Impacting Practice Through Legislative Change: Removing Statutory Barriers for
Advanced Practice Registered Nurses to Practice to the Fullest
Extent of Their Education and Training

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Abstract

This Doctor of Nursing Practice project focused on facilitating removal of a Nebraska State statute that limited advanced practice registered nurses’ (APRNs) ability to administer patient care to the full extent of their education and training. Nebraska’s Respiratory Care Act, which allowed only physicians to order respiratory care services, was discordant with revised federal legislation and the Nebraska Nurse Practitioner Act. Advanced practice nursing has evolved since the 1986 Nebraska Respiratory Care Act was created and Nebraska statutes needed to be updated to reflect APRN scope of practice and to allow seamless care to patients.

*Keywords: Advanced practice nursing, nurse practitioners, legislation*
Impacting Practice Through Legislative Change: Removing Statutory Barriers for Advanced Practice Registered Nurses to Practice to the Fullest Extent of Their Education and Training

The Institute of Medicine (IOM) released a monumental report in the fall of 2010 entitled *The Future of Nursing* (Institute of Medicine [IOM], 2010). The IOM report emphasizes, among other things, the need for advanced practice registered nurses (APRNs) to practice to the fullest extent of their education and training. Advanced practice registered nurses include nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), certified nurse midwives (CNMs), and clinical nurse specialists (CNSs). The IOM report concludes that “despite the evidence demonstrating that APRNs are educated, trained, and competent to provide safe, high-quality care without the need for physician supervision, states’ legislative decisions regarding legal scopes of practice range from permissive to restrictive” (p. 144).

Nebraska’s Respiratory Care Act was established in 1986 and exemplified antiquated legislation that proved restrictive to APRNs’ scope of practice. On a federal level, the Centers for Medicare and Medicaid Services (CMS) revised outdated regulations in 2010. The newest regulations for conditions of participation published in the Federal Register (National Archives and Record Administration, 2011) state that qualified licensed practitioners, acting within their scope of practice, may order respiratory care services. The regulations, however, are written such that individual state laws, as well as hospital facility policy, prevailed. Nebraska’s Respiratory Care Act (Nebraska Department of Health and Human Services, 2007a) contained statutes that aligned with the outdated CMS regulations, stating that respiratory care be ordered by a physician. While physicians could delegate the writing of respiratory care orders to physician assistants and APRNs, these orders then needed to be co-signed by a physician to be in
accordance with Nebraska statutes. The co-signature process created duplication and redundancy as APRNs are educated and trained in evaluation and management of respiratory care disorders. The Nebraska Nurse Practitioner Act defines NP practice as health promotion, health supervision, illness prevention and diagnosis, treatment, and management of common health problems and chronic conditions, including assessing patients, ordering diagnostic tests and therapeutic treatments, synthesizing and analyzing data, and applying advanced nursing principles (Nebraska Department of Health and Human Services, 2007b). Respiratory Care orders fall well within the scope defined in the NP Act. Advanced practice nursing has evolved since the 1986 Nebraska Respiratory Care Act was created and Nebraska statutes needed to be updated to reflect APRN scope of practice and facilitate seamless care to patients.

**Problem Statement**

The purpose of this doctorate of nursing (DNP) project was to remove a practice barrier for APRNs, particularly NPs, by facilitating introduction of a bill during the 2012 Nebraska legislative session to include APRNs as providers able to order respiratory care services. This legislation aligns Nebraska state statutes with Federal regulations involving respiratory care orders, and allows APRNs to practice to the fullest extent of their education and training.

