

Nebraska Credentialing Reform 2000

A Model for the Regulation of Health Care Professions by State Government in Nebraska

Part 2 of the Study Directed by LB 183

*A Report to Governor Nelson, Governor-Elect Johanns,
and the Nebraska Legislature
January 1, 1999*

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



Department of Services ● Department of Regulation and Licensure ● Department of Finance and Support

January 1, 1999

Dear Governor Nelson, Governor-Elect Johanns, and Members of the Nebraska Legislature:

We are pleased to present the second portion of this report of the Nebraska Credentialing Reform 2000, as required in LB 183 (1997). This report represents many months of effort by people who are committed to streamlining the credentialing system and administrative processing of credentialing for health care and human services professions in Nebraska.

We would like to thank the community and citizen volunteers and Health and Human Services System employees who have contributed their talents and energy through their participation on the steering committee, the eight work teams, or the focus group. We appreciate the time volunteered by those who attended the public forums held, the credentialing conference, and/or who provided comments on the draft report. Together we are planning innovative solutions to meet the current and future credentialing needs for health care professionals. In addition, we would like to thank David Montgomery for his leadership of the project, along with his Department of Regulation and Licensure, Administrative Services team: Harold Borchert, Ron Briel, Monica Gissler, Mary Maahs Becker, Rich Kelly, Lori Mosey and Joan Strizek.

Throughout this process, we conducted our work under the guiding principles established for the Nebraska Partnership for Health and Human Services. The result is a model credentialing system that will provide better services, be simple and efficient, be based on common sense, realize cost savings, and be accountable for achieving results.

Our work has far to go. We will continue work on implementing the policy changes and corresponding recommendations contained in the 1998 facility report, starting with introducing legislation in 1999 to create a Uniform Facility Licensure Act. This second phase of the study, streamlining the credentialing system for individual professionals and occupations, will be a major part of our work for 1999 and 2000. Thank you for allowing us to contribute to providing more common sense solutions for all Nebraskans.

Sincerely,

The Health and Human Services Policy Cabinet

Deb Thomas
Policy Secretary

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I Introduction

In April 1997 the Legislature passed LB183, which instructed Health and Human Services System (HHSS) Department of Regulation and Licensure to conduct a study of the regulation system for health facilities & professionals in Nebraska. The bill stated that, "It is the intent of the Legislature that a study be conducted for the purpose of designing a system which protects the health and safety of the citizens of this State without over regulation, is streamlined and adaptable to a changing environment, and is cost-effective." For the purposes of this study, the term *credentialing* encompasses licensure, registration, and certification. The term *consumer* includes the public, unless specified otherwise.

This study also seeks to facilitate the achievement of the following five criteria for success:

- provide better services
- create a more accountable regulatory system
- make the regulatory system simpler and more efficient
- create regulatory systems that conform to common sense
- realize cost effectiveness

The result of this study will be a comprehensive design for a model system for the credentialing and regulation of health care practitioners, facilities, and providers in Nebraska. The first part of the model, dealing with facilities, was presented on January 1, 1998. The second part of the model, dealing with professionals, is presented in this report. This model provides the basis for reforming the statutes and regulations to protect public health and safety without over regulation. If implemented, the model will streamline the regulatory system, make it adaptable to a changing environment, and make it more cost-effective, as were goals of the first model. The model system also includes a clear statement of policy on the role of State government in the credentialing of health care professionals.

The model system will include mechanisms to evaluate the:

- logic of State credentialing
 - systems and processes of State credentialing and regulation
 - decision-making processes for regulatory policy

This report is presented in the following sections:

- I Introduction
- II Summary of project procedures
- III Study boundaries
- IV Assessment of the current system of credentialing
- V Policy statements for regulating professionals
- VI The model system
- VII Recommendations grouped according to major processes
- VIII Implementation

IX Summary and conclusion

Attachments:

Glossary

Rosters of Steering Committee and work team members

Temporary Credentialing template

II *Summary of Project Procedures*

During the study on professional regulation eight work teams reviewed the following aspects of health care professional regulation:

- Continuing competency
- Discipline and enforcement
- Evaluation of credentialing systems
- Funding and fees
- Process re-engineering
- System outcomes
- Telepractice, mobility, and managed care; and
- Temporary licensure

The eight work teams comprised a total of more than 200 members representing consumers, providers, and regulators. The teams were led by Steering Committee members and supported by Regulation and Licensure staff. Public video forums were held on April 8 (day), April 9 (evening) and November 19 (day) in Lincoln, with over 20 satellite downlink sites for each forum. The purpose in April was to provide information on the overall NCR 2000 process and to discuss specific issues being considered by the work teams. At the November forum key recommendations from the draft report were reviewed, and comments were accepted. A list of the members of the Steering Committee and of the work teams is appended to this report.

In addition to the eight work teams, a Focus Group was formed of individuals who had applied for membership on one of the eight work teams. This group met on September 28 to discuss, reach consensus, and form recommendations on issues unresolved by the work teams.

The Department of Regulation and Licensure sponsored a credentialing conference on July 27-28, 1998 at the Nebraska Center for Continuing Education in Lincoln. Key speakers included: Anne Paxton, Senator Don Wesely, Deb Thomas, and Gina Dunning. This conference was sponsored by several health care professional organizations in Nebraska, in addition to a grant from Professional Examination Service.

The reports of the work teams were studied by the NCR 2000 Steering Committee which formulated its model and recommendations in part from the work of these teams. This committee was also composed of persons representing consumers, providers, and regulators. This report and the model system for professional regulation contained in this report constitute the work of this committee.

The draft report of the Steering Committee was approved by the HHSS Policy Cabinet and available for public comment from November 3 through November 30, 1998. The draft report was mailed to the Steering Committee, work team members, professional associations, members of examining boards, HHS Legislative Committee members, State Board of Health, and other interested parties. The report was available in hard copy format upon request and was also placed on the HHS System home page of the Internet.

III *Study Boundaries*

The parameters of the credentialing study on professionals were defined by LB 183, and directed the Department to coordinate a study of health care practitioners and providers, including:

Alcohol/drug testing (5)
Asbestos (9)
Athletic training (1)
Audiology/speech-language pathology (6)
Chiropractic (1)
Controlled substances (10)
Cosmetology (26)
Dentistry (7)
Emergency Medical Care (23)
Environmental Health Specialist (2)
Funeral directing (8)
Hearing aid instrument dispenser/fitter (2)
Massage therapy (4)
Medical nutrition therapy (1)
Medicine (12)
Mental health practice (7)
Nursing (15)
Nursing home administration (4)
Nursing support (4)
Occupational therapy (4)
Optometry (3)
Pharmacy (10)
Physical therapy (5)
Podiatry (1)
Psychology (6)
Radiography (6)
Radon (10)
Respiratory care (2)
Swimming pool operator (1)
Veterinary medicine (4)
Water operator (11)
Well driller (10)

Total categories of professions regulated: 32

Total subcategories of professions regulated: 220 (shown in parenthesis above)

Grand total of active credentials in Nebraska: 124,827 (as of December 1, 1998)

There was consensus among the NCR 2000 Steering Committee members that there is a need to consider the application of the model to all professions that are regulated by the Health and Human Services System, not just for those specified in the above.

IV *Assessment of the Current System of Credentialing*

In assessing the current system, the Steering Committee concluded that the system is working remarkably well considering the disarticulated and antiquated nature of many of its components.

Health professions in Nebraska are currently credentialed by more than one agency within the Health and Human Services System. For example, substance abuse counselors are credentialed by HHS Services agency.

The credentialing of health professionals in Nebraska takes the form of either licensure, certification, or registration with licensure being the most restrictive type of credentialing. Statutory language passed in 1985 established formal definitions for these three types of credentialing for the first time. Under these definitions, licensure is a credential that establishes the exclusive right to provide the services of a profession to those persons who have met specific educational and training prerequisites. Certification is defined as a credential that provides the exclusive right to use a protected title to those persons who have met specific prerequisites. Registration is defined as a credential that allows any member of a profession who agrees to have their name entered on a registry maintained by the HHS Department of Regulation and Licensure to provide the services of the profession in question as long as they practice within minimal ethical and safety guidelines defined in statute. However, much of the current credentialing system was already in existence prior to the codification of these definitions, and consequently, there are significant discrepancies in the way in which these terms are applied to credentialed health professionals. For example, the term used in the nursing statutes to describe highly educated and trained nurses is “Registered Nurse.” This traditional terminology for nurses is not consistent with the 1985 statutory definitions which would now clearly define the members of this profession as licensed rather than registered. This example illustrates the need for greater standardization in credentialing terminology.

The credentialing system also exhibits great variability pertinent to the types and levels of health professionals that are credentialed. Some professions are geared toward the diagnosis and/or treatment of conditions affecting the entire person (e.g., medicine and surgery, nursing). Some professions specialize in the care of particular body systems or organs (e.g., psychology, optometry, podiatry). Some are primarily therapeutic in nature (e.g., physical therapy, pharmacy) while others do not deal with human health at all (veterinary medicine). The work of some professions only impacts the public health and safety indirectly (e.g., well drillers, cosmetologists).

The credentialing system made great strides towards developing the means to determine whether or not to credential health professions with the creation of the credentialing review program in 1985. This program established statutory criteria that focused the attention of policy makers on the public health implications of proposals for new credentialing or for changes in the scopes of practice of currently credentialed health professions. However, the current system lacks the ability to determine whether or not there is a continuing public need to credential a currently

credentialed health profession.

