The Nebraska PSYCHOLOGICAL Association

Responses to Letters of Opposition

May 15, 2017

Committee c/o Ron Briel, Program Manager
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Dear Members of the Psychology Prescribing Technical Review Committee:

Four general themes were repeated in the letters of opposition posted on the 407 website. The applicants provide a response to each of the themes below.

Opposition theme #1: Physicians receive over 10,000 hours of supervised prescribing experience while prescribing psychologists get only 80 hours (the equivalent of one week of medical residency training).

1. *There is a serious misunderstanding of the requirements to obtain the proposed prescription certificate*; for example, the psychologist brings to the advanced prescriptive training program years of supervised experience earning a doctoral degree and state licensure, which includes clinical practicums, internship, and postdoctoral supervised experience with a provisional psychology license. Psychologists bring to the advanced prescriptive training thousands of hours of supervised experience treating mental disorders. Appendix I in the application provides a visual comparison of the behavioral health training of prescribing psychologists, psychiatrists, psychiatric nurse practitioners, and psychiatric physician assistants. In regards to the 10,000 hours of supervised, it is commonly known that physicians can prescribe the full range of U.S. Food and Drug Administration (FDA) approved drugs after completing four years of medical school and one or two years supervised practice. Physicians are not required to complete a 10,000 hour residency program to begin prescribing drugs. The public is familiar with medical residents being able to "moonlight" and prescribe drugs during a residency program.
2. *This criticism entirely ignores the fact that the supervised experience for prescribing psychologists starts during the postdoctoral master's degree program*. Per the national training standards for prescribing psychologists, the trainee is required to learn how to conduct health assessments, interpret laboratory assessments, work with special populations and a range of clinical disorders, understand complicating medical conditions presenting as psychiatric illness, and make choices of medications and manage side effects from medications. These requirements are described in detail in Appendix B (see application, pp. 51-55).

3. *The 80 hour physician supervised practicum is just one component in a series of supervised experiences for eventual prescriptive authority.* The 80 hour practicum can be viewed as a capstone assessment of specific skills listed on page 53 of the application. This practicum includes adequately taking vital signs and demonstrating competence in health assessment skills acquired during the postdoctoral training program.
4. *The critics don't mention the minimum 400 hour, 100 patient practicum specific to treating mental disorders with medications (application, p. 53), or the two year physician-supervised experience performed under a provisional certificate.*
5. As outlined in the application, the training for the prescribing psychologist is approximately five years in length. This RxP training is in addition to the 6+ years, post-bachelor's degree, graduate level training and supervised experienced required in becoming an independently licensed psychologist prior to entering the postdoctoral master's degree program. The prescribing psychologist would have a combined 11 years, post-bachelor's degree, that is intensively focused on the diagnosis and treatment of mental health conditions. By comparison, the psychiatrist (with a residency) would have 4 years of mental health specific training, less for the psychiatric nurse practitioner, and one year of specialized training in mental health for the psychiatric physician assistant. For the general family medicine or pediatric providers, MDs, DOs, PAs, who also currently diagnose and treat mental health disorders, are often the first-line prescribers for individuals in rural areas, and training in mental health conditions could be as little as one semester of didactic training and a one month rotation clinical experience. [https://www.unmc.edu/alliedhealth/education/pa/about/curriculum.html]
6. The videos of physicians experienced with supervising prescribing psychologists, available through a link on the 407 website, should help address the misunderstanding about the rigors of the training process for the prescribing psychologist. Dr. Andazola, family medicine residency director, provides a helpful overview of different training models for professionals with prescriptive authority.
7. Dr. Andazola accurately describes the role of the prescribing psychologist in comparison to other medical professionals. *For example, the prescribing psychologist's scope of practice is limited to approximately 100 medications associated with the treatment of mental disorders.* In contrast, general medical practitioners can prescribe from the full range of medications approved by the U.S. Food and Drug Administration. Also, the training of the general medical practitioner includes a variety of medical procedures (e.g., delivering babies, suturing a wound, surgeries) that is unrelated to the practice of a prescribing psychiatric medications.
8. It was very disappointing to read letters that claim the application is for current licensed psychologists to obtain prescriptive authority, presumably as-is without additional training. That is a complete falsehood. Reading only the first page of the application would prevent someone from making the error of believing the application intends to change the scope of practice for the psychology license. The wording on the first page states that the prescription certificate would be: "*A voluntary, supplemental credential for licensed psychologists who complete postdoctoral training, supervised practica, national competency examination, and two-year physician supervised conditional certification period*."
9. Lastly, letters of opposition try to portray this as psychologists supervising psychologists to gain prescriptive authority. Reading only the first page of the application again would clarify that the training involves physician supervision. Reading the proposed regulatory language in Appendix B specifies that physicians supervise different components of the training. *A psychologist must be supervised by physicians, and these physicians would need to verify the prescribing psychologist is a competent and safe prescriber.* Assuming the critics have trust in members of their own profession, if they were to review and understand the full application it is anticipated they

