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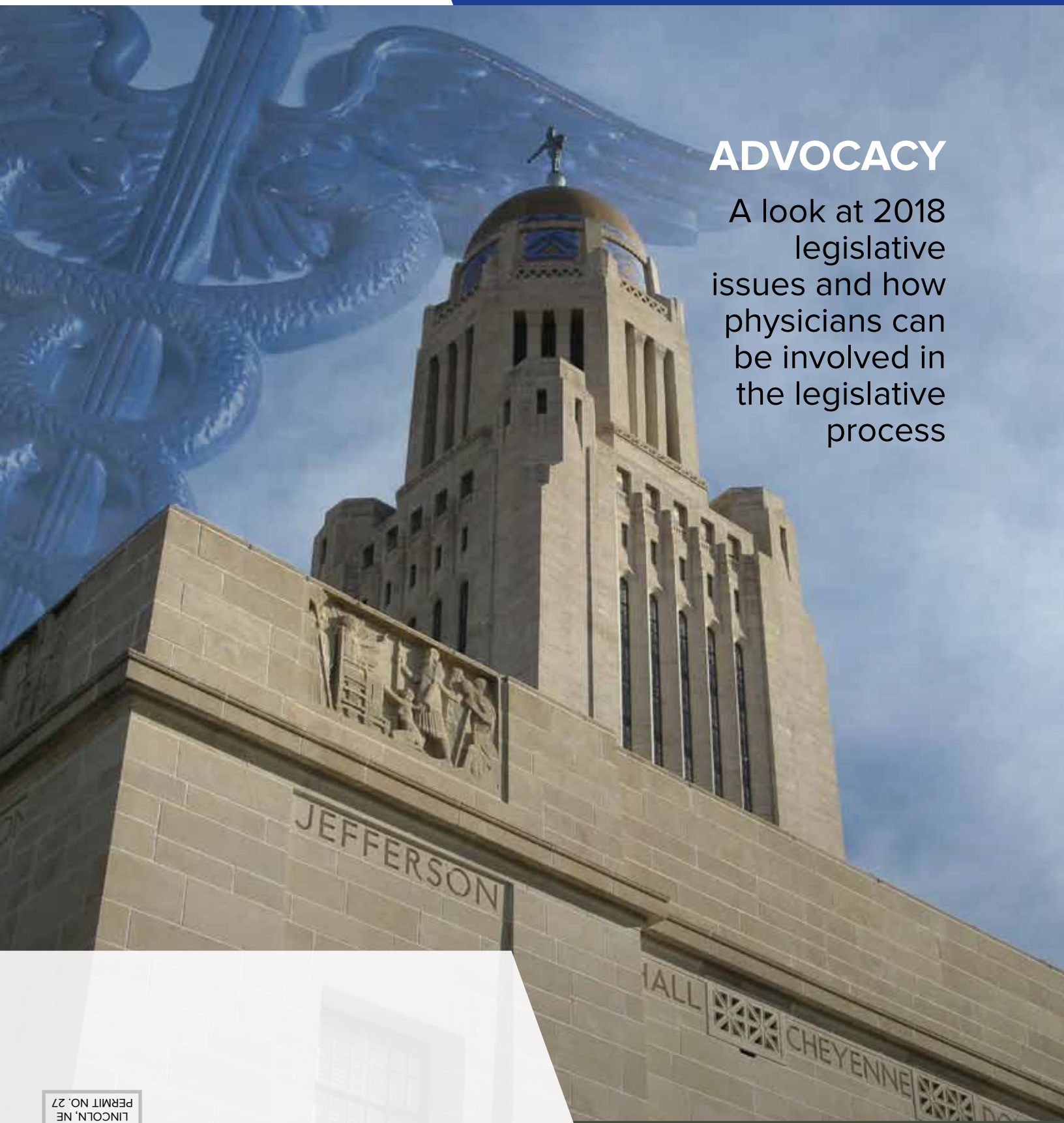

ADVOCACY

A look at 2018 legislative issues and how physicians can be involved in the legislative process

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President's Message: Advocacy in Action

By Robert B. Rhodes, MD, FAAFP
NMA President

The Nebraska Medical Association has the potential to be one of the strongest state associations when it comes to lobbying or acting as one unified advocacy group that represents physicians and the health and safety of our patients. This article will not outline what we have done well (ok - the malpractice cap is one of our largest successes that we want to preserve) or what we missed, (some of The Credentialing Review or 407 process that left us concerned/disappointed) but rather share that we have strength in numbers and our reputation to help protect our profession and patient safety and care.

Whether donning white lab coats, stethoscopes or not, having docs talk to their local or national representatives is always important; keeping our representatives informed is vital to what we do. Over the last year, I have had the privilege to witness advocacy at the local and national level. It has made me proud to be your leader.

State senators or legislative committees appreciate letters from the NMA, Nebraska Academy of Family Physicians, and other national academies, but what they say behind the scenes is that they take notice most ***when doctors show up to give testimony***. They appreciate our expertise, professionalism, and that we took time away from the office to come testify. A perfect example of a collaborative effort this year was during the attempt by optometrists to expand into eyelid injections and surgeries. NMA member testimony was well organized, thoughtful, and most importantly, it protected our patients. The second thing that senators would tell you is that ***they don't want to tell us how to practice medicine***. That means we need to communicate to the NMA as soon as we note something of concern or that has a potential threat on the horizon here or in a neighboring state. We need to keep that in mind as other scope of practice legislation arises.

On the national level, I have witnessed American Medical Association (AMA) policy on everything from gun control discussions, to the disposal of expired prescriptions, to the intricate opioid issue, to awareness of the signs of sex trafficking. I recently asked the NMA to reach out to the AMA when a patient asked me to write a letter requesting a service animal. The AMA promptly responded, and I learned about the differences between companion animals, therapy animals, visitation animals, emotional support animals, public service/military animal, and the role of animals in health care.

In a recent American Academy of Family Physicians article, Sherry L. Robbins, MD, president of the Tennessee Academy of Family Physicians (TAFP), shared the following: "It takes courage to speak up when everyone seems to have an opinion that's different from yours. It's easier, in the short term, to follow the crowd, especially if doing so can be rationalized. However, we lecture patients about making good choices, we advise our children to do the same, and as leaders in our communities and professional organizations, so should we."

Dr. Robbins shared that when Tennessee lawmakers considered legislation earlier this year that was dubbed the "Doctor of Medical Science (DMS) Act" (www.capitol.tn.gov), their state academy leaders had to make a difficult decision. "As we met with proponents of the legislation, we were told that the bill would address the access-to-medical-care issues of Tennessee's underserved. The bill called for establishing a license for a new type of provider that was, ultimately, to be called an 'Essential Access Practitioner' (EAP)." The license would be open to physician assistants with a Master's degree and three years of clinical experience after they completed a DMS program, which would be administered through a medical school and consist of 50 credit hours. The didactic portion of the DMS program offered in the state consisted of an online curriculum and web-based group discussion of cases, which was supposedly based on an internal medicine board review course. The clinical training component would consist of these PAs continuing to practice under the supervision of their primary care physician of record, with a few cases to be logged per week. The TAFP opposed this scope change as it didn't help, but would actually decrease the quality of patient care in Tennessee. The TAFP partnered with the Tennessee Osteopathic Medical

(continued on Page 22)

Executive Vice President's Message

By Dale Mahlman
NMA Executive Vice President

Einstein purportedly said, "What is right is always not popular, and what is popular is not always right." We are living in a world of "do the right thing," but sometimes the right thing is not the most pleasant road to take. This applies at the local, state, and national level as well as globally.

I have been blessed in my 16 years with the Nebraska Medical Association to work with people who continue to do the right thing every day, and to the best of my knowledge, they never worry if it's popular or not because it's the "right thing to do." Thankfully the delivery of health care is not a popularity contest, and even more important, the work on advocacy is not as well.

With adjournment of the most recent legislative session, the NMA was involved in many issues of interest, some that went in our favor and some that didn't. The joy of working with a "non-partisan" unicameral is that today's friends may be your opposition tomorrow and vice versa. As a result, you learn not to sulk or over celebrate because tomorrow can be pretty humbling.

The mission of the Nebraska Medical Association remains "To serve our physician members as advocates for our profession, for our patients, and for the health of all Nebraskans." This past session we did that to mixed results. We were fortunate to move legislation relating to HIV testing that was introduced in 2017 and carried over, a bill that would help with Foreign Medical Graduates and their pursuit of additional experience moonlighting, and also a bill that would allow out-of-state physicians in Nebraska for athletic competitions, whether that be Big 10 physicians or those in the state for Olympic swim trials, to treat their athletes without limits.

On the other side of the slate, we were disappointed our efforts to provide financial support to the Nebraska Coalition for Patient Safety, LB 1127, did not advance on the floor. This innovative legislation would have added a small patient safety fee to licenses for physicians, physician assistants, nurses, pharmacists, physical therapists, and occupational therapists with the expected outcome of increasing resources in the form of provider education to those licensees, as well as our hospital partners. While I am not the most patient person when it comes to "what is right," I understand the process and we will be back next year with a new and improved version of this effort.

We continue to stay involved in the efforts statewide to promote the Prescription Drug Monitoring Program (PDMP) and the safe use of opioids. We have worked with DHHS on the Prescription Drug Guidelines effort and hope our membership has hopped on board with their support of the PDMP and the guidelines tool.

