers, to act in collaborative clinical roles that can affect better patient outcomes.

There are NPs in this state who have experienced firsthand an unfortunate cascade of restrictive facility policies and procedures, other health care provider unwillingness or failure to collaborate, and subsequent decisions made on behalf of patients that have resulted in potential, and for some, devastating outcomes (Spohn, T.L. Manuscript in preparation). The preceding author, using a combined quantitative and qualitative study design that invites participants to narrate their personal experiences, identifies the Integrated Practice Agreement requirement as one of a succession of interrelated barriers to NPs' practice.

One emerging theme includes the failure of other health care providers to collaborate with NPs to provide timely and appropriate services to patients that had been referred to them. The Nebraska Nurse Practitioner Practice Act (Appendix F) clearly identifies the responsibility of the NP for "establishing collaborative, consultative, and referral networks as appropriate with other healthcare professionals. Patients who require care beyond the scope of practice of a nurse practitioner shall be referred to an appropriate health care provider" (2012).

2) If the application is for the regulation of a health professional group not previously regulated, all feasible methods of regulation, including those methods listed below, and the impact of such methods on the public, must be considered. For each of the following evaluate the feasibility of applying it to the profession and the extent to which the regulatory method would protect the public

- **Inspection requirements**
- **Injunctive relief**
- **Regulating the business enterprise rather than individual providers**
- **Regulation or modifying the regulation of those who supervise the providers under review**
- **Registering the providers under review**

· Certifying the providers under review by the State of Nebraska
· Licensing the providers under review

Not applicable as NPs are currently regulated by the APRN Board and Nebraska statutes.

3) What is the benefit to the public of regulating the health professional group under review or changing the scope of practice of the regulated health profession under review?

The removal of the Integrated Practice Agreement requirement would create a less restrictive practice environment for NPs that would assure the public of improved access to health care, collaboration among healthcare providers, high quality services, and cost-effective care.

Improved access to care. Skilled primary care providers are the hallmark of high-performing healthcare systems (Pohl et al, 2010). Access to primary care services has emerged as a critical concern with the passage of the Patient Protection and Affordable Care Act (Public Law 111-148) and the accompanying Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), jointly referred to as the PPACA. The PPACA aims to insure millions more individuals, thus increasing the numbers that will have payer access to primary health care services (House Committees on Ways and Means, Energy and Commerce, and Education and Labor, 2010).

Demographic changes related to age, longevity and chronic disease will impose additional strains on the health care system as it is currently organized (AARP, 2009). Assuming that practice patterns do not change and that the numbers of NP and physician assistant providers remain proportionately constant to the current physician supply, Colwil, Cultice & Kruse (2008) predict that population growth and the relative increase in the number of the aged will increase family physicians' and internists' workloads by 29 percent between 2005 and 2025. Clearly, primary care should be supported and figure prominently in the emerging health care system.

A recent workforce analysis (Goodell, Dower & O'Neill, 2011) concluded that the overall supply of primary care providers is secondary to the problems created by the inequities in distribution of providers. Following the "inverse care law", physician supply is typically lower in communities with a high proportion of minority and low-income residents with greater health needs. For every physician who settles in a low-supply region, four physicians settle in regions with an already high supply (Goodman & Grumbach, 2008).

An analysis of consumer choice rankings of state NP regulations ranked Nebraska in the lowest 20th percentile (Lugo et al, 2007). This study explored 12 specific measures of the regulatory environment that were configured into three dimensions:

1. Environment Affecting Consumers' Access to NP Providers
2. Environment Affecting Reimbursement and NPs' Patients' Access to Related Healthcare Services
3. Environment Affecting NPs' Patients' Access to Prescription Medications

Findings highlighted the states that are in the greatest need of significant revision in regulation or legislation to improve the environment in which patients receive health care from NPs. Nebraska scored *Grade D: State restricts patient choice*. The authors concluded that the regulations in place for NPs seem to be arbitrary and unrelated to evidence about associations between restrictions to NP practice and patient safety. These findings, along with 2012 updated scoring from the Pearson Report (2012) can be found in Appendix L.