would have confidence knowing that close supervision is required in the proposal for the prescription certificate.

Opposition theme #2: Psychotropic medications are very powerful with many potentially dangerous side effects, and RxP training is not sufficient to recognize these side effects and possible drug interactions.

1. The safety record of prescribing psychologists is addressed in the application and specifically in Appendix F, Prescribing Psychologists' Safety Record, pp. 65-68. Opponents have predicted serious harm to the public by permitting psychologists, with advanced training, prescriptive authority. However, the outcome data described in the application has not supported the claims of dire outcomes.
2. The objective data demonstrates the lack of safety incidents by prescribing psychologists for more than twenty years. The safety data includes the ratings of physicians who clearly indicate prescribing psychologists have been practicing safely in their communities.
3. The videos of physicians and others experienced with prescribing psychologists make some interesting observations about the reasons for the strong safety record of prescribing psychologists.
    a. Dr. Andazola, director of a family medicine residency, wishes more specialists would coordinate care with the patient's primary care provider. The prescribing psychologist is required to communicate and collaborate with the patient' primary care provider.
    b. Dr. LeVine, prescribing psychologist in New Mexico, noted that prescribing psychologists see their patients more often and can carefully increase the dose of a medication as the effects and side effects are monitored. Contrast this with much of the status quo where the medication dosage is prescribed and a follow up appointment is in four weeks.
    c. Prescribing psychologists are trained to take vital signs, review bodily systems at each visit, and detect when there could be a harmful reaction to a drug or possible presence of a general medical condition that requires intervention by the PCP or other medical provider.
    d. The physicians experienced with prescribing psychologists, that includes the psychiatrist Dr. Fineberg, noted that psychologists are safe because they frequently end up taking patients off medications that are not needed, and the prescribing psychologists have a wide range of psychological treatments to utilize instead of pills.
4. The claim by the opposition that the RxP training is not sufficient to recognize drug side effects and interactions is false. The postdoctoral master's program, per the application, would include, at minimum, 400 hours of intensive didactic education in the following areas: anatomy and physiology; biochemistry; neurosciences to include neuroanatomy, neuropathology, neurophysiology, neurochemistry and neuroimaging; pharmacology; psychopharmacology; clinical medicine and pathophysiology; health assessment, including relevant physical and laboratory assessment; diversity and lifespan factors, special populations; case reviews that cover a broad range of clinical psychopathologies, complicating medical conditions presenting as psychiatric illness, diagnostic questions, choice of medications, management of untoward side effects from medications, compliance problems, and the alternative treatment approaches. Additionally, the clinical practicum supervised by the physician will ensure the applicant for a prescription certificate has demonstrated competency in assessing a significantly ill medical population, assessing vital signs, observing the progression of illness and continuity of care of individual patients, laboratory assessment, as well as physical health assessment techniques.

