REPORT OF RECOMMENDATIONS AND FINDINGS

By the Radiologic Practitioner Assistants'
Technical Review Committee

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

July 16, 2014

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Part One: Preliminary Information

Introduction

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

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

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

The Radiologic Practitioner Assistants' Technical Review Committee

Ken Kester, PharmD, J.D., Chairperson **(Lincoln)**
Representing the State Board of Health
Nebraska Heart Hospital

Jean Fox **(Columbus)**
Public member, Board of Chiropractic, retired

Ben Greenfield, L.P. **(Hickman)**
Health professional member
Home Management, St. Elizabeth's Hospital

Teresa Hawk **(Chadron)**
Public member
Part-time music and liturgy coordinator

Norman Langemach **(Lincoln)**
Public member
Self-employed attorney

Ryan McCreery, Ph.D. **(Omaha)**
Associate Director of Audiology
Boys Town National Research Hospital

Robert Sandstrom, Ph.D., P.T. **(Omaha)**
Professor of Physical Therapy,
Creighton University

Meetings Held

Orientation and initial discussion: January 8, 2014
Discussion one: January 29, 2014
Discussion two: February 26, 2014
Preliminary recommendations: April 2, 2014
Public hearing: April 30, 2014
Final recommendations: June 18, 2014
Approval of the final report: July 16, 2014

Part Two: Summary of Committee Recommendations

The committee members recommended approval of the Radiologic Practitioner Assistants' proposal.

The committee members approved the following ancillary recommendation:

> The committee members recommended that licensure for RAs be administered by the Board of Medicine and Surgery if the proposal were to pass the Legislature.

Part Three: Summary of the Applicants' Proposal

The proposal seeks to credential a new category of radiologic technology practitioner in Nebraska. This category of provider is identified by several different titles: 1) Radiology Practitioner Assistant (RPA); 2) Radiology Assistant (RA); and 3) Registered Radiologist Assistant (RRA).

The applicants seek to create a single, common license in Nebraska for all members of these three professional categories, regardless of any differences in education and training among them. The following briefly describes the differences:

> A practitioner must undergo an additional year of education and training beyond that received by radiologic technologists in order to become an RRA. Becoming an RPA requires an additional two years of education and training including 1800 additional clinical clock hours under a radiologist. The RA category is the highest tier of the profession, receiving as much as five additional years of education and training beyond that received by radiologic technologists.

Applicant group representatives and the members of the technical review committee agreed that licensure of RAs would be administered by a Radiologic Technology Committee of the Board of Medicine and Surgery to include two RAs and one physician member who would be a Radiologist if the proposal were to be enacted by the Legislature.

Radiology Practitioner Assistants, or Radiologist Assistants (CBRPA), or Registered Radiologist Assistants (ARRT) are experienced Radiologic Technologists with at least an additional 2 years of advanced training, and are board certified as either RPAs/RAs (CBRPA), or as RRAs (ARRT).

As part of their licensed scope of practice these professionals would be allowed to provide a detailed patient history, examine the patient, take radiologic images, as ordered by a physician. They would also be allowed to perform fluoroscopy and report initial findings to a radiologist for them to interpret.

The following amendments were approved by the committee members:

Amendment One: Pertinent to initial licensure, continuing education, licensure renewal, and statutory authority issues. This amendment began by stating that:

> Pertinent to items #4 on pages 9 and 10, #s 17 and 18 on page 13 and 14, and #5 on page 17 of the Application, the applicants stated that, "The Nebraska Department of Health and Human Services will determine the standards for education and continuing education for the Radiologist Assistant. Any reference to a private organization is for example only."
>
> This amendment stated that these professionals would be required to

complete at least 24 hours of continuing education every two years. It also defined the requirements that courses must satisfy to be accepted as continuing education for this profession.