**Literature Review**

The IOM has published three important reports that support eliminating barriers to APRN practice. *The Future of Nursing* report (IOM, 2010) presents four key recommendations to facilitate the role of nurses in improving healthcare. The report emphasizes the importance of the first of these key messages: Nurses should practice to the full extent of their education and training (p. 4). This report also states, “nurses have the opportunity to play a central role in transforming the health care system to create a more accessible, high-quality, and value-driven
environment for patients. If the system is to capitalize on this opportunity, however, the constraints of outdated policies, regulations …, including those related to scope of practice, will have to be lifted, most notably for advanced practice registered nurses” (p. 85). The Institute of Medicine published an earlier report in 2001, *Crossing the Quality Chasm*, which emphasized that health care improvement could not be achieved in the current system of regulation. This report found that “regulatory and accreditation frameworks at the state level are often inconsistent, contradictory, and duplicative, in part because the needs, priorities, and available resources of the states are not equal” (IOM, 2001, p. 214). The principle limitations to nurse practitioners’ capacity to practice to the full extent of their education, training, and competence are state-based regulatory barriers (Kugler, Burhans & George, 2011; Lugo, O’Grady, Hodnicki, & Hanson, 2007; O’Grady, 2008). Individual state regulations vary in respect to APRN supervision, collaboration, and prescriptive authority, though there is no data to suggest that nurse practitioners in states that impose greater restrictions on their practice provide safer and better care than those in less restrictive states or that the role of physicians in less restrictive states has changed or deteriorated (Fairman, Rowe, Hassmiller, & Shalala, 2010).

The recommendation for practicing to the fullest extent of a provider’s scope of practice is not new. A report published in 1995 by the Pew Commission (Finocchio, Dower, McMahon, Gragnola, and the Taskforce on Health Care Workforce Regulation, 1995) provided 10 recommendations for reforming health care in the 21st century. The third recommendation issued was to remove barriers to the full use of competent health professionals. Much like the recommendations from the 2010 IOM report, the 1995 Pew report proposes that “professionals should be allowed and encouraged to provide services to the full extent of their current training, experience and skills” (p. 9). The report goes on to state that “a regulatory system that maintains
its priority of quality care, while eliminating irrational monopolies and restrictive scopes of practice would not only allow practitioners to offer the health services they are competent to deliver, but would be more flexible, efficient, and effective. (p. 13)"

Efforts are being made to standardize advanced practice nursing's structure. The Consensus Model for APRN regulation is a model that was developed through a collaborative process with representatives from licensing bodies, educational institutions, certifying bodies, accrediting bodies, and professional organizations. It establishes a framework for licensure, accreditation, certification, and education for APRNs (Stanley, 2012). The Consensus Model helps create consistency and calls for State Boards of Nursing to license APRNs as independent practitioners with no regulatory requirements for collaboration, direction, or supervision (National Council of the State Boards of Nursing, 2008).

The purpose of regulation is public protection, and this should have top priority in scope of practice (SOP) decisions. In reality however, professional self-interests in the form of medical organizations and lobbyists often have powerful influence that can overshadow published research regarding patient safety (Villegas & Allen, 2012). Scope of practice is a term used to define what activities a profession can undertake (Kleinpell, Hudspeth, Scorordo, & Magdic, 2012). Advance practice registered nurses have been shown to provide care within their scope that is at the minimum, equal to physician care in several studies (Bakerjian, 2008; Wood et al., 2007) and NP systematic reviews (American Academy of Nurse Practitioners, 2010; Horrocks, Anderson, Salisbury, 2002; Laurant et al., 2009; and Newhouse et al., 2011). One randomized controlled trial, enrolling 1316 patients in an ambulatory setting, found no significant difference in general health status or disease specific measures for asthma, hypertension, or diabetes, between an NP treated group versus a physician group at six month follow-up (Mundinger,
Kane, Lenz, et al, 2000). This study was followed longitudinally with the same population and practice providers and a two year follow-up again demonstrated no significant difference between groups in the aforementioned variables (Lenz, Mundinger, Kane, Hopkins, & Lin, 2004). The nurse practitioners in this study practiced as independently as the physician group. Of interest, the patients in the physician arm of the study averaged more primary care visits the patients than the NP group.

A systematic review of 37 studies from 1990 to 2008 compared NP outcomes with physician outcomes (Newhouse, et al, 2011). Results of these studies determined high levels of evidence supporting equivalent outcomes between NPs and physicians in the following areas: self-reported patient perception of health, functional status, glucose control, lipid control, blood pressure, rates of hospitalization, and mortality. There were no studies that found NPs provide care that is unsafe or resulted in worse outcomes than physicians.

A Cochrane review titled *Substitution of Doctors by Nurses in Primary Care* looked at 25 articles (Laurent et al., 2009). The reviewers found that the results suggest that appropriately trained nurses provide primary care and achieve health outcomes that are of as high of quality as physicians. The reviewers did find that many of the studies had methodological limitations. These findings suggest a need for further, well powered, longitudinal, outcome studies by APRNs are needed to inform policy makers and the public.