Politics remains a contact effort; how many political contacts have you made in the past year on behalf of medicine? I'm guessing the number for most of our members is low, but the positive to that is that there is only one way to go and that's up. Our excellent staff provides our membership with all the tools and information to become active in the advocacy world. It is not time consuming, it helps you better understand the legislative process, and you are advancing the profession of medicine. Becoming more active in your Nebraska Medical Association is both popular and right. □

Legislative Process and Interim Studies

By Meghan Chaffee, JD
Vice President of Advocacy and Regulation
Nebraska Medical Association

We all might be familiar with the 1976 *Schoolhouse Rock!* Segment, "I'm Just a Bill," which described how a bill becomes a law on the federal level. Many of those steps in the process ring true for Nebraska's Unicameral, but there are a few major differences. So how exactly is a law created in Nebraska?

Prior to the Legislature convening in January, senators are busy during the interim visiting with constituents, special interest groups, and state agencies in an effort to discover what concerns people have that can be addressed by the State. Senators and staff research areas of law that might impact his/her idea and then bring an idea to the Legislature's Bill Drafters office. A bill drafter works with the senator to transform the idea into the proper legal form for a bill, which is then ready for bill introduction.

Bill introduction in Nebraska's Legislature happens during the first 10 legislative days of session. Once the bill is introduced, the Legislative Fiscal Office prepares a fiscal note that estimates the anticipated change in state, county, or municipal expenses or revenue under the provisions of each bill. The fiscal note contains three estimates: one calculated by the fiscal office staff; another prepared by the governor's budget office; and a third is prepared by the affected state agency.

Each bill that is introduced in the Nebraska Legislature is referred to a standing committee (such as Health & Human Services, Business & Labor, Revenue, Banking Commerce and Insurance, etc.). At a committee hearing, the public has an opportunity to express their opinions to committee members. After the hearing, the committee may vote to advance the bill to General File with or without amendments, vote to indefinitely postpone the bill (kill the bill), or take no action on it.

If the bill is advanced from a committee to General File, this is the first time the full Legislature (comprised of 49 senators) has the opportunity to debate and vote on a bill. General File is one of the more crucial steps in the legislative process because during this phase, senators may offer "friendly amendments" in an effort to clean up language or amend language to garner additional votes. However, senators may also offer motions and amendments to create a filibuster, which requires 33 votes to end as compared to a simple 25 vote count needed to advance a bill without a filibuster. In recent years, the Legislature has engaged in numerous filibusters, which extends debate to six hours on General File (three hours under the current Speaker's rules). If the senator who introduced the bill is unable to reach 33 votes to cease debate, the bill dies. If the bill is advanced from General File, it then moves to Select File.

Select File is the second round of debating and voting on a bill. This step allows another opportunity for amendments, compromise, or a filibuster. Bills on Select File may be indefinitely postponed or advanced to the next stage: Final Reading.

Before final passage, all bills are constitutionally required to be read aloud in their entirety by the Clerk of the Legislature, unless 30 votes waive the requirement. A bill may not be amended or debated on Final Reading, but may be returned to Select File for a specific amendment. This might happen if there is a technical error that requires clean up to reduce a fiscal note or avoid unintended consequences that recently came to light. These three steps (General File, Select File, and Final Reading) are required to be met in Nebraska's Unicameral. Nebraska has the only single-house system, the goal of which is to provide efficiency and bipartisanship.

After the Legislature passes a bill on Final Reading, the bill is presented to the governor for consideration. The

(continued on Page 15)

A Look at Upcoming Legislative Races

By NMA Lobbyists

Kim Robak, JD
Mueller Robak

Matt Schaefer, JD
Mueller Robak

If it is an even numbered year then it means that we are in an election year for Nebraska's one house legislature. State senators serve four-year terms and because of a constitutional amendment that imposes term-limits, senators can serve just two consecutive four-year terms. This year Nebraskans in 24 legislative districts will select their senator on the November ballot.

This election will have a major impact on you, your practice, the medical community, and the state as a whole because in what is becoming fairly typical of late, the political dynamics of Nebraska's Legislature is likely to change next session. Six senators this election cycle are term limited and two senators chose not to run for reelection. Additionally there are five high profile challenges to incumbent senators, including a challenge of the sitting Chair of the Health and Human Services Committee, Republican Merv Riepe, by a high profile former two-term senator, Democrat Steve Lathrop. Other incumbents facing strong challengers include two senators recently appointed by the Governor to their seat: Senator Robert Clements of Elmwood, who was appointed by Governor Ricketts in February of 2017, and Senator Theresa Thibodeau of Omaha, who was appointed by Governor Ricketts in the fall of 2017. And finally, two incumbents who serve as committee chairs in the legislature face strong challenges this election: Senator Laura Ebke, who serves as the Chair of the Judiciary Committee, faces farmer Tom Brandt of Plymouth and Senator Mike Groene, who serves as the Chair of the Education Committee, faces former North Platte City Council member Judy Pederson, who successfully petitioned as a write in candidate during the Primary Election to gain General Election ballot access.

Further impact on the body is possible because two senators are running for other elected office and thus the governor may be able to appoint additional new senators that would add to next year's freshman class. And of course, there is a contested race for governor this year – incumbent Governor Pete Ricketts is running for a second term against current state senator Bob Krist of Omaha.

Several other legislative races feature candidates involved in health care. John Arch of Papillion is running against Jeff Parish, also of Papillion, for the seat vacated by term limited Senator Jim Smith. John is a long time executive of Boys Town Hospital and was formerly an executive with Omaha's Saint Joseph Center for Mental Health. Ben Hansen of Blair is a chiropractor and is running against former University of Nebraska Board of Regents member Chuck Hassebrook of Lyons. Current State Senator Bob Hilkemann of Omaha is a retired podiatrist and is running for a second term against Shannon Coryell.

One other wild card for the November ballot is the Medicaid expansion petition drive. Supporters of expanding eligibility of Medicaid to adults with incomes of up to 138 percent of the federal poverty level undertook a campaign to put that question before the voters after the Legislature has rejected expansion several years in a row. When supporters submitted the signatures to the Secretary of State's office for verification on July 5, they said more than 133,000 signatures were collected, well above the required minimum of 85,000. The verification process will take weeks, but campaign officials said they're confident voters will get to decide the issue.

Thus the November election will have major consequences for the political landscape in Nebraska. If many of the incumbent senators are ousted from office or if a sweep of contested races by either Democrats or Republicans occurs it will influence the sort of issues worked on in the Legislature next year, which convenes on January 9, 2019.

The NMA coordinated a forum for legislative candidates to meet with a health care coalition consisting of the NMA, Nebraska Academy of Physician Assistants,

(continued on Page 17)

What Physicians Need to Know about LB 931 and Opioid Prescribing

By John Massey, MD
MD Pain, Lincoln

This year finds Nebraska increasingly involved in the national question regarding prescription opioid use and abuse. This has manifested in many ways and from a physician perspective, some of the proposed and adopted remedies have been more helpful than others with respect to ameliorating some of the causes of the problem with opioids misuse. One of the important take away messages that physicians must learn is the imperative we face to do our part to address this issue as the class of individuals uniquely suited to do so. If we do not, others will increasingly step into our arena and take the matter out of our hands. It is easy to see how this can harm our patients through the law of unintended consequences and our profession by reducing the value of the patient-physician relationship.

This year multiple legislators brought forward bills aimed at reducing opioid misuse in various ways. These bills represented honest attempts at solving portions of the problem legislatively and were ultimately adopted after being combined into one bill, LB 931. These bills were created predominantly outside of any physician-directed guidance. The NMA position on the bills evolved as the bills were amended, but it is fair to say that LB 931 represents a simple attempt at improving a complex problem. When the NMA testified against a portion of the bill, we were dismayed at the comment of one senator who said essentially:

”Who cares if this is the wrong thing to do, at least we are doing something!”

This comment may have summed up the debate better than anything else.

Ultimately, LB 931 was overwhelmingly passed and is now in effect. These are the aspects for clinicians to be aware of:

1. Prior to providing a prescription for a Class II opioid for benign pain, physicians must explain to patients the risk of addiction with these drugs. Physicians must also communicate that there are other non-opioid treatments available and that concomitant use of benzodiazepines or other sedatives may increase the risk of complications with the use of these drugs. This communication must also occur prior to a third prescription for a patient if additional prescriptions are required. Documentation of such conversation is not required. This became effective July 19, 2018, and sunsets (terminates) January 1, 2029.

2. Physicians prescribing for children younger than 18 years of age should limit their prescription typically to no more than seven days unless a documented need to do so exists, such as for a cancer diagnosis or palliative care. If a clinical diagnosis, such as cancer or for palliative care, exists that would support use for longer than seven days, the clinician may exceed the seven-day cap and must document the rationale and medical condition leading to the prescription of these medications for longer intervals. When exceeding the seven-day cap, the clinician must also document that a non-opioid alternative was not appropriate given the clinical background. Additionally, the clinician must discuss the risks associated with these medications with a parent or guardian. Documentation of such conversation is not required. This law became effective July 19, 2018, and sunsets (terminates) January 1, 2029.