Amendment Two: Pertinent to scope of practice issues, this amendment stated that:

The following amendment replaces the paragraph that includes eleven bullet points on the job duties of a Radiologist Assistant in the ***Radiologist Practitioner/Radiologist Assistant New Credential Application Booklet*** *on page 6, dated Fall, 2013*

There are three levels of supervision based on the Centers for Medicare and Medicaid Services (CMS) definitions[4]

1. In addition to medical radiographer tasks, a radiologist assistant may perform advanced diagnostic imaging procedures, including fluoroscopy, under the direction of a radiologist. Those procedures include, but are not limited to:
   (a) Enteral and parenteral procedures;
   (b) Injecting diagnostic agents to sites other than intravenous;
   (c) Diagnostic aspirations and localizations.
2. A Radiologist Assistant may perform the following Pre-imaging procedures:
   (a) Review of medical records to verify patient and procedure; obtain medical history and perform physical examination, evaluate medical record, history and physical examination for contraindications for the procedure (e.g., compliance with preparation instructions for the procedure, pregnancy, medications), discrepancies and/or contraindications must be reviewed with the supervising physician;
   (b) Discuss examination/procedure details (including risks, benefits and follow-up instructions) with patient or patient representative;
   (c) Obtain informed consent (patient must be able to communicate with the radiologist for questions or further information as needed);
   (d) Apply electrocardiography (ECG) leads and recognize life threatening abnormalities when necessary;
   (e) Routine urinary catheterization;
   (f) Venipuncture;
   (g) Administer oxygen as prescribed; and
   (h) Position patients to perform required procedures.
3. A Radiologist Assistant may perform Imaging Review**:**
   (a) Evaluate images for completeness and diagnostic quality;
   (b) Recommend additional images in the same modality as required (general radiography, CT, MRI);
   (c) Evaluate images for diagnostic utility and report clinical observations to the radiologist;
   (d) Review imaging procedures, make initial observations and communicate observations to the radiologist; and

4i. A Radiologist Assistant may perform Post-processing procedures:
   (a) Routine CT (e.g., 3D reconstruction, modifications to field of vision (FOV), slice spacing, algorithm);
   (b) Specialized CT (e.g., cardiac scoring, shunt graft measurements); and
   (c) MR date analysis (e.g., 3D reconstruction, maximum intensity projection (MIP), 3D surface rendering, volume rendering).

4ii. A Radiologist Assistant may perform Post-Radiologic procedures:

(a) Record previously communicated initial observations of imaging procedures according to pre-approved protocols;
(b) Communicate radiologist report to the referring physician;
(c) Provide radiologist-prescribed post care instructions to patients;
(d) Perform follow-up patient evaluation and communicate findings to the radiologist;
(e) Document procedure in appropriate record and document exceptions from established protocol or procedure; and
(f) Write patient discharge summary for review and co-signature by the radiologist

4iii. A Radiologist Assistant may perform Quality Control procedures:
(a) Participate in quality improvement activities within the medical practice (e.g.,quality of care, patient flow, reject-repeat analysis, patient satisfaction); and
(b) Assist with data collection and review for clinical trials or other research.

GENERAL SUPERVISION[1]

1. A Radiologist Assistant may perform under general supervision the following:
(a) Administer contrast agents and/or radiopharmaceuticals as prescribed by the radiologist;
(b) Monitor intravenous flow rate; and
(c) Provide information to patients on the effects and potential side effects of the pharmaceutical required for the examination; and
(d) Monitor patients for side effects or complications and report findings to the radiologist as appropriate.
(e) Parenteral medication administration procedures, excluding imaging agents.
(f) Administer general medications as related to the procedure and prescribed by the radiologist.
2. A Radiologist Assistant may perform the following imaging procedures and the use of contrast agents and medicines as prescribed by the radiologist:
(a) Upper GI studies;
(b) Esophagus studies;
(c) Small bowel studies;
(d) Barium enema studies;
(e) Cystogram;
(f) T-tube cholangiogram;
(g) Hysterosalpingogram
(h) Nasoenteric and oroenteric feding tube placement;
(i) Fistulagram/sinogram
(j) Swallowing study
(k) Contrast media administration and catheter placement

DIRECT SUPERVISION[2]

1. A Radiologist Assistant may perform the following Imaging procedures that requires direct supervision and the use of contrast agents:
(a) Lumbar puncture using fluoroscopic guidance;
(b) Thoracentesis and paracentesis with appropriate image guidance;
(c) Lumbar, thoracic, and cervical myelogram;
(d) Ductogram (galactogram);
(e) Lower and upper extremity venography;
(f) Retrograde urethrogram
(g) Port injection
(h) Loopogram;

(i) Sialogram;
(j) Arthrogram (conventional, computed tomography (CT), magnetic resonance imaging (MRI), Ultrasound (US);
(k) Joint injection and aspiration
(l) Peripherally inserted central catheter (PICC) placement

2. A Radiologist Assistant at the direction of a radiologist , may administer imaging agents and prescribed medications as related to the procedure.
3. A Radiologist Assistant may not prescribe medications.
4. Oral medications, excluding imaging agents, always require direct supervision.