**Background and Significance of Problem**

**Evolution of APRN Profession**

The majority of APRNs are licensed as NPs (United States Department of Health and Human Services, 2010) and the NP work force has increased exponentially since its inception in the 1960s. Historically, the 1950s and 1960s saw growth in specialty fields for physicians,
which diminished the number of physicians available to practice primary care (O’Brien, 2003). The need for primary care providers increased in 1965 with the establishment of CMS (United States Department of Health and Human Services, 2011b). The first NP program was developed in 1965 in response to the increased provider need. The number of NP programs grew in the 1970s, with support from federal funding as a means of increasing primary providers. The 1980s and 1990s bought public concern for escalating health care costs and in response to the need for cost effective, accessible care; nurse practitioners continued to grow in number and autonomy. In 1992 there were approximately 28,000 NPs in the nation, rising to approximately 95,000 in the year 2000, representing an increase of more than 240 percent over the eight year period (United States Department of Health and Human Services, 2004). The most recent data estimates that there are currently 180,233 NPs nationally, with 1,016 NPs estimated in Nebraska (Pearson, 2012). The NP work force continues to grow and, with current health care reform and the expansion of health insurance recipients, the need for providers will only accelerate. Advanced practice registered nurses have historically been used to fill gaps in care (Stanley, 2012). Restrictions placed on NP practice are not congruent with accessibility to care and may unnecessarily impede healthcare delivery.

Along with growth in numbers, the NP profession has seen growth in scope of practice, advancement of education, and diversity of practice. To date there are 16 states and the District of Columbia that have passed legislation granting full plenary authority to NPs, meaning that NPs in these locations “practice to the full extent of their education, within their scope of preparation, and under their own license” (IOM, 2012). Advanced practice registered nursing education has also evolved over time. The doctor of nursing practice (DNP) degree is a doctorate with clinical emphasis on research utilization, and is available for APRNs seeking a
terminal degree. Finally, while the majority of NPs continue to practice in primary care settings, NPs care for patients across the lifespan in a wide range of practice settings. The background provided here describes the growth and evolution of the NP role and illustrates the need for updated and non-restrictive statutes that represent the current practice environment to allow for seamless provision of care to patients.

A growing number of states allow nurse practitioners to practice as licensed independent providers without physician involvement. The Pearson Report (Pearson, 2012) is published annually and describes nurse practitioner legislation. The most recent report found that there are 26 states that have very few to no state-based barriers to scope of practice, receiving A and B grades. Ten states received grades of C or C- with fair access. This is compared to the 15 states with many state barriers receiving D and F grades. Nebraska falls in the latter category scoring a D+.

**Outdated Regulations**

Conditions of Participation (CoPs) are health and safety standards developed by CMS to provide a basis for improving quality and ensuring the health and safety its’ beneficiaries. Condition of Participation standards must be met in order for a facility to be certified and reimbursed by the Medicare and Medicaid programs (United States Department of Health and Human Services, 2011a). Centers for Medicare and Medicaid Services also ensures that the standards of accrediting organizations recognized by CMS meet or exceed CoP standards; therefore hospitals approved by an accrediting organization are deemed as meeting Medicare and Medicaid certification requirements (The Joint Commission, 2010).

In 2009, The Joint Commission reapplied and was granted deemed status with CMS as an accrediting organization. The Joint Commission updated their regulations, called Elements of
Performance, with CMS regulations at that time. One outdated CoP, that went largely unnoticed until The Joint Commission began to enforce its updated Elements of Performance, was one involving respiratory care orders. The outdated regulation stated that respiratory orders “must be provided only on, and in accordance with, the orders of a doctor of medicine or osteopathy” (National Archives and Record Administration, 2010). Following this alignment of policy, a clarification was released by the Joint Commission that stated a doctor of medicine or osteopathy is required to order respiratory services, but this does not “limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under state law or a state’s regulatory mechanism” (The Joint Commission, 2010). Therefore, non-physician practitioners were allowed to write respiratory care orders provided it was within the scope of their license. However, if a doctor of medicine or osteopathy delegated responsibility for writing orders to an eligible non-physician practitioner (such as a physician assistant or nurse practitioner), the responsible doctor of medicine or osteopathy must co-sign the order” (The Joint Commission, 2010).