3. Pharmacies are required to obtain a government issued ID for patients who are picking up prescriptions for Class II medications unless they personally know the individual receiving the medication. This does not apply to the administration of medications in nursing homes. This law became effective July 19, 2018, and sunsets (terminates) January 1, 2029.

The bill that was finally approved was greatly modified from the initial presentation of its various components. NMA lobbying efforts were able to help the legislators understand some of the problematic language in the initial bills. In many ways, this leaves us with a law that is more manageable for clinicians to incorporate into clinical

(continued on Page 18)

Advancing LB 1127: NMA Leads the Challenge to Improve Patient Safety

By Katherine J. Jones, PT, PhD
President, Board of Directors,
Nebraska Coalition for Patient Safety

LEADERSHIP

In 2004, General Stanley McChrystal reflected on how the complexities of fighting terrorism required him to change his perception of leadership. He began conducting daily briefs via videoconference to link 70 sites including remote outposts in Afghanistan and the National Security Agency headquarters outside Washington, D.C. His goal was to create a "shared consciousness" regarding problems, goals, and strategies while empowering soldiers to execute solutions in their local environment. He sought to demonstrate the culture of transparency and psychological safety that is needed to support empowered execution at the front lines. He knew that his most powerful communication tool was his own behavior.[1]

SCOPE OF THE PROBLEM

Improving patient safety is as complex as fighting terrorism. The aging of our population is associated with an increased prevalence of chronic conditions that accounts for 86 percent of health care spending.[2] Medical error is estimated to be the third most common cause of death in the United States.[3] Hospital sentinel event reports identify poor communication and lack of teamwork as a root cause of 70 percent of events. Annually, every 1000 adults aged 65 and older, average 400 ambulatory care visits, 300 emergency department visits, 200 hospital admissions, 106 home health admissions, and 46 skilled nursing admissions.[4] These multiple transitions in care increase the likelihood of errors. Adverse drug events are the most common adverse events across all care settings[5, 6, 7, 8, 9] However, missed and delayed diagnoses,[10] delays in reviewing test results,[11] and missing clinical information[12] also account for a large proportion of ambulatory care errors. A 2017 survey conducted by the University of Chicago found that 21 percent of U.S. adults have personally experienced a medical error.[13]

ROLE OF PATIENT SAFETY ORGANIZATIONS

Providers need a "shared consciousness" of the nature of the patient safety problems that affect their patients. Patient Safety Organizations (PSOs) exist to facilitate the process of collecting, analyzing, and aggregating patient safety events for the purposes of shared learning. They do so by conferring protection from legal discoverability for reported events.[14] These protections are only available by working with a Federally-listed PSO. There are currently 82 PSOs that meet the criteria for listing as a PSO established by the Agency for Healthcare Research and Quality.

NEBRASKA COALITION FOR PATIENT SAFETY (NCPS)

NCPS was founded in 2006 in response to the Nebraska Patient Safety Improvement Act. The mission of NCPS is to continuously improve the safety and quality of health care delivery in the region. NCPS has been continuously listed as a Federal PSO since 2009. Founding organizations were the Nebraska Hospital Association, Nebraska Medical Association, Nebraska Pharmacists Association, Nebraska Academy of Physician Assistants, and Nebraska Nurses Association. Nebraska law mandated the formation of NCPS, but this mandate did not include a funding mechanism. NCPS relies on fees from member hospitals and the founding associations, sponsorship donations, and grants, which has limited its growth.

Since 2006, NCPS has made progress in understanding root causes of errors in Nebraska hospitals and in providing education and feedback to address these root causes.[15] However, relying on fees from voluntary hospital members limits NCPS's capacity to disseminate its findings and to understand the scope and nature of patient safety risks and hazards in ambulatory clinics, long-term care, and community pharmacies. Nebraskans—patients, health care professionals, and payers—should have access to information about the scope of patient safety problems and progress in the state as a whole.

(continued on Page 9)

Advancing LB 1127: NMA Leads the Challenge to Improve Patient Safety (continued)

LB 1127

Similar to General McChrystal, the Nebraska Medical Association (NMA) believes that their most powerful communication tool is their behavior. In the spring of 2017, NMA sought to respond to Evelyn McKnight's call to accelerate patient safety efforts in Nebraska. Evelyn is a survivor of the 2002 Hepatitis C outbreak caused by re-using syringes in an outpatient infusion center in Fremont. NMA leaders, President Rob Rhodes, MD; President-elect Britt Theddinger, MD; Executive Vice-President Dale Mahlman; and Vice President of Advocacy & Regulation Meghan Chaffee, JD; sought to leverage the existing patient safety infrastructure at NCPS to achieve this goal. NMA and NCPS collaborated to develop and support LB 1127, which was introduced by Senator Mark Kolterman during the 2018 legislative session. This bill would have created a Patient Safety Cash Fund to support the activities of NCPS by charging physicians, physician assistants, nurses, occupational therapists, pharmacists, and physical therapists an annual patient safety fee of $10. This fee would raise approximately $418,000 annually to support NCPS, which is an approximate 150 percent increase in NCPS's operating revenue.

The bill was heard before the Health and Human Services Committee (HHS Committee) on February 21, 2018. Following Sen. Kolterman's introduction of the bill, proponent testifiers included: Dr. McKnight, Dan Rosenquist, MD, who testified on behalf of the NMA and COPIC, Kurt Schmeckpeper on behalf of the Nebraska Academy of Physician Assistants, Monica Seeland on behalf of the Nebraska Hospital Association, and myself on behalf of the NCPS. The HHS committee asked many thoughtful questions and proponents reported the facts and background information about NCPS' inception, mission, and goals. Unfortunately, the Nebraska Nurses Association (NNA) and the Platte Institute testified in opposition to the bill during the hearing. The NNA's opposition focused on the issue of workforce development. The NNA stated that they perceived inadequate staffing and burnout to be major barriers to patient safety. NNA was assured that these topics would be included in the NCPS's research priorities when additional funding is available. The Platte Institute stated that they would oppose any increase in all licensure fees because increases would be a burden on household incomes and a barrier to recruiting employers, employees and businesses. During his close, Sen. Kolterman made a compelling case that refuted the opponents' positions, and LB 1127 did advance from the Health and Human Services Committee. However, because the bill lacked a priority designation and only a few weeks of session remained, the bill was not scheduled for debate and remained on General File. As is common for initial legislation, this initiative will require reintroduction during the 2019 session.

NEXT STEPS

The Health and Human Services Committee will conduct an interim study of NCPS prior to the 2019 legislative session. This study is intended to set the stage for reintroduction of a bill to create the Patient Safety Cash Fund in 2019. This study will clarify the:

- current funding mechanisms of the NCPS,
- work products of the NCPS and its value to dues-paying members,
- strategies to provide meaningful information about patient safety events to health care providers,
- best use of increased funds to meet the patient safety needs of health care providers, and
- funding mechanisms and stakeholders of patient safety organizations in other states.

SUMMARY

NCPS can help health care providers implement strategies to continuously decrease the likelihood that patients are harmed by the care that is intended to help them. These strategies include:

- locating and contributing to the evidence-base for improvement,
- providing tools and technical assistance to improve an organization's culture of safety,
- supplying benchmarks to drive comparisons and the allocation of resources for improvement, and
- calling attention to the need for leadership commitment and engagement in the process.[16]

(continued on Page 20)

The Advanced Practice Registered Nurse Compact

By Travis Teetor, MD, FASA

The Advanced Practice Registered Nurse (APRN) Compact was introduced during the 2018 Nebraska Legislative session by Senator Carol Blood as Legislative Bill 687. It ultimately failed to advance out of the Health and Human Services Committee. However, we anticipate this piece of legislation will be back in the coming years for another round of debate. The APRN Compact is a dangerous piece of legislation under the guise of licensure portability, but the true aim is expanding scope for APRNs not only in Nebraska but also nationwide. This is actually the second time the National Council of State Boards of Nursing (NCSBN) has attempted to pass the APRN Compact. The initial introduction of the APRN Compact was in the early 2000s at which time it was only adopted by Texas, Utah, and Iowa. The current iteration of this compact has been passed in Idaho, North Dakota, and Wyoming. The APRN Compact will not be implemented until 10 states have enacted legislation.

The initial APRN Compact legislation had no mention of independent practice for APRNs. Only in the newest format, currently being proposed by NCSBN, is the issue of APRN independent practice raised. Article III, Section H, of the introduced bill stated, "An APRN issued a multistate license is authorized to assume responsibility and accountability for patient care independent of a supervisory or collaborative relationship with a physician. This authority may be exercised in the home state and in any remote state in which the APRN exercises a multistate licensure privilege."

By granting APRNs patient care independent of a supervisory or collaborative relationship with a physician through the APRN Compact there is potential for usurping a requirement set out by LB 107, which was signed into law in 2015. LB 107 states the following: "In order to practice as a nurse practitioner in this state an individual who holds or has held a license as a nurse practitioner in this state or in another state shall submit to the department a transition to practice agreement or evidence of completion of 2000 hours of practice as a nurse practitioner which have been completed under a transition to practice agreement, under a collaborative agreement, under an integrated practice agreement, through independent practice, or under any combination of such agreements and practice, as allowed in this state or another." Based on LB 687, an APRN could become licensed in another compact state without completing 2000 hours of practice under a transition to practice agreement in that state depending on the prevailing laws of the licensing state and then practice in Nebraska if the APRN Compact were enacted. This sets a dangerous precedent by allowing insufficiently trained personnel to provide direct patient care to patients in Nebraska.