Barriers to NP practice directly influence the cost of, time associated with, and access to health care (Conover, 2004). Like uninsured individuals, patients who are unable to access care in a primary care provider office often seek high-cost care in emergency departments and hospitals in crisis states that might have been avoided with reliable primary care access (Decker, 2009a). There is also evidence that a lack of accessible primary care providers may drive patients to seek out higher cost specialists for primary care services (Kale, 2012).

Increase collaboration among healthcare providers. Collaboration is an ethic that is expected of all healthcare professionals. It is interpreted as follows in the American Nurses Association (ANA) Code of Ethics for Nurses:

> **2.3 Collaboration** - Collaboration is not just cooperation, but is the concerted effort of individuals and groups to attain a shared goal....By its very nature, collaboration requires mutual trust, recognition, and respect among the health care [sic] team, shared decision-making about patient care, and open dialogue among all parties who have an interest in and concern for health outcomes. (ANA, 2011)

True collaboration amongst NPs and other healthcare providers enables the patient to realize the full benefit of diverse but complementary competencies (Flanagan, 1998). Early studies of collaborative care models show improved patient satisfaction and outcomes over practice by either NPs or physicians alone. Studies of NP and physician teams demonstrated cost and quality improvements in nursing homes, emergency departments, and surgical inpatient settings (Spisso,1990; Burl, 1998; Naylor, 1999). Nurse practitioner-physician teams demonstrate better outcomes in disease prevention and chronic disease care (Wagner, 1998). Physicians working with NPs report improved job satisfaction, reduced workloads, and increased ability to offer a higher standard of care (Koperski, Rogers & Drennan, 1997). A

large evidence review found that advanced practice nurses, such as NPs, working as members of interdisciplinary healthcare teams deliver quality health care comparable to physicians in a variety of settings and received high patient satisfaction ratings (Colorado Health Institute, 2008).

Team care is strengthened by real and virtual collaborative practice (American College of Physicians, 2009; IOM, 2001; IOM, 2003). The increasing availability of information technologies such as online conferencing, telehealth, webinars, and electronic medical records facilitates better opportunities for collaboration and mutual support of patient care.

Interdisciplinary education models in health profession educational programs are seen as the antidote for improving provider willingness and ability to collaborate. Pohl et al., (2010) assert that tradition, professional socialization, and hierarchical relationships have too long stood in the way of true collaborative relationships in the health professions. Collaboration cannot occur if one profession believes "that communication would improve if what they said was heard and heeded," while the other believes "they were not heard" at times by the other (O'Brien, Martin, Heyworth, & Meyer, 2009).

Integrated care models are recognized for their patient-centered focus of care, with each profession bringing the best of their discipline to the table. Differentiation of work is applauded, and the team is accountable for performance that affects improved patient outcomes (Phillips, Harper, Wakefield, Green, & Fryer, 2002). As quality management expert Donald Berwick (2000) noted, "Achieving the highest-quality health care system will require shedding of the old model in which professional roles trump teamwork." "...[P]restige, position and payment yield to patients, populations and performance" (Phillips, et al, 2002).

Collaboration is not to be confused with supervision. Supervision impedes care and is contradictory to true collaborative relationships between nurse practitioners and physicians. The IOM (2001) and the American College of Physicians (2009) identify collaboration between providers as an essential component in quality care.

Ensure the provision of high quality care. Arguments that NPs cannot deliver primary care services as high quality or as safe as those of physicians have never been substantiated in the literature (IOM, 2010). Masters' educated nurse practitioners have been shown to be highly qualified and provide excellent healthcare in a number of diverse settings (Lenz, Mundinger, Kane, Hopkins, & Lin, 2004; Lambing, Adams, Fox & Divine, 2004; Ohman-Strickland et al., 2008; Woodburn, Smith & Nelson, 2007).