The Joint Commission and other stakeholders had communicated to CMS that by limiting the ordering of respiratory care to only physicians, other practitioners were prevented from practicing within their scope of practice (News of the Academy of Neonatal Nursing, 2011). CMS responded publicly to these comments in the Federal Register (National Archives and Record Administration, 2010) with proposed changes and stated that “We have not found any evidence that indicates that the ordering of respiratory care services should be kept to a different, and possibly higher, standard than… other hospital services”. CMS changed the respiratory care CoP to read as follows (National Archives and Record Administration, 2011):

§482.57 Condition of Participation: Respiratory Services
§482.57(b)(3) - Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures and State laws.

Following the CMS change in regulation, which was effective October 1, 2010, The Joint Commission followed suit and deleted “element of performance 14” which limited ordering of respiratory services to a physician. In response to these regulatory changes the American Nurses Association sent a letter to CMS commending them for the changes stating that “statutory and regulatory language that identifies only medical doctors and doctors of osteopathy has limited access to care and created costly administrative burdens” (American Nurses Association, 2010).

The Nebraska Respiratory Care Practice Act, portions of which were promulgated in 1986, mirrored the CMS regulations from the same era. Nebraska Statute 38-3215 stated that “the practice of respiratory care shall be performed only under the direction of a medical director and upon the order of a licensed physician” (Nebraska Department of Health and Human Services, 2007a).

At the time that the CMS final ruling was published, it was estimated that approximately thirty-five individual states had laws existing that would continue to limit APRNs from ordering respiratory care unless delegated to by a physician. Several states have overturned these laws either by legislative or regulatory means. Wisconsin, for instance, issued a statewide variance report from the Department of Quality Assurance, a division of Health and Human Services, to allow licensed practitioners, who are authorized through their practice act and are granted privileges by the medical staff of the hospital, to order respiratory care services and was effective immediately (Wisconsin Department of Health, January 28, 2011). The State of Washington passed legislation (98 to 0) on February 16, 2010. The new bill expanded ordering to health care
practitioners instead of physicians exclusively (Washington Votes, 2011). “Health care practitioner” was defined to include physicians, osteopathic physicians, physician assistants, osteopathic physician assistants, and APRN’s.

**Conceptual Model and Framework**

The Kingdon Model (Kingdon, 2003) is a classic theory on agenda setting in public policy and provides the framework for this DNP project. Kingdon’s model has been referred to as the Multiple Streams Model (Appendix A). This dynamic model differentiates itself from other public policy models by emphasizing context, timing, and fluidity in agenda setting rather than a defined, stepwise progression of policy making. Kingdon describes three processes in agenda setting he calls streams; the policy stream, the political stream, and the problem stream. The policy stream is concerned with the policy alternatives and proposals that can be linked to problems. Policy is influenced by ideas, policy entrepreneurs, and hidden participants. The political stream is where governmental agendas are formed and involves forces influencing decisions. These forces include factors such as the political mood of the community, the perspective and influence of interest groups, disputes and relationships among agencies, election results, and visible participants. The problem stream involves focusing the public and policymaker’s attention to a particular problem. Problems may be identified by indicators or data, a focusing event, such as a crisis or catastrophe, or through feedback regarding existing policies. At times budgetary constraints supersede many problems.

These three streams are independent of one another but converge when processes align. Kingdon (2003) states that “a problem is recognized, a solution is available, the political climate makes the time right for change, and the constraints do not prohibit action” (p. 88). When streams come together and there is a window of opportunity, or policy window, the conditions
are optimal for agenda setting. These windows only stay open for a short amount of time. Once agendas gain consensus and momentum there is a tilt or tipping effect that weighs in favor of a bill being enacted.

The political stream in relation to this DNP project can be associated with the change in executive branch in 2008 with the election of President Barack Obama. President Obama’s focus on healthcare reform and the 2010 passage of the Patient Protection and Affordable Care Act have brought healthcare to the forefront of United States politics. The Affordable Care Act is expected to increase demand for care with projections of up to 40 million newly insured individuals and the American Nurses Association believes that one of the most effective solutions to meeting this need is through the use of APRNs (Commins, 2012). On a state level, Nebraska has a very influential medical association held in high regard by members of the unicameral, in a state that is predominantly conservative.