There are also specific issues with both Certified Registered Nurse Anesthetists (CRNAs) and Certified Nurse Midwifes (CNMs). While Nebraska is an opt-out state for anesthesia care, this does not mean it is automatically an independent practice state. Opt-out status does not obliterate physician involvement in every anesthesia setting. In Nebraska, the underlying statues requiring physician involvement with nurse anesthetists say, "The determination and administration of total anesthesia care shall be performed by the certified nurse anesthetist or nurse anesthetist temporarily licensed pursuant to section 38-708 in consultation and collaboration with and with the consent of the licensed practitioner." (Neb. Rev. Stat. §38-711). Licensed practitioner means "Any physician or osteopathic physician licensed to prescribe, diagnose, and treat as prescribed in the Medicine and Surgery Practice Act." (Neb. Rev. Stat. § 38-705). The APRN Compact would usurp state statute that is currently in effect regarding anesthesia consultation and collaboration.

Another area of concern is that of nurse midwives. Currently in Nebraska nurse midwives must practice under an integrated practice agreement between a collaborating physician and a certified nurse midwife. This bill would negate this requirement.

Other organizations have also taken issue with the APRN Compact including the Texas Board of Nursing, the American Psychiatric Nurses Association, and the Washington State Nurses Association. The Texas Board of Nursing abstained from Article III, Section H, regarding independent ARPN

(continued on Page 19)

Lessons from LB 838

By David Watts, MD

The Indoor Tanning Facility Act first became law in Nebraska in 2014. Under that law, parents or guardians must consent for their child to tan indoors and accompany their children under 16 to indoor tanning facilities. Unfortunately, a 2017 study published in the Journal of the American Medical Association reported that approximately one third of Nebraska tanning facilities were not compliant with the law, similar to salons in other states.

Numerous agencies such as the CDC, the Surgeon General, and WHO, caution that indoor tanning causes cancers of the skin and eyes. Melanoma, the deadliest of these cancers, continues to increase nationally. Melanoma is increasing faster in Nebraska than the national average, particularly in young people. Because of the disproportionate increase in melanoma in our state, and since "parental consent" tanning laws imply to parents that tanning may be safe, many public health groups support measures that ban tanning for minors, similar to laws for other known carcinogens like tobacco and alcohol.

So State Senator Anna Wishart introduced LB 838, on behalf of the American Cancer Society, during the 2018 short unicameral legislative session. The public hearing featured testimony by young melanoma survivors, a skin cancer surgeon, and tanning industry representatives. LB 838 advanced from committee, was prioritized by Senator Kolowski, and was debated on the floor with strong bipartisan support. An informal vote tally showed not quite enough votes to advance, and further debate on the bill was postponed indefinitely so the bill "died." However, support for LB 838 well exceeded expectations.

There are three main lessons to be learned from LB 838. The first is that collaboration is key to informing our representatives. The second is that the main barrier to advancing consumer protections are the strong incentives of industry to obstruct. The third is that relationships with legislators count.

First, a strong public health coalition supports common sense, evidence-based restrictions on the intense UV radiation exposure to which skin is exposed during indoor tanning. Stakeholders include the American Cancer Society, the Nebraska Medical Association, and the Nebraska Cancer Coalition. A broad base of support is necessary to effectively inform legislators on complex issues.

Second, the indoor tanning industry is threatened by revenue loss and is well connected politically through campaign contributions and relationship-building with senators. It is well known that the main obstacle to indoor tanning legislation at the state level is industry lobbying. Despite this, 17 states now ban minors from tanning commercially.

The third lesson is that successful legislative initiatives are often multi-year projects. Relationships with lawmakers require cultivation over time. Monetary contributions demonstrate community support to politicians and can engage their attention and receptiveness to a message. However, a personal connection with a trusted constituent often carries more weight. Although scientific evidence is overwhelming that UV causes cancer, the complexity of the science is difficult to translate to non-scientists.

As physicians who understand the scientific process, it may seem obvious to us that public policy should be evidence based. The fact that a large body of science shows that indoor UV tanning is especially hazardous to young people makes the reluctance of politicians to confront it puzzling until we consider their perspective. These citizen legislators are confronted with a barrage of bills, many of which are technical and difficult to understand. They depend on us, their trusted constituents, to help inform them. It is our responsibility to earn their trust and help them make wise policy.

Eight senators who are not returning to the Legislature in 2019 were "no" votes for LB 838. There is a strong opportunity to advance a new bill in 2019. In addition, there is also interest in requiring licensure for indoor tanning facilities to operate, which is currently not the case in Nebraska.

As an NMA member, this is a great opportunity for you to help reduce preventable cancers in Nebraska by reaching out to your state representative and offering them your knowledge and support. □

Medical Scope of Practice Issues

By William J. Mueller, JD
Mueller Robak

One of the least known responsibilities of state legislatures is determining the scope of practice of health care providers in each state. Every legislative session legislation is introduced to regulate a new health care provider or expand the scope of practice of an existing health care provider. Of particular interest to the house of medicine is legislation seeking to expand the scope of practice of optometrists in Nebraska.

In 1985 the Nebraska Legislature passed LB 407, the Nebraska Regulation of Health Professions Act. The purpose of the Act was to establish guidelines for the regulation of health professions which are not licensed or regulated and those licensed and regulated health professions which seek to change their scope of practice. The Act established a procedure within the Department of Health and Human Services to review requests by applicant groups to become regulated or to expand their current scope of practice. This process is commonly referred to as the "407 process." The recommendations that come out of the 407 process are provided to the Legislature which has the ultimate authority to determine health care providers' scope of practice.

Once an application is filed by a provider group, the Director of the Department of Public Health of the Division of Public Health of the Department of Health and Human Services, with the advice of the State Board of Health, appoints an appropriate technical committee to examine and investigate each application. The committee consists of six appointed members and one member of the State Board of Health who serves as the chairperson of the review committee. The chairperson of the committee cannot be a member of the applicant group, any health profession sought to be regulated by the application, or any health profession which is directly or indirectly affected by the application. The Director shall ensure that the total composition of the committee is fair, impartial, and equitable. In no event shall more than one member of the same regulated health profession, the applicant group, or the health profession sought to be regulated by an application serve on a technical committee.

As soon as possible after its appointment the committee meets and reviews the application assigned to it. The committee is charged with serving as a fact-finding body and undertakes such investigation as it deems necessary to address the issues identified in the application. As part of its investigation, each committee considers available scientific evidence and conducts public fact-finding hearings. The applicant group has the burden of producing evidence to support its application. Each committee details its findings in a report which it files with the Board of Health and the Director of Public Health of the Division of Public Health of the Department of Health & Human Services. Each committee evaluates the application presented to it on the basis of the criteria establishing in statute and is required to make written findings on all criteria and make a recommendation for approval or denial. The committee may make additional recommendations regarding changes to the proposal or other solutions to problems identified during the review and make comment on the anticipated benefits to the health, safety, and welfare of the public.

Once the State Board of Health receives the report from the review committee it meets to review and discusses each report. The Board of Health then compiles its own report including its findings and recommendations and submits such report together with the committee report to the Director.

After receiving and considering reports from the committee or the Board of Health, the Director prepares a final report for the Legislature. The final report must include copies of the committee report and the Board of Health report, if any, but the Director is not bound by the findings and recommendations of such reports. The Director, in compiling his or her report, shall apply the criteria established in statute and may consult with the Board of Health or the committee. The final report of the Director should be submitted electronically to the Legislature no later than 12 months after the application is submitted to the Director and found to be complete. The Director may recommend that legislative action be taken on an application. If the Director recommends that an application

(continued on Page 13)

Medical Scope of Practice Issues (continued)

of an applicant group be approved, the Director also recommends an agency to be responsible for the regulation and the level of regulation to be assigned to each applicant group.

According to the language of the Act, the scope of practice of a currently regulated health profession shall be changed only when (a) the health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice; (b) the proposed change in scope of practice will benefit the health, safety, or welfare of the public; (c) the proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public; (d) The current education and training for the health profession adequately prepared practitioners to perform the new skill or service; (e) There are appropriate post professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill or service in a safe manner and (f) There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

If it is determined that practitioners of a health profession not currently regulated are prohibited from the full practice of their profession in Nebraska, the following criteria shall be used to determine whether regulation is necessary: (a) Absence of a separate regulated profession creates a situation of harm or danger to the health, safety, or welfare of the public; (b) Creation of a separate regulated profession would not create a significant new danger to the health, safety, or welfare of the public; (c) Creation of a separate regulated profession would benefit the health, safety, or welfare of the public; and (d) The public cannot be protected by a more effective alternative.

In 2013 the Nebraska Optometric Association submitted a 407 application to expand the scope of practice of Nebraska optometrists. The optometrists sought to enhance the scope of practice of Nebraska optometrists by (1) removing current restrictions on prescribing oral steroids, oral anti-glaucoma medications, and oral immunosuppressive medications, (2) allowing the injection of medications for the treatment of anaphylaxis and the injection of pharmaceutical agents into the eyelid for the treatment of cysts, infected, or inflamed glands of the eyelid and (3) Allowing minor surgical procedures to remove cysts and to treat infected or inflamed glands of the eyelid.