Meta-analysis and evidence reviews of numerous pilots, controlled studies, and research projects have substantiated that the quality of primary care services delivered by NPs, including those practicing autonomously and without supervision, is at least as high as that of equivalent physician services (Pollack, Gidengil & Mehrotra, 2010; Colorado Health Institute, 2008). Nurse practitioners have been shown to perform as well as physicians on clinical outcome measures like mortality, improvement in pathological condition, reduction of symptoms, health status, and functional status (Naylor & Kurtzman, 2010; Laurant et al., 2004; Laurant et al., 2009; Mundinger et al., 2000; Horrocks, Anderson & Salisbury, 2002; Hansen-Turton et al, 2004; Grumbach, 2003; Wilson et al., 2005).

Other studies have shown that patients are more satisfied with primary care provided by NPs than by physicians, and are more likely to have been given appropriate advice (Horrocks et al., 2002; Laurant et al, 2009). The Veterans Health Administration has long utilized NPs in a primary care model that emphasizes care coordination and disease management. Studies of the system show superior quality and outcomes of care (Asch et al., 2004).

Facilitate cost-effective care. Early health policy consultants pointed to the ability of NPs to provide the most basic health services performed by physicians but at lower costs. Research showed 75-80% of adult primary care and up to 90% of pediatric primary care services could be provided by NPs. A 1993 analysis by the American Nurses Association showed that NP care resulted in fewer hospitalizations, higher scores on patient satisfaction, and lower costs per visit (Blevins, 1998).

A study of 26 primary care practices in a large managed care organization showed that those practices that used NPs the most extensively had lower labor costs per visit (Roblin, 2004). An analysis that followed the adoption of universal coverage in Massachusetts demonstrated cost savings in the first year of implementation, with substitution of visits to physicians by visits to NPs and physician assistants (Eibner et al., 2009).

Exploding health care costs, coupled with less than optimal health care outcomes, indicates the need for change in the healthcare system (Organization for Economic Cooperation and Development, 2010). The removal of barriers to the inclusion of NPs in new primary care practice models that utilize payment reforms, including global or bundled team-based payments and medical home-based payment, is estimated to be able to provide substantial savings to publicly funded payer systems like Medicare and Medicaid. Appropriate and expanded use of advanced practice nurses for basic primary care services better leverages physicians' time and skills for the most challenging and complex patients (IOM, 2010) and is anticipated to promote the delivery of more cost effective health care (Pohl et al., 2010). The greatest financial benefit over time comes from offering patients an alternative to the

emergency room as a revolving door to acute care facilities in lieu of primary health care services.

The Association of American Medical Colleges projects that employing two NPs can reduce physician demand by one (Dill & Salsberg, 2008). In addition to projected savings on direct health care services, the taxpayer burden for educating NPs could potentially be substantially less than that of physicians. It is estimated that three to 12 NPs can be educated for the price of one physician, and more quickly (Starck, 2005).

4) What is the extent to which the proposed regulation or the proposed change in scope of practice might harm the public?

Two important steps for maintaining public safety already exist in the nursing practice act. First, NPs in Nebraska can apply for licensure only after successfully completing a national board exam in the appropriate area of practice. Second, an NP cannot sit for the exam without proof that the NP graduated from an accredited nursing education program in the relevant practice arena. National board exams for health and other professionals are routinely accepted as evidence that the successful candidates are competent practitioners in their respective fields.

Nurse practitioners have been studied over five decades, and to date, are the most widely studied of all healthcare professionals. No studies have suggested that NPs are less able than physicians to deliver care that is safe, effective, and efficient, or that care is better in states with more restrictive scope of practice regulations for NPs (Fairman, Rowe, Hassmiller & Shalala, 2011; Villegas & Allen, 2012). There is no evidence that the role of physicians in less restrictive states has changed or deteriorated (Fairman et al., 2011).

An early meta-analysis showed that nurses provide high quality care to patients, including preventing medication errors, reducing or eliminating infections, and easing the transition patients make from hospital to home (Grimes, 1995). Later systematic reviews showed that NPs provided care with quality equivalent to physicians (Horrocks et al., 2002; Laurant et al., 2004). Patients seeing NPs had higher levels of satisfaction; longer consultations; more tests; and no appreciable differences in outcomes, processes of care, or use of resources. A systematic review by Naylor & Kurtzman (2010) identified three randomized clinical trials with two secondary publications, as well as an additional 14 descriptive studies comparing NPs and physicians in primary care. Nurse practitioners provided care that was equivalent to physicians on measures of health status, treatment practices, and prescribing behavior. Nurse practitioners scored better results on measures of patient follow-up; consultation time; satisfaction; and the provision of screening, assessment, and counseling. Another

systematic review of 37 studies from 1990 to 2008 compared NP outcomes with physician outcomes (Newhouse et al., 2011) with similar findings that NPs provide care that is safe and effective, and in some ways better than care provided by physicians alone.