5. The safety of patients is ensured by the thorough training and supervision in the postdoctoral master's program, and through the required integrated care between the prescribing psychologist and the primary health care practitioner. When prescribing drugs for patient, the prescribing psychologist shall maintain ongoing communication with the primary health care practitioner who oversees the patient's general medical care. The prescribing psychologist shall provide the primary health care practitioner a summary of the treatment plan and follow up reports as dictated by the patient's condition. The purpose of the communication includes ensuring that necessary medical examinations are conducted, and determining whether a drug prescribed by the prescribing psychologist is not contraindicated for the patient's medical condition.

Opposition theme #3: Psychologists are clustered in the same population areas as psychiatrists and RxP will not address the shortage of mental health providers in rural areas. Telepsychiatry, collaboration with primary care doctors, and the use of physician assistants and nurse practitioners are a better solution to the shortage without putting patients at risk with substandard care.

1. As discussed earlier, there is no evidence that prescribing psychologists provided substandard care or present a safety risk.
2. Dr. Daniel Carlat, editor in chief of the Carlat Psychiatry Report, addressed the options, listed above, in a Psychiatric Times article (2010), that discussed the shortage of psychiatrists. Dr. Carlat's views were covered somewhat in the application on pages 6 and 37. Dr. Carlat pointed out that primary care providers are already overloaded, have long waiting lists, are trying to cope with a vast array of illnesses, and can experience double the mental health dropout rate compared to psychiatrists. Dr. Carlat also explored the option of training more advanced nurse practitioners and physician assistants, and thought the economics work in favor of this option; however, he noted these professionals receive "very little training in psychology or psychotherapy – limiting their ability to properly diagnose and treat tough cases."
3. The American Academy of Family Physician's position paper on mental health care indicated PCPs spend 13 minutes on average with a patient, and the average patient presents with six problems. Given that timeframe, how well could the overloaded PCP manage serious behavioral health conditions? Psychologists already work with complex and serious major mental illnesses that require frequent therapy sessions, use of psychological diagnostic instruments, management of a behavioral health crisis, intervention with the patient's social supports, and time spent contacting agencies/providers involved with the patient. A major advantage with adding prescribing psychologists to the team of prescribing professionals is the patient is seen more frequently and the effect and side effects of medications can be more closely monitored.
4. Would the PCP, NP, or PA have the time and skill set to provide combined treatments (psychotherapy, psychopharmacology) when indicated for a given patient? For example, take a patient who presents in your office having been on antidepressant and a mood stabilizing medications for years. This patient complains of unstable relationships with family members that sometime end up with the patient engaging in self-cutting behaviors. The prescribing psychologist, in developing a treatment plan questions the need for the mood stabilizing medication. The medical record indicated a bipolar disorder for your patient; however, psychological testing does not support a bipolar disorder, and instead testing raises concerns about the presence of substance abuse and a personality disorder involving major social skill deficits. The prescribing psychologist, with the patient's permission, contacts a family member and finds out there is no family history of bipolar disorder, and no family member has witnessed manic or hypomanic episodes with the patient. Research indicates that the reliability of ruling in

or out a bipolar disorder improves when gathering information from family members. Contacting family members takes time. The patient is interested in trying to get off the mood stabilizing medication, but wants to do a slow taper off. The prescribing psychologist, after communicating in with the patient's PCP (see application, pp. 50-51), could manage the medications and institute a reduction in the mood stabilizing medication, while frequently monitoring the impact during weekly therapy sessions and also address the substance abuse problems and social skill deficits that likely account for the reports of "mood swings." The patient presents with a history of depressive episodes and prefers to remain on the antidepressant medication while the taper is instituted with the mood stabilizing medication. The patient wants to later address the need for the antidepressant medication after a course of psychotherapy to reach a goal of abstinence from substances of abuse and improved relations with family and other members of his/her social support system. It is not uncommon to learn sometime during therapy that the patient experienced some type of trauma, abuse, or other major adverse event in a patient's background. In this example, the patient eventually discloses a history of physical and sexual abuse that pre-dated the development of the identified mental disorders. The patient is relieved to finally talk about the abuse. This course of treatment is unlikely to have taken place with any provider other than a prescribing psychologist. The consumer survey data provided to the technical review committee indicated 72% of respondents indicated: "I would like to have my therapy and mental health medications managed by the same professional (i.e., being able to talk at length about my problems and mental health medications in the same appointment)."