PERSONAL SUPERVISION[3]

1. A Radiologist Assistant may assist the radiologist with other invasive procedures.
2. Parenteral medication administration procedures, excluding imaging agents.
3. Provide information to patients on the effects and potential side effects of the pharmaceutical required for the examination.

OBSERVATIONS

1. Initial findings and observations made by a Radiologist Assistant may be communicated solely to the radiologist and do not constitute diagnoses or interpretations.

2. A radiologist will supervise no more than two Radiologist Assistants (RA).

2010 NEBRASKA MEDICAL RADIOGRAPHY PRACTICE ACT

38-1904. Interpretative fluoroscopic procedures, defined.
Interpretative fluoroscopic procedures means the use of radiation in continuous mode to provide information, data, and film or hardcopy images for diagnostic review and interpretation by a licensed practitioner as the images are being produced.

38-1905. Licensed practitioner, defined. Licensed practitioner means a person licensed to practice medicine, dentistry, podiatry, chiropractic, osteopathic medicine and surgery, or as an osteopathic physician.

[1] GENERAL supervision: A service furnished under the overall direction and control of the supervising physician, but his or her physical presence is not required during the performance of the procedure.
[2] DIRECT supervision: The physician is immediately available or physically present, interruptible and able to furnish assistance and direction through the performance of the procedure; the physician does not have to be present in the same room when the procedure is being performed or within any particular hospital boundary, such as the confines of the hospital campus.
[3] PERSONAL supervision: The physician is present in the room when the service is being performed.
[4] There are three levels of supervision based on CMS definitions: the supervising physician does not necessarily need to be of the same specialty as the procedure or service that is being performed or from the same department as the ordering physician. However, the supervising physician or non-physician practitioner must have within his or her state scope of practice and hospital-granted privileges, the ability to perform the service or procedure.
5.ALL supervision is done by a radiologist.

The text of this proposal and these two amendments can also be found under the RPA topic area of the credentialing review program link at http://dhhs.ne.gov/licensure/Pages/credentialing-review.aspx

Part Four: Discussion on issues

All sources used to create Part Four of this report can be found on the credentialing review program link at http://dhhs.ne.gov/licensure/Pages/credentialing-review.aspx

How well does the current situation of radiologic services meet the needs of Nebraskans?

Some committee members indicated that there is a need for greater access to radiologic services in remote rural areas of Nebraska. **(Minutes of the First Meeting of the Committee, January 8, 2014)** An applicant representative commented that he knows from experience that there is great need in rural Nebraska for radiologic services, adding that the proposal would not be able to satisfy all of these needs, but that it would be a step in the right direction. **(Minutes of the Third Meeting of the Committee, February 26, 2014)** Physicians with concerns about the proposal stated that there are no access to care problems in Nebraska pertinent to radiological services, and that radiologists provide coverage for all of Nebraska. **(Transcript of the Public Hearing, Held on April 30, 2014, Pages 33-34, the Testimony of Dr. Kevin Gillespie)**

A committee member commented that the current situation does not provide the public with recourse for harmful or inappropriate practice, and that licensure of RAs holds promise of providing such recourse. **(Minutes of the First Meeting of the Committee, January 8, 2014)** An interested party commented that it is not clear what qualifications a practitioner must have to be competent to work as an RA under the current practice situation, and that this opens the door for hospitals to allow unqualified providers to provide these services, which creates potential for harm to the public. **(Minutes of the First Meeting of the Committee, January 8, 2014)**

An applicant representative commented that without additional credentialing RAs can be denied the use of a fluoroscope, even though they possess the necessary education and training to utilize this technology safely and effectively. This applicant added that PAs, for example, are exempt from this restriction, and are allowed to use a fluoroscope as long as they do so under the supervision of a physician. This applicant stated that RAs need this proposal to ensure the portability of their work. **(Minutes of the First Meeting of the Committee, January 8, 2014)**