There is great variability among currently credentialed professions pertinent to the renewal of credentials, particularly in the area of continuing competency. Some credentialed professions do not have continuing competency requirements of any kind. Those professions that do have continuing competency requirements vary greatly as to the way these requirements are satisfied and the amount of time that practitioners must devote to satisfying the requirements. Continuing competency requirements often lack focus, direction, and purpose, and there is a need to develop policies in this area that focus continuing competency programs on maintaining the ability of practitioners to provide their services in a manner consistent with the protection of public health and safety.

Temporary licensure is another area where there is great variability among credentialed professions both as to the specific provisions of temporary licensure and the purpose of such provisions. In some professions, persons who have failed a credentialing examination may receive a temporary license to provide services to the public.

The current disciplinary system is characterized by close cooperation between HHS Department of Regulation and Licensure investigators, the Director of this Department, licensing boards, and the Attorney General. Under the current system, licensing boards provide recommendations as to whether complaints should be investigated, whether petitions for disciplinary action should be filed, and may provide recommendations as to the type of disciplinary action that should be imposed. The role of the boards and of the public in this process is not strong.

The current credentialing system provides for the endorsement of the credentialing of practitioners from other states that seek to be credentialed in Nebraska if the standards for credentialing in those states are comparable to those of Nebraska. Nebraska does not participate in reciprocity agreements with other states, which are agreements involving the acceptance of credentials of persons from other states by Nebraska as long as those states accept the credentials of Nebraskans who seek to practice in those states. However, technological advances have now created situations when patient and clinician are not located together, and may not even be in the same State or country. Our current system struggles to deal with these situations, when enforcement of Nebraska standards is not straightforward.

Under the current credentialing system, the funding for the system comes from fees charged to credentialed professionals. These costs vary from profession to profession depending on the number of professionals regulated, the frequency of investigations and disciplinary actions, and on whether there are programs such as continuing competency to support. Fees charged to professionals can range from as low as twenty-dollars to as high as five hundred dollars depending. Other states have explored funding systems that recognize the public protection aspects of credentialing and that provide fees based on the actual cost of services.

V *Policy Statements*

LB 183 requires the development of a statement of the policy logic for credentialing health care professionals. In order to accomplish this directive, the Steering Committee evaluated the system assessment and work team products and determined that a number of statements of policy should be recommended.

The model system calls for the clear determination of policy as the first step in creating statutes, regulations, standards, and processes with which to credential health professionals. If adopted, these statements will provide a coherent policy direction to such regulatory activities.

Each policy statement is linked to one or more specific recommendations, which are detailed in Section VII. The recommendations identify ways in which the policies would be applied and implemented.

- Policy 1:* Credentialing processes must support the following criteria for success: better services, greater accountability, greater efficiency, cost effectiveness, and common sense. (B3, B6, B8, B9, B12, D9)
- Policy 2:* All aspects of the credentialing system for health professionals should be based upon meaningful results, including quality indicators. (A14, E1)
- Policy 3:* All aspects of the credentialing system for health professionals should be based upon a partnership among consumers, providers, and regulators. (A1, B13, C3)
- Policy 4:* Health professionals should be credentialed by the State for the purpose of protecting the public from preventable harm or danger, and such credentialing should be at the least restrictive level necessary to protect the public. (A3, A10)
- Policy 5:* Health professionals must be credentialed by the State, unless they fit in a federal exemption category. (A6, A7, B5, D3, D10)
- Policy 6:* The system used for credentialing of health professionals should strive to achieve a balance between assuring the qualifications and competence of credentialed professionals, and assuring that the public has access to needed and desired services and information. It should also maintain an awareness of the effectiveness of its activities and decisions. (A4, A15, D6)
- Policy 7:* Credentialing mechanisms for health professionals should be appropriate for the profession, scope and/or type of practice being credentialed. (A2, B10, B11)
- Policy 8:* Nebraska credentialing policies should not unnecessarily impede mobility of credentialed professionals or set up artificial barriers to entry into or practice of the health professions. (B2, B4)

- Policy 9:* Before a health profession is regulated under the Uniform Licensure Law, and periodically thereafter, there is a need to demonstrate that such regulation is in the best interests of the public. (A3, E2)
- Policy 10:* Whenever possible, credentialing should utilize uniform standards, and consistent processes and vocabulary. (A8)
- Policy 11:* Quality improvement mechanisms should be used to continually assess and improve the credentialing system. (A5, E3)
- Policy 12:* Nebraska residents of every geographic area, economic status, and culture should be assured that health professionals who serve them are subject to the same credentialing and professional standards. (A9)
- Policy 13:* The State has the duty to ensure that credentialed professionals are subject to standards of continuing competency, as established by the profession. (B7, C1, C2)
- Policy 14:* Enforcement of credentialing standards should be effective, timely, and just. (D1, D4, D5, D7)
- Policy 15:* Enforcement of credentialing standards should occur within an overall strategy of prevention and education as well as sanction. (D2, D8)
- Policy 16:* All activities for the credentialing system for health professionals should seek to optimize available human and financial resources. (A11, A12, A13, B1)

VI *The Model System and Discussion of Elements*

What is a “model system”?

A model system is a representation of all the elements and relationships necessary to accomplish a task. For the purposes of this study, the task is defined as the credentialing of health professionals by the State of Nebraska.

A model system usually contains the following elements:

- a *statement of mission or purpose* (*why* the task needs to be done)
- a *vision statement* (overall *characteristics* desired of the model system)
- a description of the *capabilities* or *capacities* of the system (things the system must be *able to do* in order to fully accomplish the task)
- *components* of the system (staff, work units, inputs, sub-tasks, *pieces* that have to be organized to accomplish the task)
- *system processes* (work flow, approvals, *actions* that have to be organized to accomplish the task)
- desired *results* of the system (outputs, receivables, things that the system must *produce* in order to accomplish the task)
- a *quality assurance* mechanism (controls, feedback, outcome measures, information on system performance, data that can be used to *evaluate and modify* the system).

Proposed model system for credentialing health professionals by the State of Nebraska

PURPOSE STATEMENT FOR CREDENTIALING:

The purpose of credentialing individuals who engage in the provision of health and human services is to ensure the public safety.

VISION STATEMENT FOR A MODEL SYSTEM:

A model credentialing system should protect the public from harm; provide an efficient, flexible, and adaptive regulatory process; provide uniform consistency of practice standards and regulatory procedures; and provide system accountability.

CAPACITIES OF THE MODEL SYSTEM:

The credentialing system should have the capacity or capability to:

- Provide assurance that credentialed providers meet educational and experience requirements that are appropriate to the services defined for the profession in question.
- Provide assurance that health and human services conform to acceptable standards.
- Establish disciplinary process that enforces practice standards in a timely and efficient manner that is consistent with due process of law.
- Provide the minimum of regulatory restrictions necessary to accomplish the goals of the system (public protection, safety, maintenance of standards).
- Provide as much freedom of choice in the selection of practitioners as possible and as much access to health care services as possible consistent with the goal of public protection and public safety.
- Provide for an outcome-based regulatory system.
- Provide statutory authority to implement regulatory processes created by the Legislature including investigative processes, evaluative processes (for professionals as well as the regulatory process itself), disciplinary procedures, and the authority to enforce decisions made by these processes including the ability to suspend and revoke licenses and certificates.
- Provide for the gathering, storing, and sharing information and data among the components of the regulatory system.
- Impact legislation.
- Communicate with the public in a timely and efficient manner including the ability to receive and respond to complaints from the public.

COMPONENTS OF THE MODEL SYSTEM:

- All residents of Nebraska
- Elected State officials (Governor and Legislature)
- Boards governing credentialed health professionals
- Professional associations representing health professionals
- Health and Human Services System
 - Department of Regulation and Licensure
 - Department of Finance and Support
 - Department of Health and Human Services
 - Chief Medical Officer
- Office of the Attorney-General
- State Board of Health

MAJOR PROCESSES AND SUBPROCESSES OF THE MODEL SYSTEM:

- Policy and Capacity Development
 - Policy Development
 - Legislation
 - Funding and Resource Development
 - Information Systems Development
- Administration of Credentialing
 - Initial Credentialing

- Renewal
- Reinstatement
- Rules and Regulations Development and Promulgation
- Board Support, Training, and Maintenance
- Communication and Public Education
- Competency Assurance
- Compliance Assurance
 - Complaint Intake and Disposition
 - Investigation
 - Adjudication
 - Appeal
 - Settlement, Diversion, and Alternate Resolution
 - Consumer Protection
 - Education of Credentialed Professionals
 - Actions Against Unlicensed Practitioners
- Evaluation and Review
 - Ongoing and Periodic Quality Assurance for Board and Staff Processes
 - Periodic Performance Review for Credentialed Professions

DESIRED RESULTS OF THE CREDENTIALING PROCESS:

- A. Protection of the public: Public protection occurs through the Credentialing System when:
1. there is assurance that a credentialed person meet required standards of education and training;
 2. there is a mechanism for the public to report concerns about a credentialed person, and when the regulatory system follows up on reports from the public;
 3. there is assurance of continuing competency and quality;
 4. there is assurance of safety in service delivery by the credentialed people;
 5. there is a mechanism to ensure that uncredentialed people do not provide services limited by law only to credentialed people.

By protecting the public, we also do all that is necessary to protect credentialed people.

- B. Access to Care: Access to care is assured through the Credentialing System when:
1. the regulatory system credentials practitioners in a manner consistent with the principle of least restrictiveness so as not unnecessarily to limit access to the health care services of practitioners, but consistent with the goal of public protection.
 2. the regulatory process is neither so restrictive that the public cannot obtain needed services nor so permissive that the public is not protected against unsafe, harmful or unscrupulous practices, or loses confidence in the regulatory process.
 3. the regulatory system takes into consideration issues pertinent to unique populations, consistent with the goals of protecting the public.