5) What standards exist or are proposed to ensure that a practitioner of the health professional group under review would maintain competency?

There are several existing mechanisms that ensure NP competency. Current state licensure and certification requirements have been detailed in question 17 and 18 in this application. In addition to Nebraska requirements, requirements for competency are in place on the federal level. The Joint Commission, an accrediting body for health care organizations in the U.S., has two standards for evaluation and maintenance of clinical competency for any clinician who is credentialed by a medical staff board to provide services and perform procedures (The Joint Commission, 2008).

The first of these standards is a Focused Professional Practice Evaluation which is a process that evaluates clinical competency on, and immediately following, appointment to the medical staff. Evaluation may also occur when a question of clinical competency arises in the care of patients. This type of evaluation may include:

- Chart review
- Monitoring clinical practice patterns
- Simulation
- Proctoring/direct observation
- External peer review
- Discussion with other individuals involved in the care of each patient
- Direct observation

The Joint Commission has a second standard called the Ongoing Professional Practice Standard (The Joint Commission, 2010). This process continually monitors a provider's clinical competence on an ongoing and regular basis with appropriate, timely interventions as needed. This ongoing evaluation is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal. This type of evaluation may use the following methodologies for collecting information:

- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques

- Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

In other types of health care settings, employers vary in their competency requirements and certifications for NPs. Employers generally require that a specified number of procedures are done annually to maintain competence and expertise. There may be requirements for patient record reviews to insure safety, standard of care, referral, and adequate follow up.

Many NPs acquire and maintain additional certifications that may or may not be required by their employers. Examples of certification include, but are not limited to, the following:

- Advanced Cardiac Life Support (ACLS)
- Advanced Diabetes Management (ADM)
- Advanced Trauma Life Support (ATLS)
- Agri-Safe Training
- Basic Life Support (BLS)
- Certified Diabetes Educator (CDE)
- Certified Heart Failure Nurse
- Certified Oncology Nurse
- Certified [Insulin] Pump Trainer (CPT)
- Certified Wound, Ostomy and Continence Nurse (CWOCN)
- Neonatal Advanced Life Support (NALS)
- Pediatric Advanced Life Support (PALS)
- Peripherally Inserted Central Catheter (PICC) Insertion

6) What is the current and proposed role and availability of third-party reimbursement of the services provided by the health professional group under review?

Current availability. Third party reimbursement for NP services varies significantly between payers. Payer regulations are difficult to access and interpret, and are generally regarded as a time-consuming convolution of printed, electronic, and telephonic exchanges for providers and consumers alike to navigate. In addition, billing practices for patient encounters under a physician name and/or requirements for physician prescription make it difficult to identify care and services provided by NPs.

The Balanced Budget Act of 1997 removed restrictions that had previously limited Medicare payments to rural health clinics staffed by NPs. Nurse practitioners practicing

independently of a physician and/or billing under their own billing number are reimbursed 85% of the Medicare physician fee schedule amount that a physician would receive for the same service. Medicare payment for NP services is 100% of the physician fee schedule amount when a physician bills for the service, when the NP is employed by the physician, or when the service is provided under the physician's direct supervision (Medicare Payment Advisory Commission [MedPAC], 2002).