A committee member asked the applicants what their position is regarding professions exempted from restrictions on performing fluoroscopy, such as PAs, for example. An applicant representative stated that RAs have concerns about PAs performing fluoroscopy because some PAs are not well trained in fluoroscopy. They went on to state that PAs should undergo credentialing review in order to ascertain the extent to which their members are qualified to provide this service. **(Minutes of the First Meeting of the Committee, January 8, 2014)**

Physicians with concerns about the proposal stated that there is no need

for the proposal, and that radiologists seeking employment in Nebraska are having difficulty finding jobs. They argued that the proposal would make their employment situation worse. **(NRS Survey Results Regarding RPAs)** One committee member commented that information communicated to him from a physician practicing in Western Nebraska indicates that access to radiological services in that part of the State is very inadequate and that patients are having to travel long distances to get these services. This committee member made the observation that these access concerns outweigh concerns raised by radiologists about potential negative impacts on their employment situation, adding that the review on this issue should not be about jobs, but about the needs of patients. **(Minutes of the Fourth Meeting of the Committee, April 2, 2014)**

Would passing the proposal result in any new harm to the public?

A representative of the Nebraska Medical Association expressed concern that increasing the number of RAs who are able to perform procedures that are currently done only by radiologists could result in hospitals employing fewer radiologists. A committee member responded that someone needs to oversee the work of RAs, and, more than likely, that would be radiologists. This committee member added that RAs cannot do all the things that a radiologist can do. **(Minutes of the Second Meeting of the Committee, January 29, 2014)**

A committee member suggested that it might be a good idea to limit the number of RAs a radiologist is allowed to supervise. This might address concerns about effective oversight of RAs providing outreach services. It might also address concerns about RAs replacing radiologists in remote rural areas of Nebraska. An applicant representative responded that there is no evidence that licensing RAs has ever resulted in diminishing the number of available radiologists. The applicants were asked if oversight of RA services would always be by radiologists if the proposal were to pass. An applicant representative responded in the affirmative. The applicants indicated that they would amend their proposal to clarify that physician oversight would always mean oversight by a radiologist. **(Minutes of the Third Meeting of the Committee, February 26, 2014)**

A representative of the Nebraska Medical Association submitted the results of a survey of Nebraska radiologists. This document showed that many radiologists in Nebraska are greatly concerned that the proposal could put some radiologists out of work. They also commented that there are radiologists who are seeking employment in Nebraska who cannot find work. **(NRS Survey Results Regarding RPAs)**

A committee member commented that he could see no reason why the proposal would have any negative impact on radiologists. An applicant representative commented that radiologists do not provide outreach services, and that the outreach services of RAs would not compete with any services provided by radiologists. He commented that it is more likely that the proposal would have a positive impact on

radiologists, adding that the proposal might actually increase demand for radiologists in order to ensure that appropriate oversight for the outreach services of RAs occurs. **(Minutes of the Third Meeting of the Committee, February 26, 2014)**

A committee member asked the applicants whether the proposal would impose new restrictions on practitioners from non-physician professionals that are currently allowed to perform fluoroscopy. The applicants responded that the applicants do not seek to restrict other professions from performing these procedures as long as they are sufficiently educated and trained to perform them safely and effectively. **(Minutes of the First Meeting of the Committee, January 8, 2014)**

A committee member asked if there are procedures that must always be done under direct supervision. The applicants responded in the affirmative, but added that there are many procedures that can be done safely and effectively by RAs under indirect supervision. **(Minutes of the Second Meeting of the Committee, January 29, 2014)**

A radiologist commented that there is potential harm from the fluoroscopy components of the proposal. He argued that fluoroscopy is by its nature an interpretive process whereby the operator of the fluoroscope directs the machine to where they think it needs to go as it generates a continuous flow of images of a patient's body. This requires that the operator has sufficient knowledge and understanding to know where to direct a fluoroscope and how much exposure is sufficient to provide the physician with what is needed to make a diagnosis. He added that this requires considerable judgment, and that radiologists have concerns about RAs doing this safely and effectively. He added that within the last five years fluoroscopy has declined as a diagnostic tool, and that other technologies that involve less risk to the patient are being developed. **(Minutes of the Fourth Meeting of the Committee, April 2, 2014)**