5. To indicate "the use of physician assistants and nurse practitioners are a better solution to the shortage without putting patients at risk with substandard care" entirely ignores the specialized training psychologists go through as part of their doctoral program and supervised experience, which is the use of standardized psychological testing to arrive at a diagnosis that is supported by data. There is little to no training for physician assistants or nurse practitioners in the science of statistical analysis applied to psychometric testing and differential diagnosis. As a result, there can be a high degree of subjectivity in diagnosing mental disorders. As any healthcare provider knows, the right treatment starts with the right diagnosis. Given the absence of lab tests to diagnosis mental disorders, non-psychologist providers commonly refer their patients to psychologists when it comes to arriving at an accurate diagnosis. Psychologists with extensive training in psychometric testing, non-medication treatments such as psychotherapy, and now with advanced training in psychopharmacology, represents a practitioner with the broadest base of training specific to mental health disorders, than existing disciplines today.
6. A related concern to #3 is the fact that presently there is a shortage of primary care providers in Nebraska. According to documents, half of the counties in Nebraska meet the federal designation for medically underserved primary care areas. Also, according to the Nebraska Office of Rural Health, in 2016, 58 counties in Nebraska qualified as shortage areas for family practice physicians. See the attached map and report. Due to these shortages, it seems likely that most primary care providers are already overburdened, and do not need to add more responsibilities to their day. Prescribing psychologists can lighten the burden for physicians by taking complex, time-consuming, behavioral health cases.
7. Dr. Fineberg, a psychiatrist who was the physician member of the state (licensing) board in New Mexico overseeing the credentialing of prescribing psychologists, shared the following observations regarding the value of adding prescriptive authority for qualified psychologists in meeting the needs of the underserved. The following quotes are from a recorded interview with Dr. Fineberg, May 7, 2016. A link to this interview is posted on the 407 website.

a. "One of the problems that people have in the field of psychotropic medicine is that many people who need it don't get it, but many people who don't need it have it prescribed. It's a paradox, but one of the things that I'm really pleased about the training for the psychologists for prescriptive authority in New Mexico is that they work very hard about that difference. Because the prescriptive authority to be able to prescribe medicine also gives the authority not to give it when it's not indicated."
b. "The real answer is the continuity of care is both simplified and made more effective when the person doing the diagnosing, doing the psychotherapy, can in fact also prescribe the medication. Every psychiatrist knows that that's true and I'm quite confident that any general practitioner who's uncomfortable with the level of their diagnostic acumen for a specific mental illness would be very pleased if the psychologist who was able to make the diagnosis had the training and ability to then prescribe the appropriate medication."
c. "You know it's not unusual nowadays that non-physicians prescribe medication. Nurse practitioners prescribe and they prescribed in New Mexico before psychologists. Physician assistants prescribed also prior to prescriptive authority for psychologists. They had a general focus on their medical training, and for whom they would prescribe. There is a major difference for psychologists for prescriptive authority. The major difference is this: When it comes to psychotropic medication it is not merely a certain condition, a certain disease. You know it's not like an infection where the doctor prescribes antibiotics and then it's his drugs against your bugs. It's not like a cancer where the surgeon's scalpel or the chemotherapy is pitted against this neoplasm. This is a case when understanding of the person and the personality and the condition of the persons' mental health needs to be understood thoroughly. There is no one in the medical profession apart from psychiatrists who are actually trained to do that with the same thoroughness diagnostically and empathically as psychologists. So the real point here is who do you want to have a prescription pad their hands when it comes to mental health? Somebody who understands the condition, who has diagnosed the condition, who works with the patients who have the condition? Or somebody who's training has not given them that level of depth and understanding for prescribing?