- C. Freedom of Choice: Freedom of choice (the ability to choose among several health care

options) is assured through the Credentialing System when:

1. The development of public policy includes an awareness of and sensitivity to unique populations.
 2. There is active public involvement in the policy-making process.
 - a. the public should be included in the discussions on outcomes.
 - b. all parties to discussions on outcomes should consider how the public will be affected.
 - c. the public should be involved in the policy-making process.
 - d. public involvement is not an outcome per se, but a means by which good outcomes can be defined or implemented.
- D. Cost-Effectiveness: The regulatory process functions in an efficient, consistent, uniform, and standardized manner taking into consideration the following issues:
1. Overlap and duplication of procedures and processes
 2. Restrictiveness of rules and regulations
 3. Inconsistent definitions and applications of credentialing terminology
 4. Ineffective disciplinary systems
 5. Understandability of the credentialing system by the public

Cost-effectiveness of the regulatory process has social and health implications, and is therefore more than just dollars and cents, and a regulatory process should be efficient, consistent, uniform, and standardized in order to be cost-effective.

QUALITY ASSURANCE MECHANISMS FOR THE CREDENTIALING PROCESS:

Quality Assurance mechanisms are described in Section VII-E.

VII *Recommendations grouped according to major processes of the model system*

The most extensive activity of the Steering Committee was to develop a series of specific recommendations by which the current credentialing system might be modified to approach the configuration of the model system propounded above. Each of the recommendations presented in this section is the result of a process by which over 150 separate ideas and suggestions were assimilated, evaluated, and refined into a consistent and coherent set of 44 recommendations. The recommendations are organized according to the five major processes of the model system, and are cross-linked to other elements of the model system by parenthetical codes after each recommendation: P=Policy, Letter=Desired Result.

For each recommendation included, a rationale is provided that concentrates the major reasons why the recommendation is included. These rationales are in greatly encapsulated form, and readers in search of greater documentation of the discussions that resulted in each recommendation are referred to the meeting summaries of the Steering Committee and the work team reports.

A. Policy and Capacity Development

Recommendation A1: The development of public policy regarding the regulation of health professions should involve the active participation of all components of the credentialing system. (P3, A)

Rationale: Too often the development of regulatory policy has been restricted to selected groups or individuals. This practice has led to the fragmentation and disjoint that characterize the current system. It has created situations where scopes of practice are dissonant and where credentialing is not designed to accomplish the desired outcomes of the model system. Such disharmonies can only be overcome through a process of policy development in which all interested and affected parties are “players” from the beginning. This recommendation does not suggest that all public policy reflect *consensus* among all players, for to do so would be to relegate credentialing policy to a lowest-common-denominator system that would not necessarily protect the public.

Recommendation A2: There should be five levels of State credentialing for health care professionals: Licensure, State Certification, Registration, Functional Credentialing, and Uncredentialed. (P7, A)

- a. Licensure: Under licensure it is illegal to practice without first meeting educational and/or training prerequisites established in statute.
- b. State Certification: Under State certification anyone may provide the services of the profession, but only those who have met the standards of certification may use the protected title established by the State for the profession.

- c. Registration: Under registration anyone who wishes to provide the services in question must have their name placed in a registry maintained by the State. There are no prerequisites, but if a registrant commits certain offenses defined as unacceptable by statute, then the registrant can be removed from the registry and thereby prohibited from providing the services.
- d. Functional Credentialing: Under functional credentialing persons would only be required to be credentialed for those activities that have been deemed to have significant potential for impact on public health and safety, but they would not be required to be credentialed regarding other aspects of their work.
- e. Uncredentialed: Includes practitioners of health services for whom State credentialing has not been created.

The main thrust of credentialing in Nebraska should continue to be by profession, but there should also be a place for credentialing by function ~ especially as concerns occupational categories that play an assistive role to currently credentialed health professionals, and perhaps also to occupations and professions whose actions have implications for public health and safety, but whose services are not considered to be “health care”. (P7, A)

Rationale: The credentialing process has evolved a confusing and non-descriptive vocabulary over the past century. The goal of this recommendation is to ensure that a common definition of the different levels of credentialing is adopted and utilized insofar as possible. Granted that technically incorrect terms such as “Registered Nurse” are not likely to be replaced in the immediate future, it is nonetheless important that as much systematization be interjected into the credentialing system at this critical juncture as possible. The recommendation also identifies explicitly the category of functional credentialing which, although not conceptually novel, has heretofore not been a recognized credentialing category in Nebraska.

Recommendation A3: The Credentialing Review (407) Program should be maintained and strengthened. (P4, P9, A)

- a. Health professionals should be credentialed for the following reasons:
 - (1) to protect the public from harm;
 - (2) to establish the qualifications and competency for those who provide health care services. (P4, A)
- b. The following criteria should be added to those currently used by the Credentialing Review (407) Program to evaluate the need to credential a health profession:
 - (1) Does the profession have unique skills, knowledge or ability that distinguish it from routine work and labor?
 - (2) Can the public assess the skills and competencies of the practitioner in order to make an appropriate choice of practitioner?
 - (3) Are there other alternatives or mechanisms to government regulation to public protection? Have professional or occupational associations been able to protect the public from unscrupulous or incompetent providers of the profession in question? Have current laws on fraud or consumer protection been able to provide adequate public protection? (P9, A)

- c. During 407 reviews of professions review bodies should first consider whether credentialing by function would be more appropriate for the group under review (for example, if the group’s functions are largely assistive). If, however, the profession in question is highly complex with much potential for harm stemming from a great variety of functions typically performed, then those involved in a 407 review would have the option of applying the traditional credentialing model (professional credential rather than functional regulation) to the profession in question. (P7, A)
- d. The current statutory criteria of the 407 program and the statutory provision that calls for the Legislature to favor “the least restrictive level of regulation consistent with the protection of public health and welfare” should be maintained. (P4, C)
- e. There should be a mechanism by which the general public could initiate a 407 review without incurring many of the obligations now assumed by an applicant group. Such Citizen-Directed Reviews should be modeled after the existing Directed Reviews. (P7, C)
- f. The reviews of the technical committee, Board of Health committee, and of the agency director should continue as they are presently conducted in the 407 process. (P7, A)
- g. The existing 407 process should be extended to cover all professions regulated under the Health and Human Services System. (P12, A)
- h. Board of Health members should attend legislative hearings and testify on bills that address issues that have been subject to a 407 review. (P9, A)
- i. The Board of Health should play a role in educating members of the Legislative Health and Human Services Committee about the 407 process. (P6, A)

Rationale: The Credentialing Review (407) Program, since its inception in 1985, has served as the principal mechanism for introducing a consistent public-policy thread into deliberations regarding the regulation of new professions and changes in scopes of practice. However, it is time to make some revisions to strengthen the program and to extend its coverage beyond the traditional “health professions”. The Steering Committee also acknowledged that the three-recommendation system now employed was cumbersome and obfuscated rather than facilitating legislative debate, but the Committee was unable to identify a superior mechanism.

Recommendation A4: The development of credentialing policy should explicitly include an assessment of the effects of new or existing policies and practices on access to care and the freedom of choice of consumers. (P6, B & C)

- a. The regulatory system should credential practitioners in a manner consistent with the principle of least restrictiveness so as not to unnecessarily limit access to the health care services of these practitioners, but consistent with the goal of public protection. (P6, B)
- b. The regulatory process should neither be so restrictive that the public cannot obtain

needed services, nor so lenient that the public is not protected against unsafe, harmful or unscrupulous practices or loses confidence in the regulatory process. (P6, B)

- c. The regulatory system should take into consideration issues pertinent to unique populations, consistent with the goal of protecting the public, when making decisions that could affect access to care by such groups. (P12, B)
- d. Public policy pertinent to the ability to choose a health care practitioner or a specific therapy should include an awareness of and sensitivity to unique population and rural-urban differences. (P12, C)

Rationale: The historic role of the professional credentialing system has been to promote and protect quality. However, the modern health-care system involves a constant tension among concerns of quality, access to care, cost-containment, and freedom of choice. Quality remains an important consideration, but decisions made to preserve quality must be tempered with an explicit awareness that such decisions may result in reductions in access or freedom of choice, or raise the cost of services. The credentialing system must strive for balance in the constantly changing health-care marketplace.

Recommendation A5: A simplified and participative process should be created to resolve inconsistencies in, and provide for changes in scopes of practice among, professions. (P11, A)

Rationale: While the 407 system works well to assess the public policy implications of changes in scope of practice, it is not always the most appropriate or the most cost-effective mechanism for such deliberations. The Steering Committee felt that the Department and the boards should develop a process that would alert all professions in a timely manner to proposed changes in *any* profession's scope of practice, and allow for dialogue and interaction to resolve as many potential conflicts as possible. Only in cases where there was a clear public policy logjam should the 407 process be used to facilitate the resolution of scope of practice issues.

Recommendation A6: Employment contracts or arrangements entered into by credentialed professionals should protect the right of the professional to practice according to professional standards and within the credentialed scope of practice. (P5, A)

Rationale: The professional licensure/credential model of regulation was initially developed to apply to independent professionals who were completely and solely responsible for their conduct and practices. More and more, however, credentialed professionals are choosing to enter into employment arrangements wherein they yield control of some parts of their practice environment. There is concern that such arrangements could, at times, create conflicts between the standards of practice imposed by the State credential and the expectations of employers. The Steering Committee was adamant that the right of the credentialed professional to adhere to his or her professional standards in such situations was protected as a means of ensuring that the

public was protected as well..