The opponents stated that another source of concern about the use of fluoroscopy by RAs is the issue of excessive exposure. They stated that RAs are less likely than physicians to be efficient in the application of this potentially dangerous technology, and that the patient is more likely to receive larger amounts of radiation than when a physician directs the fluoroscope. The opponents also stated that an RA is more likely to miss important details about a patient's condition than is a radiologist. For these reasons the opponents stated that the use of a fluoroscope always needs to be under the direct supervision of a radiologist. **(Transcript of the Public Hearing, Held on April 30, 2014, Pages 48-50, the Testimony of Dr. Kyle Krehbiel)** Applicant representatives commented that RAs work closely with radiologists as a team, and that this teamwork serves to provide for efficient utilization of this technology, even in outreach situations. **(Minutes of the First Meeting of the Committee, January 8, 2014)**

The opponents expressed the concern that the applicants' use of the term 'interpretive fluoroscopy' in their proposal implies that they intend to interpret radiographic images. They added that RAs do not have the education and training

to interpret such images. The applicants responded that they have no intention of interpreting images, and that they would be willing to delete this term from their proposal if that would help to address these concerns. One committee member commented that regardless of intentions there would still is a potential problem because it is not easy to separate interpretation from the act of conducting the fluoroscopic radiography procedures. The applicants responded that, as regards these kinds of procedures, they work closely with radiologists and that they typically do these procedures together as a team or an RA would confer with a radiologist if the RA were working in an outreach situation. **(Minutes of the Fourth Meeting of the Committee, April 2, 2014)**

A committee member noted that the proposal calls for 1800 hours of education and training for RAs, and asked the applicants to clarify what this consists of in terms of curriculum and clinical preparation. The applicants responded that all education and training for RAs is accredited, and that this provides the public with assurance that RA education and training is adequate for them to provide their services safely and effectively. **(Minutes of the Second Meeting of the Committee, January 29, 2014)**

A radiologist commented that it makes no sense to jeopardize radiology services in our state by creating yet another type of radiological provider to compete with them to provide services, especially when the quality of services from these new providers would be at a lower level than those of radiologists. One applicant responded to this comment by stating that he has information indicating that the National Radiological Society is in support of RA licensure, and that it seems unlikely that they would take such a stance if RAs were a threat to radiologists' employment. A committee member commented that RAs need radiologists to oversee their work and that this would be specifically stated in statute if the proposal were to pass. **(Minutes of the Fourth Meeting of the Committee, April 2, 2014)**

Would the public benefit from the proposal? Would the proposal be effective in enhancing access to care?

Some committee members indicated that the proposal could benefit the public by making radiology services more efficient. Some committee members commented that the proposal would create greater assurance of competency as regards RA radiologic services. Other committee members commented that the proposal might increase access to radiologic services in remote rural areas. An interested party commented that the number of available residencies in radiology is declining in Nebraska, and that, overall, the number of radiologists practicing in Nebraska is declining. Comment was made that equipment necessary to provide advanced radiographic imaging is declining in rural areas of Nebraska, and that because of these trends increasing the scope of practice of RAs is unlikely to have a significant impact on access to care in rural areas. **(Minutes of the Second Meeting of the Committee, January 29, 2014)**

A committee member commented that the current situation does not provide the public with recourse for harmful or inappropriate practice, and that licensure holds promise of providing such recourse. An applicant representative commented that passing the proposal would have the effect of ensuring that RAs would be allowed to administer fluoroscopy procedures under the general supervision of a physician. **(Minutes of the First Meeting of the Committee, January 8, 2014)**

Clarification was made that under the current situation RAs are disallowed from performing 'interpretive fluoroscopy', not fluoroscopy per se. RAs can perform fluoroscopy, but only if their supervising radiologist gives them permission to do so. The proposal would allow them to perform this procedure without having to get permission from their supervising radiologist to do so. The applicants stated that passing the proposal would clarify the exact qualifications that are necessary to perform fluoroscopy safely and effectively, as well as the exact supervisory circumstances under which RAs could provide this procedure. **(Minutes of the First Meeting of the Committee, January 8, 2014)**