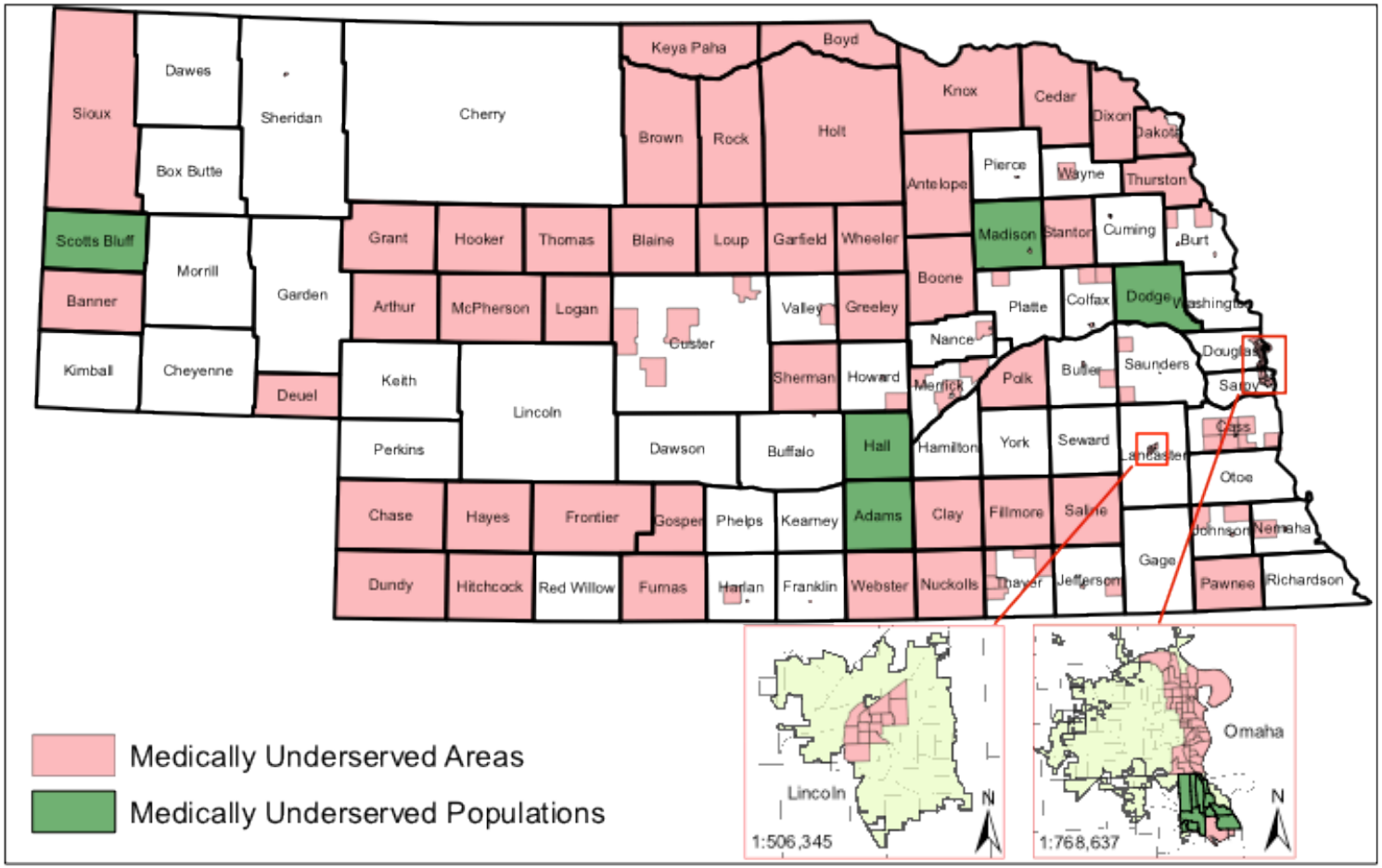
8. The application provides data on the number of psychologists in Nebraska and their distribution across the state by county. As indicated in the application, this data is from a pubic source, the Nebraska Health and Human Services, Regulation and Licensing Division. Anyone can access that data on licensed and provisionally licensed psychologists and see that the number of psychologists is increasing. Also, the data on the number of psychology internships (distributed through the state) is also from a public source that lists internship positions throughout the United States. It is true that the largest percentage of psychologists is located in urban areas. However, there are areas of the underserved even in urban areas. Telepsychiatry was mentioned as an option. Telehealth technology is also used by psychologists, so prescribing psychologists in urban areas can be available to provide care and/or consultation from urban areas.
9. There really are 11 psychologists in Scottsbluff. One has been through the postdoctoral training and another has the support of his agency to take the training necessary for prescriptive authority. There are at least two more psychologists who have expressed a strong interest in prescriptive authority. This would increase by four the number of doctoral level psychiatric prescribers in the panhandle without having to spend taxpayer money to provide incentives for new providers to move to Scottsbluff. There is nothing hypothetical about the increase in services to rural areas this proposal would provide.