Recommendation A7: The Nebraska Controlled Substances Act should be amended to eliminate the requirement for a State registration number and to require the federal Drug Enforcement Administration number to be recognized by the State. (P5, D)

Rationale: The current requirement that Nebraska providers have both a State and a Federal DEA number is a result of several forces. First, it is a source of revenue for the Board of Examiners in Pharmacy. This revenue stream will be less necessary if the new funding and fees proposals are adopted. Secondly, it was an attempt to assure that the State of Nebraska could enforce federal laws regarding the distribution, prescribing and dispensing of addictive drugs within Nebraska. Statutory changes in Nebraska laws make this “safeguard” unnecessary. Removal of this requirement will not effect Nebraska’s ability to govern addictive drugs and will eliminate duplicative registrations.

Recommendation A8: The State of Nebraska should participate in national and international efforts to increase consistency and uniformity in areas of professional credentialing so long as such efforts do not jeopardize the health, safety, or welfare of the residents of Nebraska. (P10, A)

- a. Nebraska should participate in interstate or national compacts to allow for telehealth, specific to people practicing in Nebraska, that allows Nebraska to impose all requirements determined by the State to ensure public safety. (P10, A)
- b. The State should adopt infomatics safety guidelines as determined by the federal government, including those dealing with data security and the recognition of a digital signature. (P10, D)
- c. Nebraska should adopt use of the Uniform Provider Identification currently being designed by the Healthcare Resources Services Administration (HRSA) as a professional identifier for all aspects of State government. (P10, D)

Rationale: Professional credentialing has moved from being a highly insular concern of individual States and professions to being part of national and international systems of information and regulation. These efforts, for the most part, have resulted in improvements in the State’s abilities to protect its citizens and in cost-effectiveness and efficiency. Similar opportunities should be pursued so long as they are consistent with the protection of Nebraska’s residents.

Recommendation A9: The Legislature should consider/examine Nebraska Revised Statute, §44-32,170 to ensure that individuals have adequate recourse in any disputes with managed care entities. (P12, A)

Rationale: The section in question reads as follows: “Any health maintenance organization authorized under the Health Maintenance Organization Act shall not be deemed to be practicing medicine and shall be exempt from sections 71-1,102 to 71-

1,107.14 relating to the practice of medicine.” The Steering Committee was concerned that, in environments such as HMOs where health professionals are employees and are not in control of all decisions regarding the rendering of health care, the lines of accountability become tangled and exemptions such as this one may leave the public vulnerable to adverse actions and without adequate legal protection.

Recommendation A10: All managed care entities, including HMOs, operating in Nebraska, must have a Nebraska licensed, health care professional who is accountable for health care decisions of the managed care entity and can be disciplined for unprofessional conduct. (P4, A)

Rationale: Continuing the line of thought from recommendation A9, the Steering Committee was concerned that sometimes there does not seem to be a person accountable for health care decisions since all credentialed professionals are employees of the entity. In this situation health care decisions might sometimes be based on policies without considering alternative health care options to better serve the customer. The intent is to provide public protection in that someone can be held accountable for health care decisions made by a managed care entity.

Recommendation A11: The boards and the Department should explore ways to ensure that resources allocated to the credentialing system are and remain adequate to carry out the system’s mission of protecting the public. (P16, A)

- a. Fees from regulated persons should pay for all credentialing, investigation, and disciplinary costs associated with credentialing. (P16, D)
- b. Fees from regulated facilities (those requiring licensure as a health care facility and related to requirements for credentialed professionals) should pay for all credentialing, inspection, investigation, and disciplinary costs associated with the facility credentialing. (P16, D)
- c. Costs such as inspection, investigation, and discipline previously funded from controlled substances registration fees should be funded by the professions and facilities according to category. (P16, D)

Rationale: Nebraska is one of a very slight majority of States in which credentialing activities are funded almost exclusively by fees paid by regulated individuals and facilities. While there was considerable discussion of other funding models (e.g., through general funds, especially for disciplinary activities) the Steering Committee came to agreement that the fee-based structure provided for the greatest accountability for funds and provided the greatest flexibility in applying available funds to priority needs.

Recommendation A12: The Department should set fees within limits set in statute. (P16, D)

Rationale: The current process of requiring boards to promulgate fees by regulation does not provide adequate flexibility to deal with short-term financial situations and is costly to the boards. The Steering Committee was confident that, were this authority to be given to the Department, that the boards and the Department could work out ways to ensure adequate participation by all parties in a cost-effective and timely fashion.

Recommendation A13: The fees for initial and renewed credentials should be based on the actual cost of issuing such credentials. (P16, D)

- a. The Department should establish categories based on historical inspection/investigation costs for each profession and profession-related facility for use in calculating the investigation component of the renewal fee. (P16, D)
- b. Fees for initial credentials for all professions should be set as the sum of the following for each profession:
 - (1) The *base cost* of issuing the credential (which is the total cost of issuing initial credentials in *all* professions divided by the total number of credentials issued in *all* professions);
 - (2) The actual cost of the examination(s) used;
 - (3) The actual average cost per candidate of administering the examination(s); and
 - (4) The actual average cost per candidate of any unique requirements for credentialing. (P16, D)
- c. Fees for the renewal of credentials should be set as the sum of the following for each profession:
 - (1) The *base cost* of renewing the credential (which is the total cost of renewing credentials in *all* professions divided by the total number of credentials renewed in *all* professions);
 - (2) The actual average cost per renewal of administering continuing education/competency requirements for the profession; and
 - (3) The actual average cost per renewal of investigation and disciplinary processes for the profession. (P16, D)
- d. The accounting system for tracking funding and fees should be simple and accountable. (P16, D)

Rationale: Under current law, each board is required to be financially self-sufficient, and all costs of administration must be pro-rated by board. This creates a cumbersome and costly bookkeeping system and results in an inequitable situation wherein members of large professions pay artificially low fees while members of small professions pay artificially high fees. Adoption of this funding model, based on the system used successfully in Wisconsin, would equalize costs for the most common processes and reduce the costs of bookkeeping, while having no effect on the total amount of fees collected.

Recommendation A14: The boards and the Department should ensure that the

credentialing system has a data and information system appropriate to meet its needs. (P2, D)

- a. Data are necessary to make quality recommendations. Making recommendations in credentialing without data is making recommendations based solely on anecdotal evidence. Surveys should be conducted to ascertain public satisfaction or dissatisfaction with current services and scopes of practice. (P2, A)
- b. Establish a policy identifying the type of data that are needed for credentialing to occur. (P10, D)
- c. Establish a policy identifying confidentiality standards pertinent to the collection and use of data on candidates. (P6, A)

Rationale: The Nebraska credentialing system currently collects some data but not necessarily in a format or within an information system. In order for data to be standardized and utilized effectively data usage must be evaluated and an information system put into place to meet the needs of the credentialing system.

Recommendation A15: Authorize social security numbers to be withheld from the public, but allow the agency to require the provision and sharing of such information for official use. (P6, A)

Rationale: Even though social security numbers are required to be collected as part of the initial credentialing process, they are sensitive information that should be protected by law from general disclosure. However, their use in administrative activities such as verifying credentials and checking for actions against credentials in other jurisdictions should not be impeded. The Steering Committee discussed including addresses in information to be withheld from the public but did not reach agreement. The same arguments about releasing sensitive information had been discussed. There was some concern that by eliminating addresses from the public records, there may be some difficulty identifying correct providers and if a provider did not wish to utilize an office address, they could always purchase a post office box.

B. Administration of Credentialing

Recommendation B1: The organizational structure and enabling legislation of the Health and Human Services System should promote the model credentialing system. (P16, D)

- a. All persons credentialed by HHSS to provide either health, health-related, or human services should be covered by the Uniform Licensing Law (ULL) in order to establish greater uniformity in general credentialing requirements. (P16, D)
- b. Administration of all HHSS credentialing programs for both individuals and facilities/places should be housed in the Department of Regulation and Licensure. (P16, D)

- c. In recognition of the magnitude of the responsibilities inherent in the position of Department Director, and of the strong need for involvement by a credentialed health professional in the credentialing system, the current system of having two separate individuals hold the positions of Director of Department of Regulation and Licensure and of Chief Medical Officer should be retained, and a requirement that the two positions be separate should be enacted into statute. (P16, D)

Rationale: A fundamental precept of organizational efficiency calls for the adoption of the most simple and effective models wherever possible. The rationale for the creation of a Department of Regulation and Licensure was to house in one unit all regulatory programs and operations so that cost savings could occur through the combination of efforts on similar or identical processes. The justification for having such an agency is lost if, through organizational fragmentation, such efficiencies are impeded. The same rationale applies for a Uniform Licensure Law. Experience has shown that the administrative duties of an agency director require the full-time attention of a skilled administrator; there is concern that, if the positions of Chief Medical Officer and Department Director are combined, critical functions each, administration and clinical oversight, will be short-changed or delegated, thus negating any cost-savings that might result from combining the positions. There was also considerable debate within the Steering Committee regarding the title *Chief Medical Officer*. The Committee was evenly divided on the issue of whether this position should be required to be filled by a medical doctor or whether an alternate title such as *Chief Health Officer* should be adopted and the position allowed to be filled by another type of clinician (e.g., an advanced-degree registered nurse, a pharmacist, a dentist, etc.).