The applicants stated that passing the proposal would improve access to radiologic services by allowing radiology assistants to function as physician extenders. **(Minutes of the First Meeting of the Committee, January 8, 2014)** A committee member asked whether RAs are able to work under general supervision or must they work under more direct kinds of supervision. The applicants responded that the nature of the supervision depends on the particular procedure being performed. The applicants later submitted a detailed description of their scope of practice including information detailing which scope elements could be provided under indirect or general supervision. This information is provided on pages 6-9 of this report. **(Minutes of the Second Meeting of the Committee, January 29, 2014)**

A physician testifier stated that the use of a fluoroscope should occur only when a radiologist is present to provide direct supervision in order to maintain adequate safety standards. They argued that the use of fluoroscopic technology by RAs in outreach situations without a radiologist present would not be consistent with adequate public protection. **(Transcript of the Public Hearing, Held on April 30, 2014, Pages 48-50, the Testimony of Dr. Kyle Krehbiel)** Applicant testifiers commented that their use of this technology would always be under the supervision of a radiologist, and that an RA and a radiologist are always in close communication when such a procedure is underway, and this would also pertain when an RA is providing services in an outreach situation. **(Minutes of the First Meeting of the Committee, January 8, 2014)**

A radiologist from central Nebraska stated that there is clear need for greater access to radiologic services in rural areas of our state. He went on to state that there continues to be a need for fluoroscopy in rural Nebraska because some of the more advanced technologies being used in place of fluoroscopy are not yet available in rural hospitals. He added that he supports the proposal because it offers promise of greater access to radiologic services in rural Nebraska, and he added that RAs would be able to help radiologists improve access to radiologic services in these

rural areas. He added that to ensure the safety of this proposed RA-radiologist partnership, it would be a good idea to limit each radiologist to supervising no more than two RAs. He added that it is also important that there be a close relationship between an RA and their radiologist supervisor in order to ensure safe and effective services for the public. **(Minutes of the Fourth Meeting of the Committee, April 2, 2014)**

Part Five: Committee Recommendations

Final Committee Discussion on the Issues

The committee members briefly reviewed the four criteria preparatory to formulating their recommendations on the proposal.

Committee Actions Taken on the Four Statutory Criteria:

Criterion one: Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public.

Action taken: Voting in favor of the proposal on criterion one were Greenfield, Langemach, Sandstrom, and Hawk. There were no nay votes. Dr. Kester abstained from voting. By this action the committee members determined that the proposal satisfies criterion one.

Comments from committee members:

- Dr. Sandstrom commented that there is a need to regulate RAs because their work involves invasive procedures.
- Ms. Hawk commented that regulation is needed to provide greater assurance that appropriate oversight of RAs occurs.
- Mr. Greenfield commented that harm is inherent in the unregulated practice of RAs, and there is a need to clearly delineate education and training requirements for RAs in statute.
- Mr. Langemach commented that there is a need to regulate RAs because of the invasive procedures inherent in their work.

Criterion two: Regulation of the profession does not impose significant new economic hardship on the public, significantly diminish the supply of qualified practitioners, or otherwise create barriers to service that are not consistent with the public welfare and interest.

Action taken: Voting in favor of the proposal on criterion two were Greenfield, Langemach, Sandstrom, and Hawk. There were no nay votes. Dr. Kester abstained from voting. By this action committee members determined that the proposal satisfies criterion two.

Comments from committee members:

- Dr. Sandstrom commented that, initially, the proposal would only license three RAs, and there is no reason to believe that this action would result in any harm to the services provided by radiologists. He added that the proposal holds promise of enhancing access to care.

- Ms. Hawk commented that the proposal would enhance public protection, and that there is no reason to believe that it would impose barriers to service or in any way harm other health professions.
- Mr. Greenfield commented that RAs are a small group and that regulating them should not involve any significant new costs.
- Mr. Langemach commented that no new harm is likely to come from the proposal, nor would it be likely to create any barriers to services.

<u>Criterion three</u>: The public needs assurance from the state of initial and continuing professional ability.

Action taken: Voting in favor of the proposal on criterion three were Greenfield, Langemach, Sandstrom, and Hawk. There were no nay votes. Dr. Kester abstained from voting. By this action committee members determined that the proposal satisfies criterion three.