Medicaid is administered by the states and subject to significant variations between states. In Nebraska, clients may select an APRN whose specialty is Family Practice, General Practice, Pediatrics, Internal Medicine, or OB-GYN as a primary care provider in the state's contracted managed healthcare plans (Nebraska Department of Health and Human Services [DHHS], 2012b). Medicaid covers NP services in other primary care settings, including rural health clinics, federally qualified health centers, community mental health centers, and Indian Health Services clinics. Medicaid-reimbursed services include family planning and pediatric well-child services to individuals age 20 or younger (Nebraska DHHS, 2012a). Nurse practitioners are reimbursed at 100% of the physician rate. Reimbursable private clinic services also include outpatient mental health services provided by the NP under the supervision of a psychiatrist or other qualified physician (Nebraska DHHS, Medication Management Clinical Guidelines). Medicaid and some insurance plans, however, require preauthorization for mental health clinic visits.

Private insurance reimbursement rates for NPs are especially prone to variances from the physician rate, even when the same services are provided. Currently, Blue Cross Blue Shield of Nebraska reimburses NP primary care services at 85% of the physician rate, following Medicare schedules. Other insurance companies may or may not reimburse NP services at the physician rate. There are significant variances in payment rates for NP services across the state on the basis of negotiated rates and/or interpretations and billing practices by employers. Simply stated, some practices may be billing for NP services under the collaborating physician name and thus, claiming higher negotiated rates, making it difficult to generalize payment schedules (T. Spohn, personal communication, November 11, 2012).

Proposed. It is generally accepted that private payers follow the lead of federal models like Medicare and Medicaid. Third party payer reforms for reimbursement disparities for NPs as health care providers are currently in process or discussed in the following areas (a) physician rates for equivalent services, (b) authorization as prescribers for medical supplies and services, and (c) authorization to order home health services.

Reimbursement parity for equivalent services. The Medicare Payment Advisory Commission, the federal agency that advises Congress on Medicare issues, has determined

that there is no analytical foundation for reimbursing NPs at a fraction of the physician rate for equivalent work (Health Policy Brief, 2012). Nurse practitioners are not excluded from the arguments that lower-tiered reimbursement rates and the practical difficulties of navigating the interpretations of the regulations result in provider reluctance to accept Medicare and Medicaid patients (Decker, 2009a; Decker, 2009b; Decker, 2012).

Nurse practitioners as fully authorized prescribers. In Nebraska, NPs may prescribe medications without restrictions. However, prescriptions for durable medical equipment, orthotics, prosthetics and medical supplies - the latter including widely utilized items like glucose meter strips, insulin syringes, and dressings - are only recognized by Medicaid if ordered by a physician. Nurse practitioners are also unable to order therapies including physical therapy, occupational, speech pathology and audiology (Nebraska DHHS, 2012a). In real-time practice, prescriptive restrictions impose a significant administrative burden, unnecessary expenditure of time, and inconvenience to providers and patients alike to merely affect a physician signature.

Authorization of home health. The Home Health Care Planning Improvement Act has been introduced in the both the House and Senate. This bipartisan legislation would allow NPs to order home health services and meet the face-to-face requirement under Medicare in accordance with state law. Currently, NPs may perform the required face-to-face encounter with the client. They are required to document the clinical findings of the encounter and communicate those findings to the certifying physician. The physician then writes a narrative based on those findings that support the patient's status and need for skilled services (Brassard, 2012).

7) What is the experience of other jurisdictions in regulating the practitioners affected by the proposal? Identify appropriate statistics on complaints, describing action taken, etc., by jurisdictions where the profession is regulated.

Boards of Nursing and APRN boards typically regulate nurse practitioners. While states vary considerably in terms of what they allow NPs to do, this variance has not been correlated with performance on any measure of quality or safety. There are no data to suggest that NPs in states that impose greater restrictions on their practice provide safer and better care than those in less restrictive states (Fairman et al., 2011). One study that reviewed claims from 1998 to 2008, found that NPs who faced claims (9%) were more likely than NPs who did not face claims (4%) to practice in a state that required supervision (CNA/NSO, 2009). Nurse practitioners have been shown to have high rates of patient satisfaction and lower litigation rates, and therefore, lower malpractice fees than their physician counterparts (Hooker, Nicholson, & Li, 2009).