Recommendation B2: Nebraska law should address issues of remote practice in a systematic fashion. (P8, A)

- a. Distance practice should be called “telehealth” rather than “telemedicine”. Telemedicine would be the distance practice of medicine, telenursing the distance practice of nursing, telepharmacy the distance practice of pharmacy, etc. (P10, D)
 - (1) Telehealth occurs when a clinical relationship exists between the practitioner and the patient.
 - (2) Practicing telehealth does not include consultation with fellow health professionals
 - (3) Practicing telehealth does not include didactic education for health professionals or students studying health professions.
- b. A professional must have a full practice permit to practice telehealth with citizens located in this State. (P5, A)
- c. The State should, with certain exemptions, credential out-of-state facilities that dispense drugs or devices into Nebraska; however, the current practice whereby Nebraska practitioners fill prescriptions from out-of-state prescribers who are not credentialed in Nebraska should be continued. (P8, B)

Rationale: Increasingly the practice of health care is being unchained from the limits imposed by location and distance through the application of more and more sophisticated technology. Nebraska risks denying its residents access to the most current innovations if its practice acts are not updated to reflect technological advances. The goal of public protection remains paramount, but a systematic response to environmental changes in health care delivery will be of great benefit to the public and will help to hold down costs.

Recommendation B3: The process of issuing an initial credential should be streamlined. (P1, D)

- a. Procedures for initial credentialing should be clear and understandable to all candidates. (P1, D)
- b. Professional boards should adopt national examinations whenever the board determines that all areas of competency and clinical practice are covered by the examination. (P10, D)
- c. Computerized testing and processing should be established and used to the greatest extent possible to make the credentialing process accessible year-round. Legislative changes should be made to recognize this as an acceptable method of examination. (P16, D)
- d. Maintain the requirement that credentials be affixed with the signature by officers of the board, the director of the agency, and the governor. (P5, A)
- e. Modify the requirement that information regarding all credentialed professionals be “in a book” to include “or record”. (P1, D)
- f. Delete the requirement for affidavits of “good moral character”, but require new credentialing candidates to put in their application a signed statement that s/he is of “good moral character”. (P1, D)

Rationale: As in B2, this recommendation seeks to update certain practices and statutory language that reflect the regulatory environment of the past and that are no longer appropriate.

Recommendation B4: The process of issuing a Nebraska credential based upon the possession of an equivalent credential in another jurisdiction should be streamlined. (P8, A)

- a. Allow Nebraska to credential practitioners who are credentialed in other jurisdictions if they meet comparable education, training standards and credentialing requirements and hold credentials that are in “good standing” in other jurisdictions. (P8, B)
- b. The credentialing system should recognize as valid all documents and other prerequisites submitted to this or other jurisdictions for previous credentialing without

requiring duplication.

- (1) Any question of comparability of standards is to be determined by the Board for that specific profession.
- (2) Nebraska should continue to enforce its own standards that are particular to the various credentialed professions: e.g., jurisprudence examinations. (P8, D)

Rationale: Many requirements for “reciprocity” or “endorsement” reflect an environment when standards of credentialing differed widely from state to state. This is no longer the case and Nebraska practices should encourage interstate mobility to ensure greater access to services by Nebraska residents.

Recommendation B5: The process of issuing a temporary credential should be streamlined. (P5, A)

- a. Adopt the Temporary Credentials Template (Attachment C). Unless a board determines otherwise, temporary credentials should be granted only when the applicant documents a triggering condition as identified in the template. Among the results of adopting this recommendation would be the discontinuation of the following practices:
 - (1) Granting a thirty-day temporary credential to out-of-state psychologists
 - (2) Granting of temporary credentials to practitioners credentialed in another state, pending completion of application for Nebraska licensure by reciprocity or endorsement. (P5, A)
- b. If a temporary credentialed professional, as a result of residency training, qualifies and receives a permanent license, then the temporary credential should automatically become null and void. (P5, A)

Rationale: In too many instances policies for the issuance of temporary credentials have come to be based on the convenience of the professional rather than upon the best interests of the public. The template proposed will standardize to a great extent the situations in which a temporary credential is deemed necessary for the good of the public.

Recommendation B6: The process of renewing credentials should be streamlined. (P1, D)

- a. Procedures for renewal should be clear and understandable to all candidates. (P1, D)
- b. Establish three options for a credentialed professional to follow at the time of renewal:
 - (1) to renew;
 - (2) to change the credential to inactive status; or
 - (3) to allow the credential to lapse. (P10, D)
- c. Establish a minimum of one and a maximum of three years for renewal. (P10, D)
- d. Use national data banks for information on candidates. (P10, A)

- e. A record check should be made on all candidates pertinent to any actions taken against the credentialed professional. (P10, A)

Rationale: Of all credentialing processes, the renewal process most lends itself to improvement by the adoption of uniform standards and procedures. These recommendations will help ensure that renewal process operate efficiently and effectively.

Recommendation B7: Evidence of continuing competency should be a prerequisite for renewal for all credentialed professionals, with each board determining the method of assessment and amount and type of verification appropriate for its profession(s). (P13, A)

Rationale: The pace of change in health care knowledge and technology ensures that professionals who are to practice safely must improve on their knowledge and skills regularly. When issuing an original credential, the State is declaring the possessor to be qualified according to agreed-upon standards. However, no such assurance pertains to a renewed credential unless the State also maintains standards for assessing continuing competency. For further discussion of this topic, see Recommendation C1 below.

Recommendation B8: The process of reinstating credentials should be streamlined. (P1, D)

- a. Procedures for reinstatement should be clear and understandable to all candidates. (P1, D)
- b. Require that persons seeking reinstatement of a credential would have to meet the “continuing competency” requirements set by the profession. (P13, A)
- c. The boards should be able to require education as a condition for reinstatement of a license. This requirement should be imposable without having to file a petition and it should provide credentialed professionals with an opportunity for a hearing to contest the imposition of the requirement. (P13, A)
- d. Grant the boards the authority to define the standards that a person needs to meet when seeking to return from lapsed or inactive status. (P1, D)

Rationale: Once again, the goal of these recommendations is to improve the effectiveness of the credentialing system by updating procedures.

Recommendation B9: Rules and regulations necessary to support the credentialing system should be developed through a participatory process and should not be more extensive or burdensome than necessary. (P1, A)

- a. There should be clear statutory authority for all rules and regulations. (P5, D)
- b. Regulations should be current, streamlined, understandable, simple, minimal as

possible, focus on results, and not be prescriptive. (P1, D)

- c. Procedures should not be in regulations unless absolutely necessary. (P1, D)
- d. Professionals, especially those active in the workforce, should be involved in every step of developing regulations. (P3, C)
- e. Continue the mechanism for public input into the regulations review and development process. (P3, C)

Rationale: Rules and regulations provide the setting for much of the day-to-day interaction between State regulators (boards and staff) and credentialed professionals. Communication and efficiency are enhanced when those regulations are developed through open processes and when they are written as tightly and accurately as possible.

Recommendation B10: Closely related professions should be regulated by the same board when possible. (P7, D)

Rationale: The operating model of “one profession, one board” has many advantages, but such a model lends itself to a series of professionally isolated groups and enhances issues of “turf protection” over those of professional cooperation and interaction. Professions that have similar scopes of practice should explore the possibility of being regulated under a single board as long as care is taken to consider input and representation from all professions involved. Such consolidation, when accomplished through an inclusive process, should be considered when there is commonality in the activities of the groups and when there is a significant opportunity for cross-fertilization of ideas pertinent to practice and discipline.

Recommendation B11: Alternatives to a standing board should be considered for professions that have clear and limited scopes of practice and infrequent need of professional expertise for examinations, rulemaking, or credentialing decisions. (P7, D)

Rationale: The board model works best for professions that meet the criteria noted in the recommendation, but may not be optimum for other groups. In those cases the board may be an unnecessary expense to the profession and the public, and its role could be assumed by *ad hoc* advisory panels or contracted services.

Recommendation B12: Activities through which boards are appointed and supported should be streamlined to maximize public involvement and to clarify the board’s role. (P1, D)

- a. Each board of examiners should be renamed “board of *name of profession or professional area governed*”. (P10, D)
- b. Each board should have at least one public member; boards of six or more members should have at least two public members; boards of 11 or more members should have at

least three public members. (P7, A)

- c. Public members of boards should meet the following requirements in order to fulfill their role as representatives of the general population:
 - (1) Never have been a credentialed health professional
 - (2) Not currently an employee of a member of the profession
 - (3) Not an immediate family or household member of someone currently regulated by the board to which an appointment is to be made.
 - (4) Be a resident of Nebraska who has reached the age of majority (P10, A)
- d. Continue the statutory provision that professionals have immunity when performing their duties on the board, and by statute extend such immunity to experts called in on behalf of the board. (P5, A)
- e. Professional boards and the Board of Health should communicate about appointments prior to the appointments being made in order to assure that the boards include appropriate expertise. (P3, A)
- f. Professional boards should be involved in the disciplinary process with follow through to the end. (P3, A)
- g. The boards should have the opportunity to request outside expertise as needed. (P1, D)

Rationale: Nebraska's "umbrella" regulatory structure can only be effective if it represents a true partnership among the public, the professions, and the State. These recommendations enhance this partnership in various ways.

Recommendation B13: The boards and the Department should enhance the access of the public and credentialed professionals to non-protected information about the credentialing system. (P3, A)

- a. The Department should develop and disseminate widely a statement identifying the basic rights of all Nebraskans regarding issues of professional credentialing (e.g., right to ask for and receive information about a practitioner's qualifications, right to file a complaint whenever a violation of the practice act is suspected, etc.). (P3, A)
- b. The public should have ready access to public-record information on the disciplinary status of individual practitioners. (P6, A)
- c. The public should be informed about all disciplinary actions consistent with requirements of confidentiality and due process. (P6, A)
- d. Communication tools should be developed that will serve as a general communication medium for the Department and boards. The tool should contain information on disciplinary actions, scope of practice rulings, new or revised regulations and laws, upcoming meetings and hearings, board vacancies, and other information of general interest to the credentialed professionals and the public. (P3, D)

Rationale: The partnership necessary for the success of the credentialing system can only come about through open communication among all parties. Because of the resources and information at their disposal, boards and the Department have the responsibility to be pro-active in seeking ways to enhance communication.