The policy stream is represented by the trend for state legislation supporting independent practice for advanced practice nurses with elimination of integrated practice agreements with physicians. Allowing APRNs to practice to the fullest extent of their education and training allows for improved access to care and efficient service and this has been highlighted in many publications, most notably the Future of Nursing Report (IOM, 2010).

Finally, the problem stream is reflected in the constraints to APRNs’ ability to practice fully within their scope due to state regulatory constraints stating that only physicians may order respiratory care. A recent IOM report concludes that “given the shortage of primary care providers in the United States and specifically in rural areas—it would be reasonable to remove barriers in Medicare language and address inconsistencies in state laws so that all qualified practitioners are able to practice to the full extent of their educational preparation” (IOM, 2012).
The window of opportunity is open for policies that promote full scope of practice due to the release of the IOM reports and anticipated changes with the Affordable Healthcare Act. With the merging of the streams described, and the open window of opportunity, the conditions were opportune for a policy entrepreneur to take the lead for change in Nebraska and remove a restriction to practice for APRNs.

**Implementation**

After concluding that legislative change was necessary to amend Nebraska’s Respiratory Care Act, I began to research the feasibility and necessary steps for implementation as a DNP project. Nebraska is the only state in the United States to have a unicameral legislative system. Because there is only one voting branch there are fewer senators than a bicameral system, and I evaluated both of these factors to be an advantage to advancing a bill. Disadvantages faced were a short time frame with a 60 day legislative session and lack of experience in the political arena.

The introduction of a bill in the Nebraska Unicameral involves the support and interest of at least one senator champion. I contacted Senator Kathy Campbell, chosen in part for her position as chair of the Health and Human Services Committee, as well as her reputation for supporting nursing issues, and our initial meeting was held on October 20, 2011. Senator Campbell was provided a portfolio with literature to support the change in respiratory care statutes and after our discussion she agreed to sponsor the bill in the 2012 legislative session. Senator Campbell recommended contacting the Nebraska Nurses Association (NNA) and the Nebraska Medical Association (NMA) to notify them of my intent to facilitate statute change in the Respiratory Care Act.

Following Senator Campbell’s advice, I arranged a meeting with the NNA lobbyist and the NNA executive director in November of 2011. I found that NNA was very supportive of the
proposed bill as both the lobbyist and the executive director stated that they would support me in any way I needed. The NNA lobbyist arranged a meeting for me with the NMA lobbyist that same day. Both lobbyists felt that it would be best to not include all APRNs in this bill, as I had initially presented it to Senator Campbell, because they felt there may be resistance with certain areas of advanced practice. I was in favor of including physician assistants (PAs) in the bill as they also were restricted by the respiratory statutes. The decision was made to propose legislation that included NPs and PAs as providers able to order respiratory care services, in addition to physicians.

During this time, I contacted the Chairpersons for the Nebraska Academy of Physician Assistants (NAPA), the Nebraska Nurse Practitioners, the Nebraska Neonatal Advance Practice Association (NNAPA), the Nebraska Respiratory Care Society (NRCS), the Nebraska chapter of the American College of Nurse-Midwives, and a member of the Nebraska Association of Nurse Anesthetists Board. Nebraska does not currently have a professional organization for CNSs. In general, the professional organizations contacted were supportive of updating the Respiratory Care Act.

In December 2010, I met with the Legislative Aide to Senator Campbell to prepare the bill for the bill-drafting department. The two statutes in the Respiratory Care Act were addressed to include NPs and PAs as providers who could order respiratory care and the after some minor adjustments the final draft was forwarded to, and approved by, the lobbyists for NMA, NNA, and myself.

The 102nd Legislature, 2nd session of the Nebraska Unicameral opened January 4, 2012 and LB 788, change respiratory care practice requirements, was introduced by Senator Campbell on January 5th. The bill was referred to the Health and Human Services (HHS) committee and a
public hearing was scheduled. Prior to the hearing I wrote lobby letters to each member of the HHS committee.

The HHS committee public hearing took place on January 19th. There were five proponents of the bill that testified; representatives from the RT organization, the PA association, the NNA, as well as an individual RT employed in home care, and me. My testimony described the federal regulatory updates and included personal stories of how NP training and practice in an acute care setting involved respiratory management on a daily basis. There was no opposing testimony; however the representative for the respiratory organization in Nebraska stated that all APRNs should be included in LB 788.