The Pearson Report, published annually, describes the status of NP practice in the United States (Pearson, 2012). In this report there are comparisons of safety data using the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB). These two banks are federal data banks that have been created by the Health Resources and Services Administration (HRSA) to serve as repositories of information about health care providers in the United States. The NPDB was set up to protect the public from unfit providers and was implemented in 1990. This database requires reporting of adverse licensure, hospital privilege and professional society actions against physicians and dentists related to quality of care. In addition, the NPDB tracks malpractice payments made for all healthcare practitioners. Federal law requires that adverse actions taken against a healthcare professional's license be reported to these data banks. The HIPDB bank was established in 1996 and is a tracking system to alert users that a comprehensive review of the practitioner, provider, or supplier's past actions may be warranted (National Council of State Boards of Nursing, 2012).

This data consistently indicates the safety of NP practice. The following table illustrates the 2011 ratios for Nebraska and for the nineteen jurisdictions that allow NPs full practice without mandatory physician involvement in practice (Pearson, 2012). Nebraska event statistics are congruent with other states in demonstrating rates lower than physicians (Doctor of Medicine [MD]) and osteopathic physicians (Doctor of Osteopathy [DO]). When compared to states without integrated practice agreements, events reported in Nebraska are not dissimilar indicating that physician supervision is unnecessary to the safety and regulation of NP practice

State	**NP State Ratio for NPDB Event**	**DO State Ratio for NPDB Event**	**MD State Ratio for NPDB Event**	**NP State Ratio for HIPDB Event**	**DO State Ratio for HIPDB Event**	**MD State Ratio for HIPDB Event**
1. Alaska	1:123	1:8	1:4	1:39	1:5	1:5
2. Arizona	1:74	1:3	1:3	1:521	1:6	1:7
3. Colorado	1:91	1:5	1:4	1:3184	1:5	1:10
4. D. C.	1:146	1:5	1:5	0	0	1:22
5. Hawaii	1:456	1:7	1:5	1:456	1:13	1:17
6. Idaho	1:73	1:8	1:4	1:82	1:16	1:13

7. Iowa	1:148	1:3	1:3	0	1:6	1:9
8. Maine	1:155	1:7	1:4	1:544	1:7	1:11
9. Maryland	1:134	1:14	1:4	0	1:33	1:16
10. Montana	1:69	1:4	1:2	0	1:11	1:13
11. New Hampshire	1:139	1:15	1:3	1:764	1:15	1:13
12. New Mexico	1:51	1:2	1:2	1:584	1:261	1:11
13. North Dakota	1:238	1:6	1:3	1:475	1:3	1:6
14. Oregon	1:82	1:7	1:5	1:106	1:8	1:12
15. Rhode Island	1:77	1:2	1:3	1:345	1:15	1:17
16. Utah	1:131	1:9	1:3	1:131	1:10	1:13
17. Vermont	0	1:12	1:4	1:250	1:7	1:10
18. Washington	1:91	1:5	1:4	1:36	1:8	1:13
19. Wyoming	1:85	1:2	1:2	0	1:5	1:7
NEBRASKA	**1:339**	**1:7**	**1:3**	**1:508**	**1:15**	**1:19**

8) What are the expected costs of regulating the health professional group under review, including the impact of registration, certification, or licensure on the costs of services to the public? What are the expected costs to the state and to the general public of implementing the proposed legislation?

There are no expected costs associated with the implementation of legislation that would remove the integrated practice agreement requirement in the state. Further, it is reasonable to assert that there would be lower administrative costs to the Department of Health and Human Services due to decreased clerical time and fewer documents exchanged to manage a roster of Integrated Practice Agreements between NPs and physicians in the state.

9) Is there any additional information that would be useful to the technical committee members in their review of the proposal?

Legal considerations seem to favor a trend towards increased scope of advanced nursing practice. Recent Federal Trade Commission (FTC) evaluations of proposed laws in three states "found several whose stringent requirements for physician supervision might be considered anticompetitive" (Fairman, et al., 2011, p. 195). The FTC has also investigated proposed state policies that would protect professional interests above those of consumers (IOM, 2010).

A March, 2012 letter to a Kentucky senator from the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics responds to an inquiry regarding a proposed Kentucky Senate Bill to remove a requirement for a signed physician collaboration agreement with APRNs (Appendix M, FTC, 2012). FTC staff acknowledged professional licensure requirements as necessary to protect patients, but counter that the potential benefits of competition are also consistent with patient safety, including improved access to care, lower costs and increased consumer options for care.