10. The applicants provided consumer survey data from Scottsbluff involving a total of 252 respondents. Several respondents were receiving mental health medications from a psychiatrist, other physician, nurse practitioner, or physician assistant. The survey results, posted on the 407 website, indicated that 42% of the respondents reported difficulty getting an appointment with someone, "who understands my mental health needs, or the mental health needs of my family member(s)." The locations where these surveys were distributed have psychologists motivated to take the training for prescriptive authority to meet the need, as expressed by the consumers.
11. The Medical Director Institute that advises the National Council for Behavioral Health, and recently (March 28, 2017) released a report to develop "concrete solutions" to the problem of the "ongoing difficulties communities face providing adequate access to basic psychiatric services" (p. 1). The report describes the difficulty for the psychiatrists working in the community settings who are often limited to "a series of brief medication management appointments, some as short as 15 minutes, with patients who have severe, persistent and chronic mental health disorder. This cramped schedule leaves limited time for in-depth assessment and limits their ability to perform other critical activities, such a leading and participating in care teams, consulting with primary care clinicians, engaging in problem-solving with other health professionals on complex cases and providing clinical supervision" (p. 11). Psychologists are uniquely poised to provide the in-depth assessments and comprehensive treatment needed, as is standard for the longer and more frequent appointment times with patients. The report also notes that rural communities suffer a "severe shortage of psychiatrists" (p.26). One of the primary recommendations of the report is to expand the psychiatric workforce. The report noted that, "over the past 20 years, many other health professionals gained additional capacity to participate in the mental health and substance use disorder field as prescribers and clinicians" (p. 57). (https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council.pdf)
12. There was a 28 percent increase in licensed and provisionally licensed psychologists in Nebraska from 2006 to 2016, based on data from the Nebraska Department of Health and Human Services. In 2006 there were 449 psychologists licensed through Nebraska. In 2016 there were 576 Nebraska licensed psychologists. That is an increase of 127 licensed psychologists in ten years (see application, p. 4). These psychologists are an important asset to the state in meeting the need of behavioral health patients.

Opposition theme #4: Physicians receive far more training in the basic sciences that are the foundation for psychopharmacology.

1. Appendix A in the application addresses this concern. In the appendix it was noted that some medical schools are taking students without the prerequisite basic science courses, and then provide the basic science courses within their curriculum.
2. The postdoctoral training programs for psychologists, per the national standards, must ensure that the basic sciences are covered in the postdoctoral master's degree curriculum. Therefore, the psychologist is receiving graduate (not undergraduate) level basic science courses. The field of psychology is recognized as making significant contributions to the neurosciences, and some psychologists have a substantial background in basic sciences and neurosciences, prior to receiving their doctorate. The postdoctoral training program may accept some graduate level basic science credits from other schools.