Following the HHS hearing, a discussion regarding an amendment to include all APRNs occurred. This discussion involved Senator Campbell’s office, the NNA lobbyist, and the NMA lobbyist, and me. The NMA was not in favor of including all APRNs but agreed that CRNAs should be included. With the knowledge that NMA would not support a bill with the inclusion of all APRNs, an amendment, AM 1839, to include CRNAs as providers able to order respiratory care services was filed, and the bill advanced to General File.

Legislative Bill 788 advanced unopposed though General File and Select File with a minor wording correction added in an enrollment and review stage. The bill went to Final Reading on April 4, 2012 and was scheduled on the Consent Calendar. A Consent Calendar is a portion of the agenda in which noncontroversial bills are considered and quickly advanced to the next legislative stage. Typically, a bill on consent calendar can be debated for no more than 15 minutes (Nebraska legislature, nd). The bill progressed through the Unicameral unopposed and was signed by the Governor on April 10, 2012, and went in to effect on July 19, 2012 (Appendix B).
Evaluation

This DNP project uses a Logic Model to assess short-term and long-term outcomes (Appendix C). A logic model gives an overview of how the project developer believes the program will work using a diagram that indicates how parts of a program are sequenced (Zaccagnini & White, 2011). Logic models can be used for all phases of a project from planning, implementation, and evaluation.

The inputs in this logic model are the resources that are utilized for implementation and include myself as a policy entrepreneur, the Future of Nursing Report (IOM, 2010), federal regulatory updates and the era of healthcare reform, and the statutory barriers within the Nebraska Respiratory Care Act. The most significant constraints to the introduction and passage of LB 788 were the short legislative session, the existing power of the NMA and the restrictive APRN environment in Nebraska, and personal inexperience policy and advocacy. I was fortunate to have opportune experiences throughout the legislative session. I attended the Nurse in Washington Internship (NIWI) and the American Association of Colleges of Nursing Student Policy Summit in Washington, D.C. These conferences focused on advocacy on a national level and I had the opportunity to take part in lobbying efforts on Capitol Hill with meetings with state representatives and their staff members. In Nebraska, I met with my state senator to discuss LB 788 and educated other APRNs about the statutes within the Respiratory Care Act. The support gained from Senator Campbell and many organizations led to achievement of the introduction and passage of LB 788. My short term goal in the logic model was met, although not all of the long term goals were met. On a facility level, additional work is required to remove hospital restrictions that exists in respiratory care policies and documentation work flows. Though the Nebraska State law is now in effect allowing NPs and CRNAs to order
services for respiratory care, the CMS regulation for ordering respiratory care services states that not only state, but hospital regulations prevail. Future efforts will focus on updating hospital policy to reflect the state changes with LB 788 and inclusion of all APRNs in future legislative efforts.

Advanced practice registered nurses can have an impact by making incremental changes through advocacy and policy change. O’Grady (2012) stated that “small incremental changes are the only way forward in states that cling to tradition and the pull of the familiar, i.e., the physician as the historical and most familiar type of healthcare provider”.

**Conclusion**

The timing is right to take advantage of the momentum from the release of the IOM Future of Nursing report to remove barriers to APRN scope of practice. Advanced practice registered nurses are increasingly used to fill needs for services, and represent a significant component of the United States health care workforce. Restrictions placed on NP practice are not compatible with evidenced based findings that demonstrate the ability of NPs to provide safe, quality care, shown to be consistent with physician performance. Barriers to practice should be removed so that APRNs can practice to the fullest extent of their education and training.
References


http://www.gpoaccess.gov/fr/


Appendix A
Kingdon’s Multiple Streams Model for Agenda Setting

## Appendix B

### LB 788 Timeline

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<td>1/10/12</td>
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<td>1/19/12</td>
<td>Health and Human Services Committee Hearing</td>
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Appendix C

Logic Model for DNP Project

**Project:** Amending Nebraska’s State Respiratory Care Act

**Problem Identification:** Restrictions to APRN scope of practice, duplication of ordering process, undo emphasis on APRN’s ordering respiratory care versus other services

Logic Model for DNP Project: Adapted from M. Zaccagnini, & K. Waud White. (2011, p. 481)