Gardner (2010) suggests that physicians, who have traditionally had all-encompassing responsibility in health care and are generally resistant to sharing authority, may view the expansion of APRNs as economically threatening. Counter to that concern is a recent descriptive study comparing physician salaries in states with full APRN autonomy to physician salaries in states with limited APRN scope of practice that found physician earnings to be unaffected (Pittman & Williams, 2012).

The discussion surrounding restrictions related to scope of practice for all APRNs are historically dichotomous between nursing and medicine. Each group, however, seems to agree in some context that patient care is the highest priority (Villegas & Allen, 2012). The argument that physician supervision of NPs is the best way achieve patient safety is a long-standing precedent within medical organizations (American Medical Association, 2009). The IOM (2010) has countered that APRNs not only provide safe care, but are positioned to increase access to cost-effective care.

The argument for changes related to scope of practice in a profession should have a foundational basis within four areas: (1) an established history of the practice scope within the profession; (2) education and training; (3) supporting evidence; and (4) appropriate regulatory environment. If a profession can provide support evidence in these areas, the

proposed changes in scope of practice are likely to be in the public's best interest (National Council of State Boards of Nursing, 2009).

The following summarizes the key points in this Application for Credentialing Review:

1. State regulations for an Integrated Practice Agreement with provisions for physician supervision are no longer relevant to the role of the NP in contemporary healthcare, and pose a significant barrier to the ability of NPs as highly qualified and autonomous health care providers to offer much needed services in this state.

2. There is no evidence for physician supervision of NPs. Furthermore, the provision for supervision in the Integrated Practice Agreement is subject to multiple inconsistencies in interpretation and application that serve no demonstrable benefit to the public that NPs care for, with none being worse than the forced suspension of NP services in progress when a physician abruptly withdraws from an agreement.

3. Nurse practitioners' skills are not the result of physician supervision. They are acquired through education and clinical training; and assessed by national certification. Continuing education and experience add to skill development.

4. The nursing profession has consistently provided for the education, training and testing of NPs as advanced practice nurses. Nurse practitioners have demonstrated accountability and responsibility to the public they serve with ample and emerging nationally integrated standards for education, accreditation, certification, licensure and scope of practice.

5. The conditions of the waiver option to the Integrated Practice Agreement are not applicable in those geographic areas that do not have an overall shortage of health care providers. The historically limited tenure of initial and renewed waivers is not a sustainable risk for those who have significant financial, personnel and client investments in healthcare practices.

6. Fees paid to physicians in association with Integrated Practice Agreements have no market precedent and offer no measurable return to the consumer in terms of the services provided by NPs.

7. Nebraska workforce data and federal HRSA designations have identified substantial primary care and mental health provider shortages in the state.

8. There is no evidence that identifies NPs as less qualified or less able than physicians to provide equivalent and high quality health care services in any setting. Nurse practitioners have been studied by researchers for decades in the fields of nursing, medicine, economics and public policy, with papers published in top peer reviewed journals.

9. Policy development has clearly shifted from the question of NPs as qualified health care providers to how best to utilize their skills as accessible, collaborative, high-quality and cost-effective providers in new models of care and third party reimbursement schemes.

10. The overriding premise of this application is a call for commitment and action that supports collegial, collaborative, consultative, and referral relationships between NPs and other health care providers. Without coordinated, interdisciplinary access to care, health outcomes are diminished and costs rise for payers, employers and ultimately, consumers.

11. Laws and regulations exist to protect the safety of the public. The long-standing paradigm that physician supervision and oversight is necessary to assure patient safety has given way to legal considerations that it is competition, and not the restriction of equivalent practice, between healthcare providers that is the best assurance of safety to the consumer.

12. The greatest risk to health care consumers in this state is that nursing and medicine will persist in miring themselves in old arguments regarding their relationship for others to referee. "Fighting fractures our support and reduces our effectiveness with our legislative, business and consumer advocates" (Susman, 2010).

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