C. Competency Assurance

Recommendation C1: Continued credentialing should assume continuing competency. (P13, A)

- a. Continuing competency requirements should be profession-specific and should relate to historically relevant practice or changes that have occurred in the practice of the profession. (P13, A)
- b. Continuing competency requirements, as determined by the board, should be delineated in regulations. (P13, A)

Rationale: Continued credentialing and continuing competency do not always relate in the current system. This recommendation would assure that at the time of a renewal, the professional has demonstrated to that professional board's satisfaction they are competent.

Recommendation C2: Boards should establish methods appropriate for determining continuing competency for the profession(s) they govern. (P13, A)

- a. Assessment strategies/tools such as the following should be considered by each board for adoption as a method for determining continuing competency:
 - (1) national certification;
 - (2) self/peer assessment;
 - (3) testing;
 - (4) continuing education;
 - (5) documentation of results;
 - (6) documented exit interviews with consumers;
 - (7) office audits;
 - (8) professional portfolio; and
 - (9) continuous quality improvement plans and documentation. (P13, A)

Rationale: Traditionally, continuing education has been the chief or only method used by professions to demonstrate continuing competency. However, the state of the art of continuing competency assessment has expanded to include a variety of methods of making such assessments, each with its unique strengths and weaknesses. Rather than default to the continuing education model, boards should aggressively pursue options that are appropriate for them.

Recommendation C3: Regulatory boards, professional associations, consumers,

employers, and the credentialed individual have roles and responsibilities that should be observed in the process of assuring continuing competency. (P3, A)

- a. Individual: Continuing competency is ultimately the responsibility of the credentialed individual.
- b. Professional associations: When professional associations want to exercise authority (voluntary) concerning continuing competency, they should have national standards, protect the profession, address ethics, have or set education standards, and must work with the professional board. They also do or should consider doing the following:
 - (1) Assure increased involvement in development of professional standards;
 - (2) Promote the profession and professional standards;
 - (3) If the association chooses, one possible role is peer review for complaints regarding continuing competency of professionals. They should report to the regulatory board for the profession as appropriate under the mandatory reporting law;
 - (4) If the professional association does peer review for complaints regarding continuing competency as part of the disciplinary process, it must include the following:
 - Ensure *confidentiality* of the patient and the professional;
 - Include communication between the board and professional associations;
 - Have a well-defined process with a specific time line.
 - (5) In the event that there is no professional association, continuing competency complaints go directly to the regulatory board; the regulatory board has the authority to consider and/or appoint a peer review group as one of its roles.
- c. Regulatory boards: are created by statute, protect the public, and have a role in discipline. They also do or should do the following to assure authority of boards in relation to continuing competency:
 - (1) Have ultimate authority for continuing competency, just as for initial credentialing;
 - (2) Provide peer review process for complaints (for those groups without a professional association).
 - (3) If a continuing competency complaint is referred to a professional peer review group, delay investigation of complaints until the peer review process has been completed (by professional association or board process).
 - (4) Review continuing competency complaints forwarded from peer review process and take appropriate action.
 - (5) In the event of no regulatory board for a profession, continued competency complaints would go to the Director of Regulation and Licensure, who would have the authority to review and make appropriate decisions on the matter.
- d. Employer: responsibility for ensuring that the employee is working within her/his area of competence.
- e. Consumer: encouraged to provide feedback, and also seek information through available resources.

Rationale: No area of modern credentialing is quite so complex or constantly changing as the assessment of continuing competency. Only in an atmosphere of partnership and shared responsibility can the necessary processes occur that will ensure protection of the public. This summary of roles contains several hypotheticals, but in essence it outlines the expectations that should be held by the public of each participant in the process of assuring continuing competency.

D. *Compliance Assurance*

Recommendation D1: Compliance assurance processes should function at a high level of efficiency and integrity. (P14, A)

- a. All aspects of the disciplinary process should exhibit fairness to the credentialed professional and respect due process without jeopardizing public safety. (P14, A)
- b. Disciplinary actions should be based on verified evidence. (P14, A)
- c. The disciplinary process should earn public trust and solicit public participation and cooperation. (P3, A)
- d. The disciplinary process should be conducted in a framework of cooperation and communication among the boards, HHSS representatives, and the Office of the Attorney General. (P3, A)
- e. The terms and conditions of discipline should be objective, reasonable, and consistent. (P10, A)

Rationale: As with other similar recommendations, these are designed to fine-tune some aspects of the current compliance assurance process and provide guidelines for the development of future processes in this area.

Recommendation D2: The State should adopt a model compliance assurance process. (P15, A)

- a. Professional boards should be involved in the disciplinary process with follow through to the end.
- b. Except in emergency situations, a decision to open an investigation is made by a screening committee. The screening committee, with a board representative, decides to open an investigation when any one screening committee member votes to do so. (Screening Committee membership consists of at least representatives of the board, agency, and Office of the Attorney General.)
- c. Investigations are to be resolved as quickly as possible. The role of the professional board in the process includes initial review of investigative reports. The board may

decide:

- (1) To continue the investigation in order to discover more information;
- (2) That the investigation has disclosed a “technical or insubstantial violation”; the board then has the authority to proceed with one of the following:
 - (i) Call for a non-public informal conference (after an investigative fact-finding report shows there is some validity to the complaint) in order to hear the credentialed individual’s version and to be able to consider all options;
 - (ii) Issue a Letter of concern;
 - (iii) Request an Assurance of Compliance; or
 - (iv) Close the case.

* Public information for the above situations is limited to information on the technical or insubstantial nature of the case. It does not include the accused individual’s name or identifier.

- (3) Recommend that a petition be filed; or
* If the representative of the Attorney General does not agree that a petition should be filed, the board may take its request for filing a petition directly to the Attorney General.
- (4) Recommend that the Attorney General’s office close the case.

- d. The option to settle a case should be open throughout the discipline process.
- e. If there is not a settlement, a hearing is held in response to the filing of a petition. Based on information from the hearing, the CMO decides whether the individual is guilty or not.
- f. The CMO shall provide an opportunity for the board and the licensee to provide input regarding the level or type of discipline. Notice is sent to the licensee and the board along with a transcript of the hearing and the date (within 30 days) by which they must respond. The CMO reviews all available information and imposes discipline.
- g. The CMO decision should have legal status to stand up in a court.
- h. A tripartite process should be used to develop proposed settlements:
 - (1) The proposed settlement can only occur when all parties (Attorney General’s representative, board, and individual) agree.
 - (2) The proposed settlement can occur any place in process
 - (3) The proposed settlements are used for cases other than “technical or insubstantial”.
 - (4) No prior approval is required for the parties identified to pursue a proposed settlement. However, if a proposed settlement is reached, it must be approved by the CMO. The CMO may reject the proposed settlement only if s/he can demonstrate that the proposed settlement could result in harm to the public. If the CMO does not sign the proposed settlement within 10 working days of receiving it, the settlement is approved.
 - (5) The settlement is considered to be a form of discipline and is therefore public record.
- i. The types of discipline available should be as follows, with the understanding that

education and diversion may be components of any discipline (non-public or public):

- (1) Non-Public Discipline (not part of the individual's record and not public)
 - (i) Letter of concern
 - (ii) Assurance of compliance
 - (iii) Non-public informal conference
- (2) Public Discipline
 - (i) Fine: up to \$20,000
 - (ii) Probation: the credential has certain terms and conditions placed on it for a specified length of time (public service; creative probation terms; multiple drug & chemical screenings, etc.).
 - (iii) Limitation: the credential is restricted to certain types of services or patients and/or to certain locations.
 - (iv) Suspension: the credential is taken away for a specific length of time.
 - (v) Revocation: the individual loses the right ever to be licensed in that profession again; if the individual holds more than one license and a license is revoked, the board(s) issuing the remaining license(s) receive information about the revocation so the board can evaluate the need for action on its part.

Rationale: The proposed model compliance assurance process enhances public protection by expanding the disciplinary options available to regulatory officials in several areas such as use of sanctions and settlement of disputes. It offers opportunities to control the cost of some lengthy investigations and provides greater assurance that the level of sanction will fit the violation. It also clarifies and expands the involvement of the boards in compliance assurance.

Recommendation D3: The State should develop a process through which sanctions similar to those applied to uncredentialed practitioners could be applied to employers of health professionals who encourage or permit professionals to practice outside the bounds of professional standards or scope of practice, or who maintain operational systems that do so. (P5, A)

Rationale: Compliance assurance processes are clearly designed to be enforced at the level of an individual credential, yet there are clearly instances where poorly designed operational systems doom any professional working within their bounds to failure and possible sanction. This recommendation would allow for a mechanism to be created to deal with such system failures that are neither the design or under the control of the health professionals.

Recommendation D4: Put into place a mechanism where once a complaint or other information enters the credentialing system a letter is sent informing the credentialed person of the complaint and to request a written response to the complaint (except for complaints dealing with sex, drugs, and record keeping). (P14, A)

Rationale: This process is allowed under the current system. The Steering Committee recommends expanded usage.

Recommendation D5: Investigation processes should be streamlined. (P14, D)

- a. Prior to and during an investigation, an investigator should consult with a member of the profession if expertise is needed. (P3, A)
- b. Agency investigators should focus their activities on specific professions as much as possible to enhance knowledge and expertise in the issues of those professions. (P16, D)
- c. An investigation “interim progress report” should be submitted to the board within 45 working days into the process. The board can at that point continue the case, close the case, or redirect the case as appropriate. (P3, A)

Rationale: Investigation processes can be fine-tuned in the ways recommended to bring them closer to the goals of the model system.