A review committee was appointed and considered the application. Following approximately 70 hours of review and discussion, the technical committee recommended against approval of the proposal. The State Board of Health recommended approval of the applicant's proposal but recommended that a standardized training program in minor surgical procedures be required as a minimum requirement for Nebraska optometrists who seek to perform such procedures and that this program consist of hands-on training on actual patients and that it be taught at an accredited optometry program in in an accredited college of optometry.

The proposal was then reviewed by the Chief Medical Officer and Director of the Division of Public Health of the Department of Health & Human Services who recommended against the proposal. In recommending against the proposal the Director wrote: "What is clear, however, is that the applicant group did not establish that optometrists can perform the procedures and prescribing practices they are proposing safely and effectively."

In 2014, despite the strong opposition from groups including the Nebraska Medical Association and the Nebraska Academy of Eye Physicians and Surgeons, the Nebraska Legislature passed a bill to allow optometrists to prescribe pharmaceutical agents but it rejected the request to expand the optometric scope of practice to include injections and surgical procedures.

In 2017, legislation was introduced by the optometrists to further their scope of practice. The bill, LB 391, failed to advance to the floor of the Legislature by the senators on the Health & Human Services Committee and therefore died at the end of the 2018 legislative session. The bill would have authorized, among other things, optometrists to inject medications into the eyelids, to perform surgery on the eyelid, authorize suturing of the eyelid, and perform additional surgical procedures to treat cysts and infected or inflamed glands of the eyelid. This proposal was the same

(continued on Page 20)

Heritage Health Implementation – A Legislative Perspective

By State Senator Merv Riepe, LD 12
Health and Human Services Committee, Chair

Heritage Health, Nebraska's Medicaid integrated managed care, is now close to its eighteenth month of operation, and according to the Division of Medicaid and Long-Term Care of the Department of Health and Human Services (Nebraska MLTC), the majority of the systemic issues regarding the Heritage Health 2017 "rollout" have been resolved. There will always be individual provider concerns, and need for improvement; therefore, continual legislative oversight will be necessary. Now that the initial "rollout" is in the rearview mirror, I, as Chairman of the Health and Human Services Committee, believe an evaluation is needed this interim to determine if Heritage Health is meeting the performance measures established by the Nebraska MLTC prior to 2017. I will provide insight into how I intend to approach whether Heritage Health is meeting its performance measures through an explanation of the legislative oversight process, historical information about managed care nationally and in Nebraska, and finally providing an overview of some of the opportunities and barriers of Heritage Health since January 2017.

Under the Nebraska Constitution, the legislative branch not only creates the laws of the state, but also provides an important check on the executive branch by providing oversight over the governor's administration and agencies. The Legislature's standing committees assist in providing direct oversight over the agencies within its jurisdiction. The Health and Human Services Committee has a daunting task to provide oversight over all five divisions of the Department of Health and Human Services (the Division of Medicaid and Long Term Care Services, the Division of Children and Family Services, the Division of Behavioral Health, the Division of Developmental Disabilities, and the Division of Public Health), one-third of the state budget.

During my tenure as chairman of the Health and Human Services Committee, one major issue driving legislative oversight has been the "rollout" of Heritage Health. The committee members have taken their oversight role of Heritage Health seriously. Four official quarterly briefings and hearings have been held to better assess the progress of Heritage Health. The briefings allow the Department to present updated data and address systemic problems within the program. The hearings allow for the public, including providers, to present additional information regarding the implementation. After the briefings and hearings, committee members and staff follow up with the Department and providers to facilitate resolution.

Through this oversight process, I have learned the implementation of integrated managed care is complicated, but the goals of integrated managed care may assist the state in providing better outcomes for patients while reducing costs. Nebraska has participated in some form of managed care for over 20 years, including behavioral health. Medicaid is the single largest payer of behavioral health services in the United States, with nearly one in five Medicaid beneficiaries having a behavioral health diagnosis. Spending for individuals with behavioral health diagnosis are nearly four times higher than for those without. Fragmented systems of care, with no coordination, often results in poor health care outcomes and higher costs. In recent years, numerous states have changed the delivery of Medicaid services to provide integrated "whole-person care" to improve outcomes for Medicaid patients. Nebraska MLTC determined in 2015 that without whole-person coordination the state would continue to see poor health outcomes and continual unsustainable increases in Medicaid costs.

Nebraska MLTC worked from 2015 through December 2016 to have a smooth transition to integrated managed care. In the last 18 months, the Committee has observed systematic and individual barriers regarding clean claims, accuracy of reimbursements and interest, credentialing and pre-authorizations. The Department has initiated stakeholder sessions to troubleshoot systematic issues through the Administrative Simplification Committee, the Behavioral Health Integration Advisory Committee and the Quality Management Committee. The Department has issued two

(continued on Page 15)

Heritage Health Implementation – A Legislative Perspective

(continued)

corrective action plans and continues to log and track its Issues Log for individual provider concerns. In Heritage Health's second year, the MCOs are moving toward value-based contracting with providers, which may also lead to better patient outcomes and cost savings. The MCOs and the Department need to continue to work with providers to reduce administrative burden and the Legislature should look at a comprehensive review of reimbursement for all DHHS providers.

As the Health and Human Services Committee evaluates Heritage Health, we should look at the specific "carve-in" services including: behavioral health, home health, durable medical equipment, 599 babies, and pharmacy to see how the integration of services have been implemented and if there is marked improvement from fee-for-service. We should analyze whether patients were able to obtain care while reducing the need for emergency department visits, examine if those with serious mental illness have had better coordinated care for behavioral and physical health, evaluate how the MCOs are managing the care for the over 13,000 patients in active care management and if the MCOs have been able to improve outcomes through care management. Further analysis is needed to determine if additional "carve-in" services would help to improve or hinder coordination for patients.

Finally, as an elected official, an overseer of Nebraska's most vulnerable population, and a steward of state tax dollars, I believe it is our legislative duty to provide continual oversight, not micromanage, all of the divisions of the Department of Health and Human Services, including Medicaid. We, the Health and Human Services Committee, must provide vigilant oversight that strikes a balance between "boots-on-the-ground," and a 10,000 foot – systemic –approach. At last, I would like to thank those who are one of the 38,000 Heritage Health providers who are helping to improve outcomes for 230,000 of the most vulnerable Nebraskans. □

***For providers with Heritage Health concerns, first please contact the MCO involved to resolve. If resolution is not complete or timely, contact Nebraska MLTC, DHHS.HeritageHealth@Nebraska.gov. If resolution is not complete or timely by Nebraska MLTC, please contact the Legislature's Health and Human Services Committee to assist with resolution, 402–471–2623.

Legislative Process and Interim Studies (continued)

governor has five days, excluding Sundays, to decide what to do. If the governor signs the bill or declines to act on it, the bill becomes law. The governor also has the opportunity to veto a bill. If a bill is vetoed and the Legislature is in session, they may override a veto if they reach 30 votes for the override. However, if the governor vetoes a bill after the Legislature has adjourned, there is no opportunity for an override.

Most bills passed and approved by the governor become law three calendar months after the Legislature adjourns, which means for this session, most laws become effective on July 19, 2018. However, a bill may take effect immediately after the governor's signature if it contains an emergency clause. Other bills contain a specified operative date, such as January 1 of the next year.

Because the genesis of a law is an idea, senators may introduce interim studies which help guide research for future legislation. These study proposals vary significantly in topics, depth, and purpose. Interim studies can be used to research future legislation, which provides an opportunity to identify stakeholders that may engage on an issue. They may also examine a concept that failed to advance in a prior session, which helps to refine and improve legislation for future years.

This interim, the NMA will be researching various topics that could result in future proposed legislation. We look forward to working with our members to hear what might be beneficial to the practice of medicine in Nebraska that could be addressed by the Legislature. □

Yes, you can make a difference

By Edward Truemper, MD
Saunders County, Nebraska

"If you're not at the table, you're on the menu" is an oft-quoted political proverb, which means if you are not part of the legislative discussion, you are bound to suffer the consequences of new or amended law. Many physicians take little or no interest in government or interacting with elected officials. Let's face it, medical school and residency did not prepare us for the political realm. During training, our focus was learning medicine, treating patients, and developing skills to thrive either in private or academic practice. Because of our infrequent interactions with elected officials, our views may not be considered during the legislative session when physician input is vital.

Individually, we may not think that we have an impactful voice in what happens to our profession, but we certainly do! Understanding the Nebraska legislative process is key to knowing how to advocate for issues that are important to you and our profession.

The Nebraska Legislative Process – Quick Overview

Starting in January, the 49 Nebraska state senators engage in a 60-day (even years) or 90-day (odd years) legislative session. Senators introduce bills in the first 10 days of session. Every bill receives a hearing from the committee of jurisdiction. The committee votes whether to bring the bill out of committee for the entire Legislature to debate. The bill must pass through three rounds of debate before the bill goes to the governor. The governor has five days to sign the bill into law, not sign the bill and after five days the bill becomes law, or the governor may veto the bill. If the governor does not approve the bill, the Legislature can override the veto with 30 votes and the bill then become law. To find bills, statutes, and information about the Nebraska Unicameral visit www.nebraskalegislature.gov.