Federally Designated Primary Care Medically Underserved Areas/Populations



Source: Office of Shortage Designations
http://muafind.hrsa.gov/
Definitions of MUA Area and MUA Pop can be found at
http://bhpr.hrsa.gov/shortage/muaps/index.html

0 15 30 60 90 120
Miles

Cartography: Maggie Harthoorn, Community & Regional Planning Intern, DHHS
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File Location: K:\Rural Health Intern\Federal MUA_MUP\Federal MUA_MUP 2017\MUA_MUP 2017 Mapfiles

Map Updated 01/09/2017

NEBRASKA RURAL HEALTH ADVISORY COMMISSION
2016 STATE DESIGNATED SHORTAGE AREAS
MEDICAL AND MENTAL HEALTH
Effective Date: October 5, 2016
Updated: November 18, 2016; March 3, 2017

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* indicates county is not eligible by definition for that specialty
X indicates shortage area for that specialty
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Numbered footnotes are on page 4

COUNTY NUMBER	COUNTY NAME	2016 FAMILY PRACTICE see footnote (1)	2016 GENERAL INTERNAL MEDICINE see footnote (2)	2016 GENERAL PEDIATRICS see footnote (3)	2016 OB/GYN see footnote (4)	2016 GENERAL SURGERY see footnote (5)	2016 PSYCHIATRY & MENTAL HEALTH see footnote (6)
1	ADAMS	*	X		X		X
2	ANTELOPE		X	X	X	X	X
3	ARTHUR	X	X	X	X	X	X
4	BANNER	X	X	X	X	X	X
5	BLAINE	X	X	X	X	X	X
6	BOONE		X		X	X	X
7	BOX BUTTE	X	X	X	X	X	X
8	BOYD			X	X	X	X
9	BROWN	X		X	X	X	X
10	BUFFALO	*	X			X	X
11	BURT	X	X	X	X	X	X
12	BUTLER		X**	X**	X**	X**	X**
13	CASS	*	X**	X**	X**	X**	X**
14	CEDAR	X	X	X	X	X	X
15	CHASE	X	X	X	X		X
16	CHERRY	X	X	X	X		X
17	CHEYENNE	X	X	X	X		X
18	CLAY	X	X	X	X	X	X
19	COLFAX	X	X	X	X	X	X
20	CUMING	X	X	X	X		X
21	CUSTER	X	X	X	X	X	X
22	DAKOTA	*	X	X	X	X	X
23	DAWES	X	X	X	X		X
24	DAWSON	*	X	X	X	X	X
25	DEUEL	X	X	X	X	X	X
26	DIXON	X	X	X	X	X	X
27	DODGE	*	X			X	X
29	DUNDY	X	X	X	X		X
30	FILLMORE		X	X	X	X	X
31	FRANKLIN	X	X	X	X	X	X
32	FRONTIER	X	X	X	X	X	X
33	FURNAS	X	X	X	X	X	X
34	GAGE	*	X**	X**	X**	X**	X**
35	GARDEN	X	X	X	X	X	X
36	GARFIELD	X	X	X	X	X	X
37	GOSPER	X	X	X	X	X	X
38	GRANT	X	X	X	X	X	X
39	GREELEY	X	X	X	X	X	X
40	HALL	*	X		X	X	X
41	HAMILTON		X	X	X		X
42	HARLAN	X	X	X	X	X	X
43	HAYES	X	X	X	X	X	X
44	HITCHCOCK	X	X	X	X	X	X
45	HOLT		X	X	X	X	X
46	HOOKER		X	X	X	X	X