Recommendation D6: Compliance assurance processes should strive for consistency and uniformity of process, but results should take into consideration other issues that might affect the public. (P6, A)

- a. Disciplinary actions limiting or terminating a professional’s practice privileges should be targeted at those areas of practice in which the professional has shown deficiency, and should take into consideration the possible effects of limiting other aspects of her/his practice on the access to care of the population . (P6, C)
- b. The type of discipline imposed should be consistent across the professions for the same offenses, but the level and degree for the terms and conditions of the discipline should be consistent with the circumstances in each case. (P10, A)

Rationale: Sanctions need to be tailored so that the public is not punished along with an errant professional, and so that some professions do not exact greater sanctions for the same offense as others.

Recommendation D7: Make specific legislative changes (reprimand, suspend judgment penalties and ULL) to enhance the effectiveness of the compliance assurance process. (P14, D)

- a. Eliminate the penalty of “reprimand” because it provides nothing meaningful, and probation would be used more if reprimands were gone. (P1, D)
- b. Eliminate the penalty “suspend judgment” because it adds nothing to the process. (P1, D)
- c. Review the following items defined as “unprofessional conduct” under §71-148 in the ULL as to their continuing relevancy. Recommended changes are:
 - (1) In #1 of §71-148 reword to: Solicitation of professional patronage by agents or persons, popularly known as cappers or steerers.

- (2) In #2 of §71-148 leave as is: Receipt of fees on the assurance that a manifestly incurable disease can be permanently cured.
- (3) In #3 of §71-148 reword to: Division of fees, or agreeing to split or divide the fees, received for professional services with any person for bringing or referring a patient except as applicable for managed care contracts.
- (4) In #8 of §71-148 reword to: Performing, procuring, or aiding and abetting in the performance of a criminal action.
- (5) Delete #9 of §71-148
- (6) In #13 of §71-148 move to correct profession: Performance by a physician of an abortion as defined in subsection 1 of section §28-326 under circumstances when s/he will not be available for a period of at least 48 hours for postoperative care, unless such postoperative care is delegated to and accepted by another physician.
- (7) In #14 of §71-148 move to correct profession: Performing an abortion upon a minor without having satisfied the notice requirements of sections §71-6901 to §71-6908
- (8) In #16 of §71-148 move to correct profession: The provision by a massage therapist of sexual stimulation as part of massage therapy. (P1, D)

Rationale: The Steering Committee identified these elements as being obsolescent or unenforceable. Appropriate statutory change would streamline the Uniform Licensing Law and enhance its application.

Recommendation D8: Compliance assurance should be conducted within a policy framework that emphasizes rehabilitation and education over punishment so long as the public is adequately protected. (P15, A)

- a. The credentialing system should emphasize remediation and rehabilitation options designed to change behavior whenever such options are consistent with the protection of the public. (P15, A)
- b. Disciplinary policy should emphasize education whenever possible, and should resort to punitive options only in instances where educational options would not adequately protect the public. (P15, A)
- c. Expand and enhance the Licensee Assistance Program (LAP). Making this type of program more accessible and increasing its scope of practice. Specific expansion should include eligibility by virtue of physical or mental deterioration or disability. Methods of access should include self-referral, referral by the screening committee, or by the board.
 - (1) Voluntary contract initiated and implemented: “I agree to go for evaluation. I agree to follow through with the treatment program.”
 - (i) If in the professional therapist’s (evaluator) judgment the individual is a threat to the public, the individual would be referred to the State.
 - (ii) Failure to comply with the voluntary contract would result in a complaint being filed with the Department.
 - (2) Mandatory contract initiated and implemented that requires the individual to go for evaluation and appropriate treatment program. The individual must agree to

follow through with the treatment program. If the contract is violated by the individual s/he would be reported to the State. (P15, A)

- d. The diversion process would only be applicable for potentially correctable issues, problems and situations. If the credentialed professional's problem is correctable and treatable through education and diversion, upon the successful completion of the diversion process, there would not be a public record of the complaint against the credentialed professional. (P15, A)

Rationale: In egregious cases of direct harm and criminal conduct, some professionals must be dealt with through punitive means. However, such cases are not the norm. In the majority of instances compliance will be better attained through combinations of approaches that stress education and remediation of borderline practices. The compliance assurance process should be structured and implemented with this recognition in mind. The LAP has proven itself to be an effective method of public protection through diversion of appropriate impaired professionals into a rehabilitative setting and program. These recommendations will result in even greater ability of the public to benefit from this approach.

Recommendation D9: Eliminate the requirement that credentials be displayed in the office where the professional practices, but require that practitioners show proof that they have a credential upon request. (P1, D)

Rationale: Recent surveys conducted by the Nebraska Pharmacists Association have revealed that few if any members of the public are aware of the posting requirement or are able to distinguish between a diploma and a license. This requirement may seem to be in the public interest, but in fact does not accomplish its goal of increasing consumer awareness.

Recommendation D10: The boards and the Department should have a greater ability to control the uncredentialed practice of any regulated profession. (P5, A)

- a. The boards should continue the practice of sending out cease and desist orders to those who are found to be practicing a credentialed profession without a license. Copies of the order should be sent to the complainant, the Office of the Attorney General and the appropriate county attorney. (P5, A)
- b. Failure to obey a cease and desist order should be considered a felony. (P5, A)
- c. The boards and the office of the Attorney General should develop strategies to encourage county attorneys to pursue more vigorously the prosecution of cases involving uncredentialed practice. (P5, A)

Rationale: As credentialing proliferates, an increasing number of people, by design or accident, are being identified as practicing a protected act without a credential. Enforcement of such statutory violations has traditionally been the purview of the

appropriate county attorney, and the role of the board has been limited to filing complaints and providing testimony as to the boundaries of legal practice. As the workload of county attorneys has increased, many have become reluctant to pursue prosecution of uncredentialed practitioners unless there is an obvious threat to public health or safety. Thus many statutes are essentially unenforceable. The Steering Committee felt that mechanisms should be found to provide greater authority to the boards and the Department to enforce these statutes.

Recommendation Dx: A mechanism should be developed that will allow consumers readily to identify the qualifications of individuals who provide them with health care services, while protecting the personal identity (last name) of practitioners. (P6, A)
Unresolved.

Rationale: The Steering Committee felt that it was important, in this era of supporting technicians, interns, and others without full practice credentials, for consumers to have a way of knowing the qualifications of persons rendering them health care, especially in retail and other non-clinical settings. However, there was great concern and no agreement as to the methods by which this could be accomplished and the level of responsibility for the credentialed professional to inform. The issue is included to ensure its future consideration, but no consensus or recommendation was agreed to by the Steering Committee.

E. Evaluation Processes/Quality Assurance

Recommendation E1: There should be a defined method of evaluation or feedback loop for measurement of the improvement and/or quality of the health, safety and welfare of the consumer resulting from the credentialing system. (P2, A)

- a. Periodic evaluation of the credentialing system and regulatory sub-systems should solicit feedback from public and professional groups. (P3, A)

Rationale: All systems and processes can be improved and should be consumer focused, involve professionals and employees, and utilized data to improve decision-making. The consumers of the credentialing system have a strong role in evaluation. Without feedback from consumers the system may not have complete and appropriate information on which decisions can be based.

Recommendation E2: Periodic reviews should be conducted for each credentialed profession focusing on the continuing need/purpose of credentialing the profession. Parameters of these reviews should include timeliness, data collection and analysis, public input, professional input and Board of Health input. (P9, A)

Rationale: There is a process for reviewing new professions or changes in scope of practice of professions (407 process). The process or components of a process to evaluate the currently credentialed professions needs to be put into place.

Recommendation E3: Quality assurance for the credentialing system should include periodic reviews of the major processes and subprocesses focusing on implementing and maintaining results. (P11, A)

- a. Elements and characteristics of desirable results for processes and subprocesses of the model system (policy, administration, competency assurance, compliance assurance, evaluation) should have evaluation criteria and measures identified and the evaluation completed on a regular basis. (P11, A)
- b. The existing Credentialing Review (407) Program should be subject to the same quality assurance mechanisms as other components of the State's credentialing system for professionals. (P11, A)
- c. Professional board self-assessment reviews and the internal review of agency credentialing functions should consider the following general criteria: cost-effectiveness; due process; timeliness; efficiency; inconsistencies of board structure; public satisfaction/professional satisfaction with processes; representation of public/professionals; public input at "front end" and conclusion; overall "quality" of the system. (P11, A)
- d. Procedures should be defined to conduct agency internal reviews, and provision should be made for public input into this process. (P11 A)
- e. A focus on implementing and maintaining results when reviewing credentialed professions would need answers to such questions as:
 1. Are statutes governing the profession reflective of current practice standards, education, study and technology?
 - (a) Regulation should not overstep the intention of the statute and statutes should provide clear guidance.
 - (b) Boards should examine their statutes to see if they need to be cleaned up or changed and to check them regarding their feasibility.
 - (c) Boards should cooperate with the agency to reconcile conflicts between the boards over scope of practice.
 2. Is there public education?
 - (a) There is a need to make the public more aware of health care services, professions, and the overall regulatory system. Public education is not a result, but instead is a means by which good results can be realized.
 - (b) Make information on the regulatory system available in all media
 - (c) Advocacy groups should be used in public education efforts
 - (d) Board members should talk to the general public
 - (e) Members of the public should be able to access information on the regulatory system whenever they wish. Printed information should be available upon request.
 - (f) The HHSS advocate should be maintained to answer questions, take concerns, and make referrals.
 - (g) The System must be user friendly, and options and alternatives for getting information should be identified.