How to interact with the Nebraska Unicameral

There are three impactful ways to express your opinion on legislation and policy. First, you can contact individual senators, such as the senator that represents your district. Second, you can contact the committee of jurisdiction or individual committee members. Finally, you can work in conjunction with an association such as our Nebraska Medical Association (NMA).

When speaking to an individual state senator, especially your district senator, it is important to develop a professional relationship well before the session starts to discuss an issue, policy, or new legislation. Bringing a brief outline and supporting materials to your meeting demonstrates preparedness and a respect for the senator's time. To identify your state senator go to the website https://nebraskalegislature.gov/senators/senator_find.php and type in your address.

Meaningful communication with committee members who focus on your policy interest is valuable to achieving a desired outcome. The members of the Health and Human Services (HHS) Committee act as the Legislature's subject matter experts in medical and health legislation. Also, HHS Committee provides oversight for the Department of Health and Human Services.

The current chairperson of the committee is Senator Merv Riepe, former hospital executive (Legislative District 12 – Omaha/Ralston).

You can request a meeting with individual committee members or you can provide testimony regarding the bill of your interest. Providing testimony is an essential part of the legislative process since Nebraska citizens are the "second legislative house" and should provide a check on Legislature's power. Senators appreciate physicians providing expert testimony regarding the bill in question. A well-crafted three to five-minute presentation outlining your position is impactful by committee members. Often testimony leads to multiple questions by senators, which affords you the opportunity to provide more information and clarify your position. If you are not able to attend the hearing, you can provide written testimony to the committee and request the letter be placed in the official record. Copies of your letter are provided to all committee members.

An effective advocacy option that can magnify your

(continued on Page 17)

Yes, you can make a difference (continued)

effort is working in conjunction with the NMA or another association or lobbying group that has expertise on your issue. The NMA maintains a robust focus on legislation that affects physicians and all health care related legislation. The staff can assist in helping with legislative issues. The NMA maintains a legislative committee composed of physicians from across the state and NMA staff. The legislative committee reviews all proposed legislation and determines whether to support or oppose bills. Committee physicians and NMA staff frequently meet with senators to improve legislation. At the annual NMA membership meeting, NMA members adopt resolutions requesting legislative action. The NMA directs the resolutions to senators for consideration to draft bills for the upcoming legislative session. During the session, physicians, NMA staff, and NMA lobbyists are present at the Capitol meeting with senators, attending committee hearings and providing testimony. The NMA welcomes all physicians to contribute their time and expertise during the legislative session.

During session, if you have fostered a professional relationship with a senator you can send an email or written correspondence to weigh in on legislative debate of a bill. Even if a senator does not personally know you, don't hesitate to email or write the senator during session to express your views. If you are at the Capitol building, you can request individual senators to speak with you during floor debate to directly express your position.

Physicians must be part of the legislative process as it can affect our ability to practice and favorably impact the lives of our patients. Still do not think you can make a difference? Consider this example: in the 2015 legislative session LB 330 was introduced which allowed for personal possession of powdered alcohol. One physician was alarmed by the abuse potential of this new product in the adolescent population. Five days before the scheduled floor debate, the physician contacted all 49 senators by telephone and email outlining reasons for opposing LB 330. The Legislature subsequently passed an amended LB 330 prohibiting possession of powdered alcohol.

One issue, one physician, and four hours of focused effort spread over five days made the difference.

Yes, you can make a difference. □

A Look at Upcoming Legislative Races (continued)

Nebraska Healthcare Association, Nebraska Hospital Association, Nebraska Pharmacists Association, and Nebraska Association of Behavioral Health Organizations. The forums were held in late July and early August, which provided legislative candidates who advanced to the General Election an opportunity to meet with our organizations to gain a high-level of understanding as to who our organizations represent, what our priorities are, and how we advocate for our members and the health of all Nebraskans. It also allowed us to meet the legislative candidates, hear about their campaign, what their priorities might be should they be elected, and understand how we can work together to accomplish those goals. □

What Physicians Need to Know about LB 931 and Opioid Prescribing

(continued)

practice and which will still allow appropriate clinical discretion to allow for us to care for our patients. This bill, for better or worse, represents significant and specific oversight of how physicians treat their patients.

We must not lose sight of the overall implications of this large volume of legislative activity aimed at addressing this problem.

First, if we do not lead in this effort, others will. They will do so in ways which necessarily lack the nuance of understanding that physicians have of this complex issue. This problem has many faces: physiological, behavioral, legal, and economic with deep roots associated with problems in our society at large. Physicians are uniquely suited to lead the way out of this great national dilemma.

We will only be allowed the opportunity to do so if we exhibit leadership in this regard. While the legislative arena is arguably not the best way to accomplish this, it is very important that we be involved as early in the process as possible to guide policy makers in the most helpful directions.

This is also an important time to reiterate the work of the NMA and HHS-led committee which created the Nebraska Pain Guidance Document. This document, unlike LB 931, has the depth to address the wide variety of clinical issues associated with effective pain treatment and at the same time identifying problematic drug use issues before they advance to a point where serious adverse effects occur. It is a resource which is both evidence based and practical, and which can assist all Nebraska clinicians daily. Its use is intentionally voluntary, and in this way is a resource for clinicians rather to use in the way they find most helpful rather than feeling coerced. We now face the challenge of building awareness among physicians, and the public of the value and scope of this document to improve our care of pain while reducing problematic medication use and misuse. We urge all Nebraska physicians to familiarize yourselves with this document and how it can help you take care of your patients.

MORE INFORMATION:

Nebraska Pain Management Guidance Document: http://dhhs.ne.gov/publichealth/PDMP/Documents/Nebraska%20Pain%20Management%20Guidance%20Document%20v3.2.pdfs:

LB 931 FINAL:

https://nebraskalegislature.gov/FloorDocs/105/PDF/Slip/LB931.pdf □

The Advanced Practice Registered Nurse Compact (continued)

practice since it is not authorized under Texas state law. The American Psychiatric Nurses Association's CEO states in her letter that this section of the APRN Compact's "language is very confusing and contradictory." The Washington State Nurses Association has many issues with the APRN Compact including independent APRN practice, erosion of state sovereignty, and increased expenses for the state.

How the APRN Compact will govern licensing is another concern. Many of the decisions that are currently made by our state Board of Nursing would be taken away and put into the hands of the NCSBN and the Interstate Commission established by the Compact. Allowing an outside organization authority over who should or should not receive a license to function as an APRN is not a responsible choice. The Commission also can adopt its own rules for licensing and monitoring as well. This Compact carelessly brushes aside laws and regulations that have been carefully crafted by our state's democratically elected legislators and executive-appointed regulatory boards. Nurses who receive multistate licenses under the Compact will have more contact with this Interstate Commission rather than with the local Nebraska Board of Nursing.

Other licensure compacts have been enacted to help expedite the process of obtaining professional licenses once entering Nebraska, and the NMA has supported those efforts. However, the APRN Compact does much more than that. This compact seeks to expand scope of practice under the false pretense of improving license portability. The Interstate Medical Licensure Compact, on the other hand, allows for expedited processing of licensure applications. However, applicants still must apply to the Board of Medicine in each state they wish to practice in.

As physicians, awareness of the intricacies built into multi-state licensures, such as the APRN Compact, are critical in providing safe care for our patients in Nebraska. The Nebraska Medical Association and its advocacy team are constantly at work to protect physician-led care as well as protecting the health and safety of all Nebraskans. □

Advancing LB 1127: NMA Leads the Challenge to Improve Patient Safety (continued)

We—health care providers—have a problem that we must understand and solve. We are more likely to achieve this goal if we share what we know about the scope of the risks and hazards to patients in our care by contracting with a PSO. We must communicate our commitment to the public with our behavior. □

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Medical Scope of Practice Issues (continued)

proposal that was evaluated by the 407 review committee, the Board of Health, and the Chief Medical Officer of the State of Nebraska and was rejected by the technical review committee and the Chief Medical Officer as not being in the best interest of Nebraskans.

LB 391 was opposed by many medical professionals including the Nebraska Medical Association, the Nebraska Academy of Eye Physicians and Surgeons, the Nebraska Dermatology Society, the American Society of Plastic Surgeons, the American Medical Association and the Metropolitan Omaha Medical Society. It is critical that the Nebraska Medical Association and other medical specialty groups take public positions on scope of practice issues and provide input on these complicated, medical issues that affect the health and safety of all Nebraskans. Individual physicians are urged to contact their state senator and provide him or her your professional opinion on scope of practice issues. □

NMAIG, Examining Your Financial Health

By Pam McCawley, AAI, CPIA, AINS
Manager of Personal Insurance

Personal Excess Liability Insurance

When considering your personal excess liability insurance, consider the risks of losing everything you worked hard to achieve and the wealth you may earn in the future. How much do you have to lose?

Personal lawsuits are increasing and so are the judgments, as evidenced by new liabilities and jury verdicts that can run in the millions. Even when the costs of damages appear minor at first they may end up being quite costly over time. The liability coverage provided through your automobile or homeowners insurance policies may not be enough. Would you be able to cover the additional costs?

Personal excess liability insurance offers the higher limits you may need to cover damages for which you, or a member of your household, may be legally responsible. Often labeled an umbrella policy, excess liability insurance is a key part of a personal insurance portfolio that is often overlooked. A personal excess liability policy is triggered when the amount you must pay in a covered lawsuit exceeds the limits of liability under your homeowners, condo, renters, automobile, recreational vehicle, motorcycle, or watercraft insurance policies.