Comments from committee members:

- Ms. Hawk commented that the proposal would implement continuing education for RAs, and this would be important for public protection.
- Dr. Sandstrom commented that licensure would require education, training, and continuing education for RAs, which would help address concerns about the risks associated with the invasive procedures they perform.
- Mr. Langemach commented that regulation would ensure that all RAs satisfy a level of education and training necessary to protect the public.
- Mr. Greenfield commented that the proposal would provide greater assurance of competency in the provision of radiological services.

<u>Criterion four</u>: The public cannot be protected by a more effective alternative.

Action taken: Voting in favor of the proposal on criterion four were Greenfield and Langemach. Voting no were Sandstrom and Hawk. Dr. Kester then voted to break the tie vote. Dr. Kester voted no. By this action the committee members determined that the proposal does not satisfy criterion four.

Comments from committee members:

- Dr. Kester expressed concern that the applicants did not demonstrate that RAs have been able to provide services as safely as radiologists in outreach situations, for example. Greater access to the services of RAs might entail greater risks of harm to the public.
- Dr. Sandstrom commented that the proposed scope of practice for RAs includes procedures that entail a high degree of risk. He added that it might be better to recommend certification for this group. RAs work only under the supervision /

direction of a radiologist. The proposal limits the number of RAs to be supervised by a radiologist to two. There was disagreement in the testimony by the radiologists as to the types of procedures and amount of supervision necessary for safe RA practice. This is best left to the judgment and responsibility of individual radiologists in their practice environment.

- Mr. Greenfield argued that licensure is the best way to protect the public. He added that nearly all states that regulate RAs do so through licensure, and asked if Nebraska were to pass certification for RAs, how would Nebraska manage reciprocity for RAs coming into Nebraska from states that currently license them? He added that licensure imposes the highest standards of practice for a given profession and does so across the entire profession.
- Ms. Hawk commented that licensure is necessary to protect the public.

Action taken on the entire proposal was as follows:

The committee members took action to determine whether or not to recommend approval of the proposal:

Action taken: Voting yes were Greenfield, Hawk, Langemach, and Sandstrom. There were no nay votes. Chairperson Kester abstained from voting. By this vote the committee members recommended approval of the proposal.

Comments from committee members:

- Dr. Sandstrom commented that there is clearly a need to create a regulatory process for RAs to ensure quality and to improve access to care.
- Ms. Hawk commented that there is a need to provide greater assurance of the competency of RAs, and that licensure would accomplish this.
- Mr. Langemach commented that only licensure can provide assurance that all practicing RAs have satisfied appropriate standards of practice.
- Mr. Greenfield commented that only licensure can provide the education and training standards necessary to protect the public and to provide a disciplinary process for RAs.

Committee discussion and action on ideas for ancillary recommendations:

The committee members discussed matters pertaining to the administration of the proposal if it were to become law. Concern was expressed about the small number of practitioners currently eligible for licensure in Nebraska. Dr. Sandstrom commented that there are currently no more than three persons in Nebraska who would be eligible for licensure, and that creating an independent board for such a small group would not be good public policy. Mr. Greenfield expressed agreement with this comment, adding that nearly the entire profession would need to be seated on such a board, and that this would create a potential conflict of interest for this board. Several alternative ideas were discussed, one being the idea of direct administration. The other being the idea of creating a committee under an existing board. A majority of the committee members

indicated that the idea of creating a committee under an existing board was the better of these two alternatives. Some committee members cautioned that it might be best for the committee to leave the resolution of this matter to subsequent review bodies. Dr. Sandstrom then made a motion regarding this matter, which is stated below.

> Dr. Sandstrom moved and Mr. Greenfield seconded that the committee members recommend that licensure for RAs be administered by the Board of Medicine and Surgery if the proposal were to pass the Legislature. Voting yes were Greenfield, Hawk, and Sandstrom. Voting no was Langemach. Dr. Kester abstained from voting. The motion passed.
>
> Prior to the roll call vote on this motion Dr. Kester asked Dr. Sandstrom whether it might be a good idea to include another comment in this motion to state that this task would be done by a committee of the Board of Medicine and Surgery. Dr. Sandstrom replied that he would rather not include such a comment in his motion, adding that the technical committee members should not attempt to define how the Board of Medicine and Surgery should go about this task.