3. Is the system evaluated periodically?
 - (a) This should be done by the agency and the boards
 - (b) Evaluations should be done so as not to interfere with the basic work of the credentialing system. (P2, A)

Rationale: A quality assurance and improvement mechanism for the credentialing system is critical. Significant work has already been done in developing evaluation criteria and indicators or measures for the credentialing system, processes and sub-processes as part of the NCR 2000 Steering Committee's work this year.

VIII Implementation

In general, there are five mechanisms through which the recommendations in this report can be implemented.

- Administrative action by the Department and/or the boards;
- Changing rules and regulations;
- Changing State statutes;
- Making recommendations to the federal government; and
- Making recommendations to private professional organizations.

The next major task that should be undertaken is to determine which implementation method is most appropriate for each recommendation. Once this is done, a full implementation plan can be developed that will provide direction to appropriate parties responsible for implementation activities.

IX *Summary and Conclusion*

The proposed model for the credentialing of health care professionals is a significant improvement over the current regulatory system. The proposed model creates a system and structure which are more:

- ***cost-effective*** than the current system because:

It assures that fees are based directly on the cost of services.

It provides for periodic evaluation of currently credentialed professions and the credentialing system to assure they are still supporting the credentialing system results.

- ***adaptive and responsive*** because:

It provides for greater public and provider input into the credentialing processes and subprocesses.

It emphasizes voluntary compliance and diversion options rather than the more traditional adversarial approach to discipline.

It emphasizes continuing competency as necessary, but leaves the specifics to the boards to be appropriately determined.

It provides the inclusion of assessment of the effects of new or existing policies and practices on access to care and the freedom of choice of consumers.

- ***accountable*** because:

It provides for more unified and streamlined procedures for administrative and compliance processes of the credentialing system, and it emphasizes consumer satisfaction.

- ***amenable*** to the ideal of system-wide quality improvement because:

It creates a unified system of regulation as opposed to the current system which divides regulatory functions among three agencies.

It incorporates quality improvement mechanisms for the evaluation of regulatory processes, both internal and external.

- ***easily understandable*** to the public because:

It creates a system that is more in accordance with the ideal of *one-stop, one-shop*.

It emphasizes both the participation of, and the Department's communication with, credentialed professionals and the public.

Glossary

Definition of Terms for NCR 2000

1. **ASSURANCE OF COMPLIANCE**

An agreement where the credentialed person assures he or she will not engage in such conduct that would violate the statute, rule, or regulation in question. The agreement includes a description of conduct that would violate such statute, rule, or regulation and an acknowledgement by the credentialed person that violation of the assurance constitutes unprofessional conduct .

2. **“BY THE PROFESSION”**

Means by the Board through a consultative process with professional members, or in the absence of a Board, by the Department in consultation with members of the profession.

3. **CERTIFICATION**

A credential that gives each credentialed person the right to use a protected title that only those persons who have met specific requirements may possess. Under certification there is no scope of practice, and certification does not restrict practice to those who are possess the credential.

4. **CONTINUING COMPETENCE**

The ability to use professional knowledge, skills, and judgement within the scope of practice of a given profession to ensure public health, safety, and welfare.

5. **CREDENTIALING**

The processes and procedures by which the state grants permission to practice a given profession, or grants permission to use a protected title that signifies that a person is qualified to provide the services of a certain profession.

6. **CREDENTIALING SYSTEM**

The programs and procedures pertinent to a state’s administration, monitoring, and discipline of persons who possess either a license or a registration from the state to provide health care services, or who possess a protected title from the state that indicates that they are qualified to provide health care services.

7. **DISCIPLINE**

The process by which the state ensures that persons credentialed by the state provide services in a manner consistent with the laws governing their respective professions. These actions do not include letters of concern or assurance of compliance.

8. DIVERSION

A referral to and acceptance by a voluntary, non-disciplinary counseling and monitoring program.

9. ENDORSEMENT

A process whereby a given profession in a given state evaluates the credentials of persons from other states who seek to practice in their state. Under this process those persons whose credentials are being evaluated by the Board must demonstrate that their educational and training standards are equivalent to those of the state to which they seek to establish practice.

10. ENFORCEMENT

The decisions and actions of those who comprise a regulatory system (or a credentialing system) to achieve compliance on the part of those whose professional or business activities are regulated by the laws, rules and regulations, and standards of the system.

11. FACILITY

Either a place or a service built or established to provide treatment or care.

12. FUNCTIONAL CREDENTIALING

A form of credentialing under which persons would only be required to be credentialed for those activities that have been deemed to have significant potential for impact on public health and safety.

13. HARM TO THE PUBLIC

Any commission or omission on the part of health care providers that results in adverse outcomes for patients or clients that current medical knowledge or judgement considers to be preventable. Harm can also stem from lack of access caused by an unnecessarily restrictive regulatory system.

14. HEALTH CARE SERVICES

Those services associated with the diagnosis and treatment of physical, mental, or emotional injury or illness, or the rehabilitation or continuing care related to these kinds of health problems or conditions.

15. HUMAN SERVICES

Services created for the purpose of assisting persons in the conduct of their daily living. Such services can include but are not limited to the provision of health-related services.

16. **LETTER OF CONCERN**

A letter sent to the credentialed person that includes a statement of the statute, rule, or regulation in question and a statement advising the credentialed person of the conduct that would violate such statute, rule, or regulation.

17. **LICENSURE**

A credential that grants each credentialed person with a right to provide the services of a specific profession. This right is limited exclusively to those who have met specific requirements and educational prerequisites, and who have passed some type of examination indicating that they are capable of providing services safely and effectively.

18. **PETITION**

A formal written charge against a credentialed person alleging acts or conduct in violation of statutes or regulations governing professional practice, and requesting the imposition of sanctions.

19. **PRACTITIONER**

An individual who personally provides health care services to patients or clients.

20. **PROVIDER**

A more generic term than practitioner that includes, in addition to practitioners, persons who manage facilities or businesses wherein health care is provided.

21. **RECIPROCITY**

A process whereby representatives of a given profession from two or more states agree to form a compact under which they agree to allow practitioners of the profession in question to provide services in any of the states that are party to the compact provided that the practitioners in question are licensed.

22. **REGISTRATION**

A credential that provides each credentialed person with permission to provide services of a specific kind if the person in question agrees to have their name placed on a registry maintained by the state. There are no prerequisites under registration, but if a registrant commits acts that are unacceptable under the terms of the statute, the registrant can be removed from the registry and thereby prohibited from providing services.

23. **REGULATION**

The processes and procedures, laws, and rules and regulations associated with a given activity or endeavor such as health care, business, environmental quality, or labor relations.

24. **REGULATORY SYSTEM**

The programs and procedures of the state that are designed to enforce statutes and rules and regulations pertinent to a given societal activity or endeavor such as health care, business, environmental quality, or labor relations.

25. **SANCTION**

A mechanism of enforcement used to provide incentives for obedience to statutes or regulations.

26. **TELEHEALTH**

A situation wherein health services or information are being provided to patients in a given state from another state using electronic media.

27. **UNCREDENTIALLED**

Providers who have not been credentialed by the state.

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TEMPORARY LICENSURE WORK TEAM
Triggering Conditions for Temporary Credentialing

- I. A template is proposed for consistent requirements related to the triggering conditions for temporary credentialing. It is agreed that each professional board would need to define the following:
 - A. Basic competency as defined by the boards, and the educational requirements to trigger this.
 - B. Supervision requirements
 - C. Post-graduate training levels which would warrant temporary licensure
 - D. How professional re-entry into the field after inactive status would be supervised
 - E. National/international graduates

- II. Disciplinary purview of the board
 - A. Purpose of temporary credentialing
 - B. Bridging to next exam cycle and actual issuance of exam results and credential
 - C. Reciprocity
 - D. Multi-level temporary credential; i.e., visiting professor or faculty
 - E. Specific limitations with respect to practice, e.g. time
 - F. Renewability, reissue and duration issues - scope of renewability to be addressed by boards

- III. Potential triggering conditions that may be applicable:
 - A. To get temporary credential as a bridge, must have registered for next available exam. If failed exam, temporary credential is revoked. Temporary credential may be extended for good cause (surgery, weather, death of family member). Must not have failed exam in another state.

 - B. In cases where temporary credentials are granted to practitioners licensed in another state, pending completion of application for Nebraska credentialing. The work team recommends this practice be discontinued. Temporary credentials should not be granted where people from other states are seeking reciprocity.

For example, MDs who are fully credentialed and working in an emergency room setting, while still holding a temporary credential because they are in a residency program for another specialty training. The group agreed that if a professional becomes fully credentialed, the temporary credential should become null and void.

 - C. Allow current practice of temporary credentialing for applicant accepted/enrolled in a postgraduate residency/fellowship program. Annual renewability as long as the person is

still enrolled in program (instead of current five-year limit).

If a recipient of a temporary credential as a result of residency training qualifies and receives a permanent credential, the temporary credential automatically becomes null and void.

- D. The team recommends discontinuing the practice of 30-day credentials for out-of-state professionals.
- E. Concerns are raised for granting temporary credentials to persons coming from another state seeking reciprocity, where their credentials have not been completely verified.
- F. Temporary visiting faculty permit; propose expansion of concept where appropriate across professional educational settings.
- G. Practitioner credentialed in another state to practice pending completion of application for Nebraska credential.
- H. Allows practice of those reinstating credential to practice pending completion of refresher course (may be necessary as part of course).
- I. Temporary hardship (well drillers only).
- J. Supervision must be a component, as determined by the profession, in cases of temporary credentialing awaiting the examination
- K. Temporary visiting professional permit be considered for persons qualified by previous training and experience to engage in specialized training, under supervision, at designated educational institutions.