The amount of excess liability coverage that is right for you depends on your personal financial situation. If you are sued and do not have adequate liability coverage for the amount of the legal damages, you could lose current assets as well as future earnings. When selecting the appropriate amount of personal excess liability insurance, consider the following steps:

1. Review all of your assets, including your house, automobiles, personal belongings, valuable collections, and investments.
2. Determine your risk factors such as long commutes to work, teen drivers in your household, number of residences owned, pets, domestic employees, watercraft owned, and online activities of household family members.
3. Consider the unknown. Who might a family member in your home hurt in a car accident? What would the lost wages and medical expenses be for a lifetime of critical care?

The world is full of the unexpected no matter how careful you are. Don't lose what you have spent a lifetime building. The team at NMAIG has carriers that specialize in excess liability protection for highly successful individuals and families. □

NMAIG
Nebraska Medical Association
Insurance Group

About NMAIG (Nebraska Medical Association Insurance Group)

NMAIG, a partnership between NMA and The Harry A. Koch Co., provides services statewide to NMA physicians, their families, and employees. The Koch Co. has been insuring the healthcare industry for over 50 years. We currently work with 40 acute care and critical access hospitals, as well as 1,500 physicians in Nebraska and the surrounding area. They range in size from solo practitioners to fully integrated health care systems. The dedicated team of insurance professionals is ready to develop programs that fit your needs from commercial insurance and employee benefits to personal insurance.

Medical Student Update

Rural Medicine: Health Care's Final Frontier

By Jenna Lamendola Sitenga, M4
Creighton University School of Medicine

It truly is tougher in Alaska. Up here, in the Last Frontier, the people are bold, the elements are rugged, and the challenges are many. Living in Alaska is not for the faint of heart. When the temperature plunges below -60 degrees and the National Guard has to rescue a city from an 18-foot snowfall, residents must pull together, form community, and help one another. I have proudly been an Alaskan for 17 years. Here, at Latitude 59, nestled literally at the 'End of the Road', is my town, Homer. A hamlet of 5,000, Homer is a place where moose roam the streets, where cell phone service is scanty, and where my youngest brother was diagnosed with Type I Diabetes at age two. My sister's diagnosis followed after that. Up here in the Great Land, where survival for even the heartiest proves difficult, I was a primary care provider for my two siblings with Type I Diabetes.

For 10 years I have cared for siblings with Type 1 Diabetes in rural Alaska, where insulin and diabetic supplies are precious and health care provider options are limited. I have monitored nighttime blood glucose levels for hypoglycemia, programmed basal rates into Humalog delivery systems, and witnessed the daily effects a chronic disease has on both the individual and family. My unique experience with rural health in Alaska is what brought me to medical school in Nebraska, which became my home away from home as a great state that offers much in the way of rural health care experience.

My years as a medical student in Nebraska has lent me the perspective of the providers, and my understanding of how a physician meets the needs of a rural community has further been broadened. Rural medicine is perhaps one of the greatest frontiers in modern medicine, necessitating physician innovation and determination to provide comparable health care for patients that lack access to specialists, new surgical technologies, and other big city medical luxuries. The rural provinces of Nebraska still remain significantly medically underserved and call for our service in a way that I believe challenges our commitment to the Hippocratic Oath.

The experiences that Creighton medical students gain in rural family medicine clerkships, medical relief trips to rural Nebraska, and the Nebraska wilderness medicine interest group are invaluable gifts in our lives. In the future, I hope to further dedicate myself to the people of the state I call home and to provide excellent care to the most medically underserved in parts of rural Alaska. I hope this dream is realized by my colleagues too and that their medical calling takes them to other rural sectors of America. Alaska has taught me how to conquer a challenge, how to be resourceful, how to depend on others, and how to recognize a need. I see a need in the world for compassionate, competent, committed health care for all, and I hope to someday give back to others what has so richly been given to me. □

President's Message: Advocacy in Action (continued)

Association and American Osteopathic Association along with the American Academy of Family Physicians and showed the power of numerous organizations with once voice. The bill did not make it out of committee, but that doesn't mean the idea or movement is dead in Tennessee or that it couldn't make its way to Nebraska.

I am asking you to please be courageous and bring your talents and expertise as a concerned NMA physician member and step up to make the potential of our organization **a reality**. Be present, be active, be heard. □

Medical Student Update

Nebraska's Referendum on Medicaid Expansion

By Michael Visenio, MPH, M4
UNMC

Having now spent a few weeks on the trauma surgery service at Nebraska Medical Center, I've witnessed firsthand the barriers individuals face by being uninsured. Besides the prospect of paying astronomical costs for their hospital stays, many patients face limited rehabilitation options following their traumatic injuries, since most facilities require insurance. Those who are low-income and uninsured may otherwise qualify for Medicaid had they lived in a state such as Colorado or Iowa. That is why among health care musings in the state of Nebraska, one notable event is the petition campaign to place Medicaid expansion on the ballot in November.

Although the rhetoric may be fierce on either side of the issue, understanding what Medicaid is and the nuances of current programs in other states is important. Medicaid itself was signed into law alongside Medicare via the Social Security Amendments of 1965 by President Lyndon B. Johnson. This program was established as a joint federal and state effort to insure many low-income groups. By law, state Medicaid plans were required to cover children, parents of dependent children, those with disabilities, and certain adults over 65 who are dually eligible for Medicare. Notably absent is the large contingency of adults without children who live at or near the federal poverty level (FPL), which the Affordable Care Act aimed to address in 2010. The law required states to offer Medicaid to those up to 138 percent FPL, with marketplace premium subsidies covering those from 138 to 400 percent FPL. However, the Supreme Court decision under *NFIB v. Sebelius* in 2012 essentially made Medicaid expansion optional, thus creating a patchwork of states that opt to expand Medicaid or not.

Because Nebraska is a state that has so far not adopted Medicaid expansion, the current ballot initiative is the culmination of numerous unsuccessful bipartisan efforts at legislation in the statehouse. Discussion on Medicaid expansion in Nebraska goes back as far as 2013, and senators have introduced a bill in almost every year since—LB577 in 2013, LB887 in 2014, and LB472 in 2015, and LB1032 in 2016. Although the Nebraska State Legislature is officially nonpartisan, these bills have been introduced by both Democrats and Republicans. Now, instead of introducing another bill in the unicameral, Nebraska may join Maine, Utah, and Idaho in putting forth a referendum to have voters decide on the future of this state's Medicaid program.

It is estimated that about 90,000 Nebraskans would benefit from Medicaid expansion and the benefits of having health insurance such as access to primary care, rehabilitation, and long-term services and supports. One of the concerns is cost, for which the state would be responsible for 10 percent of the cost for expansion enrollees to the federal government's 90 percent commitment. Officials have raised the issue of whether the federal government would maintain their commitment to funding Medicaid, but a simple "circuit breaker" clause that renders expansion null should that be the case could remedy any concerns that the state would be on the hook for more than their promised share.

Then there are various modifications to Medicaid that many states have requested through a waiver process to make expansion more palatable. Options such as work or volunteer requirements, cost sharing for medical services, and small premium payments have been billed as encouraging personal responsibility. However, data show that many individuals on Medicaid already work or have a reason for not working, such as disability or caring for a family member. Instead, this policy can introduce administrative hurdles and red tape that may cause otherwise eligible individuals to fall off the rolls and lose insurance. It is also important to remember low-income individuals live near or below poverty, so every dollar counts when it comes to making ends meet. And, as we have seen in Kentucky, work requirements may also run afoul of the law given the recent federal injunction against enacting this policy.

(continued on Page 25)

Medical Student Update

Nebraska's Referendum on Medicaid Expansion

(continued)

With more than the requisite number of signatures, it seems that the initiative to expand Medicaid may appear on the November ballot. Already, there is at least one lawsuit to that seeks prevent this from happening, citing more technical aspects of the ballot proposal itself. However, if the initiative clears all major hurdles by November, Nebraskans will have the opportunity to decide whether to expand Medicaid and health care access to about 90,000 fellow citizens. □

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Ask a Lawyer

LB 104 – Nebraska's New Health Care Surrogacy Act

What Is the Health Care Surrogacy Act?

The Health Care Surrogacy Act, 2018 LB 104 ("LB 104"), is a new Nebraska law that provides a way for individuals to designate a person to make health care decisions on their behalf if they do not have a court-appointed guardian or health care power of attorney.

When Does Nebraska's Health Care Surrogacy Act become effective?

Nebraska's Health Care Surrogacy Act, 2018 LB 204 was not enacted with an emergency clause. Therefore, it became effective on July 19, 2018.

Who Can Designate a Surrogate?

Adults (persons age 19 or older or emancipated minors) can designate "a natural person" to act as the individual's surrogate to make health care decisions on his or her behalf. This is possible if the individual does not have a health care power of attorney or does not have a court-appointed guardian.

How Can Patients Designate a Surrogate?

Designating a surrogate is relatively easy. All the law requires an individual to do is to "personally inform[]" the individual's "primary health care provider." This can be done verbally or in a written document such as an annual demographic update that a patient completes. Although the law does not require it, for the sake of documenting the designation, having the patient make the designation in a signed and dated writing that is witnessed by a person who is not related to the individual is advisable. No matter how the individual designates a surrogate, once the designation is made, the patient's primary health care provider must document the designation in the individual's medical record.

Even if a patient has designated a surrogate, if the patient is capable of making his or her own health care decisions, the patient can do so. A surrogate's authority to make health care decisions only begins after a primary health care provider has determined that the patient is incapable of making his or her own health care decisions.

When Does a Surrogate's Authority to Make Health Care Decisions Begin?

Once the primary health care provider determines that an individual is "incapable," the authority of a surrogate begins. For purposes of the statute, "incapable" means that the patient

> [L]ack[s][] the ability to understand and appreciate the nature and consequences of a proposed health care decision, including the benefits of, risks of, and alternatives to any proposed health care, or lack[s][] the ability to communicate in any manner such health care decision.

2018 LB 104, § 3(12). If the primary health care provider and any physician consulted about the decision determines that a patient is "incapable," the determination must be made in writing and documented along with its nature and cause in the patient's medical record that the physician maintains, and, if applicable, the medical record of the facility in which the patient is being treated or resides. Notice of the determination is to be given to the patient if the patient may understand, to the surrogate, and to the health care facility, if applicable.

What Should Happen if a Patient Has Not Designated a Surrogate and a Health Care Decision Needs to be Made?

First, ask if the patient has any type of advance directive, whether a Living Will or health care power of attorney. If so, the next step is to determine what the advance directive says and whether it is operative under the circumstances. If a patient does not have an advance directive, a physician will want to determine whether a guardian has been appointed for the individual. If not, the Health Care Surrogacy Act comes into play.

If an individual has not designated a surrogate and no agent under a health care power of attorney or no guardian has been appointed, LB 104 establishes an order of priority of natural persons who may act as an individual's surrogate if the potential surrogate is "reasonably available at the time" a health care decision "is to be made" on behalf of the individual and if the potential surrogate has not otherwise been disqualified under the statute.

(continued on Page 28)

Attorney Requests for Medical Records

By COPIC's Legal Department

Sometimes, health care providers may receive a medical records request from an attorney. These requests can occur in a variety of situations:

- When you are treating a patient involved in a motor vehicle accident, or a patient who is under investigation in a criminal situation such as a DUI or an assault and battery.
- Custody battles between parents also result in requests for records from attorneys involved.
- Requests may involve an attorney investigating whether to bring a medical malpractice claim.

Different legal rules may apply depending on who makes the request, whether it is an informal request or a subpoena, or if the request is tied to a criminal case.

INFORMAL REQUESTS BEFORE A LAWSUIT:

Who usually requests the records: The patient or the patient's attorney.

What to know: If the patient, or the patient's personal representative[1] asks that you send all or part of a medical record to an attorney, then the patient's "right of access" under HIPAA applies and the records must be provided as soon as reasonably possible, but no later than 30 days. If unusual circumstances exist, beyond the control of the provider, such that the records cannot be produced within 30 days, one additional 30-day extension may be obtained by notifying the patient of the unusual circumstances and that an additional 30 days will be required. If the informal request for medical information does not come through the patient, then the provider must have a HIPAA-compliant authorization signed by the patient, before care is discussed or copies of records are provided.

REQUESTS AFTER A LAWSUIT IS FILED:

Who usually requests the records: One or more of the attorneys involved.

Informal requests: A HIPAA-compliant authorization signed by the patient or the patient's personal representative must be obtained before any information may be disclosed, oral or in writing.

Subpoenas: The provider will need to determine if it involves a civil lawsuit or a criminal case:

- Most subpoenas involve civil lawsuits including motor vehicle accidents, premises liability claims, and divorce and child custody issues.
- Subpoenas in criminal cases usually have a state or federal government entity or agency listed as a party and are signed by a deputy district attorney or assistant attorney general.

OUT-OF-STATE SUBPOENAS

Occasionally, providers receive subpoenas from out-of-state attorneys or record retrieval services. Generally, a subpoena, whether civil or criminal, is not valid in any state except the state in which the action is pending (unless the attorney goes through a process to get a state court to issue a subpoena for the out-of-state proceeding). Providing records to an invalid subpoena could result in civil claims for breach of confidentiality and administrative action for violation of HIPAA.

CONCLUSION

Many providers are unfamiliar with the rules pertaining to responding to subpoenas. We encourage you to discuss these principles and educate your staff about properly responding to an attorney request for information. If you have any questions, it is recommended that you speak with an attorney or contact your medical liability insurance provider if they are able to provide assistance in these situations. □

1 Under HIPAA, a person authorized to act on behalf of the patient in making health care related decisions is the patient's "personal representative." Typically, this is a person holding a medical power of attorney. An attorney does not usually have the authority to make health care decisions for a patient-client and would not normally be a "personal representative."

Ask a Lawyer (continued)

The order of priority for identifying a patient's surrogate in the absence of the patient's own personal designation is as follows:

1. The individual's spouse, unless legally separate or legal separation or divorce proceedings are pending;
2. An adult child or emancipated minor child of the individual;
3. A parent of the individual; or
4. A brother or sister of the individual who is an adult or emancipated minor.

What Happens if a Potential Surrogate Declines to Serve?

A person in a higher priority class can decline to serve as a surrogate by informing the individual's primary health care provider, and that fact must be noted in the individual's medical record. The primary health care provider can then determine whether another potential surrogate is willing to serve in that capacity.

In addition to those listed in order of priority above, a person who has "exhibited special care and concern for the individual, who is familiar with the individual's personal values, and who is reasonably available to act" as a surrogate may also serve as a surrogate in the absence of those having a higher priority. This provision allows even an unrelated person to serve as a surrogate under certain circumstances.

Who is a "Primary Health Care Provider"?

A "primary health care provider" is a physician designated by the individual, by an agent under a health care power of attorney, by an individual's guardian, or by a surrogate who has the "primary responsibility" for an individual's health care. The term includes a physician who undertakes that responsibility if there has been no designation of a physician or if the primary health care provider physician is not reasonably available. The term may also include a health care provider who undertakes primary responsibility for an individual's health care.

What Else Should a Physician Know about LB 104?

- Surrogates must consult with a patient's health care providers and make health care decisions in light of the patient's instructions if known. If such instructions cannot reasonably be determined, health care decisions must be made according to the individual's best interests, with due regard to the patient's religious or moral beliefs if known.
- LB 104 provides immunity from criminal liability, civil liability or professional disciplinary action related to acting or declining to act in reliance upon decisions made by a person the health care provider believes in good faith is a patient's surrogate.
- A primary health care provider can use his or her discretion to disqualify a surrogate if he or she has "documented or otherwise clear and convincing evidence of an abusive relationship or of another basis for determining that a potential surrogate "is not acting on behalf of or in the best interests of the individual." Information about the basis for disqualifying a surrogate must be included in the individual's medical record.
- LB 104 mirrors Nebraska's existing advance directives laws about the limits to a surrogate's decision-making authority (e.g., pregnant patients, illegal acts, and the withholding/withdrawal of life-sustaining treatment or of artificial nutrition or hydration.
- LB 104 includes a framework for addressing conflicts between multiple surrogates having the same priority.
- A surrogate's authority does not supercede any other advance directive.
- Surrogates have no authority to withhold or withdraw consent to routine care to maintain patient comfort or the usual and typical provision of nutrition and hydration.

This article is not intended to be a complete discussion of LB 104. If you have specific questions, please consult with legal counsel.

Ask a Lawyer is a feature of the NMA Advocate*. If you have a legal question of general interest, please write the Nebraska Medical Association. Answers to submitted questions are provided by the Nebraska Medical Association's legal counsel, Cline Williams Wright Johnson & Oldfather, L.L.P., 1900 U.S. Bank Building, 233 S. 13th St., Suite 1900, Lincoln, NE 68508–2095. The answer in this issue was provided by Jill Jensen of the Cline Williams Law Firm. Questions relating to specific, detailed, and factual situations should continue to be referred to your own counsel.*

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Is it Time to Review Your Estate Plan?

MATT ABELS CFP®, CPWA®, *Director of Wealth Management*

While most of the conversation about tax reform has focused on the income tax implications for individuals and businesses, another notable change happened with the estate tax exemption. As part of the Tax Cuts and Jobs Act, the estate tax exemption doubled from $5 million to $10 million for individuals and $10 million to $20 million for married couples with portability. Adjusted for inflation, the exemption for 2018 will be $11.18 million and $22.36 million respectively.

While the exemption changed significantly, the estate tax remains at 40%. Also, portability and the step-up in basis remain unchanged.

One interesting and challenging aspect of the tax reform is that this exemption sunsets in 2026, reverting back to the original $5 and $10 million indexed amounts.

Even though increasing the exemption to more than $22 million for a couple eliminates the estate tax for most families, it does not eliminate the need for estate planning. Estate planning might look different than it has in the past, with an increasing focus on income tax planning and maximizing the step-up in basis.

Much like the income tax changes present new and different financial planning opportunities for individuals and businesses, the change in the estate tax exemption will create similar opportunities. This should prompt many to review their current plans to ensure they still accomplish what was intended.

If you are not sure if you need to update your estate plan, or if it has been a few years since you looked at it, it's probably a good time to contact your financial advisor for a review.

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