Nebraska Office of Rural Health
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47	HOWARD	X	X	X	X		X
48	JEFFERSON		X	X	X		X
49	JOHNSON	X	X	X	X	X	X
50	KEARNEY	X	X	X	X	X	X
51	KEITH	X	X	X	X		X
52	KEYA PAHA	X	X	X	X	X	X
53	KIMBALL	X	X	X	X	X	X
54	KNOX	X	X	X	X		X
56	LINCOLN	*	X	X	X	X	X (3/3/2017)
57	LOGAN	X	X	X	X	X	X
58	LOUP	X	X	X	X	X	X
59	MCPHERSON	X	X	X	X	X	X
60	MADISON	*	X				X
61	MERRICK	X	X	X	X		X
62	MORRILL	X	X	X	X		X
63	NANCE	X	X	X	X	X	X
64	NEMAHA		X	X	X	X	X
65	NUCKOLLS		X	X	X	X	X
66	OTOE	*	X**	X**	X**	X**	X**
67	PAWNEE		X	X	X	X	X
68	PERKINS		X	X	X		X
69	PHELPS	X	X	X			X
70	PIERCE	X	X	X	X		X
71	PLATTE	*	X		X	X	X
72	POLK	X	X	X	X	X	X
73	RED WILLOW		X	X	X	X	X
74	RICHARDSON	X	X	X	X		X
75	ROCK	X	X	X	X	X	X
76	SALINE	X	X**	X**	X**	X**	X**
78	SAUNDERS	*	X**	X**	X**	X**	X**
79	SCOTTS BLUFF	*	X	X		X	X
80	SEWARD	*	X**	X**	X**	X**	X**
81	SHERIDAN	X	X	X	X		X
82	SHERMAN	X	X	X	X	X	X
83	SIOUX	X	X	X	X	X	X
84	STANTON	X	X	X	X	X	X
85	THAYER		X	X	X	X	X
86	THOMAS	X	X	X	X	X	X
87	THURSTON	X	X	X	X		
88	VALLEY	X	X	X	X		X
89	WASHINGTON	*	X**	X**	X**	X**	X**
90	WAYNE	X	X	X	X	X	X
91	WEBSTER	X	X	X	X	X	X
92	WHEELER	X	X	X	X	X	X
93	YORK		X	X	X		X

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	Charles Drew Health Center (Omaha)	**need to request**	*	*	*	*	*
	Community Action Partnership of Western Nebraska (CAPWN) (Gering)	**X** (11/18/2016)	*	*	*	*	*
	Good Neighbor Community Health Center (Columbus)	**need to request**	*	*	*	*	*
	Heartland Health Center (Grand Island)	**X** (3/3/2017)	*	*	*	*	*
	Midtown Health Center (Norfolk)	**X** (3/3/2017)	*	*	*	*	*
	One World Community Health Center (Omaha)	**X** (11/18/2016)	*	*	*	*	*
	People's Health Center (Lincoln)	**X**	*	*	*	*	*
	Ponca Tribe of Nebraska - Health & Wellness Centers	**X**	*	*	*	*	*

State of Nebraska employees are NOT eligible for the rural incentive programs.

STATE DESIGNATED MEDICAL AND MENTAL HEALTH
SHORTAGE AREAS - Statewide Review 2016
FOOTNOTES

(1) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "Family Medicine" in one of the state-designated family medicine shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in family medicine in one of the family medicine shortage areas to be eligible for financial incentives under the Act.

(2) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "general internal medicine" in one of the state-designated general internal medicine shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in general internal medicine in one of the general internal medicine shortage areas to be eligible for financial incentives under the Act.

(3) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "general pediatrics" in one of the state-designated general pediatric shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in general pediatrics in one of the general pediatric shortage areas to be eligible for financial incentives under the Act.

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NEBRASKA RURAL HEALTH ADVISORY COMMISSION
2016 STATE DESIGNATED SHORTAGE AREAS
MEDICAL AND MENTAL HEALTH
Effective Date: October 5, 2016
Updated: November 18, 2016; March 3, 2017

"blank" indicates county is not a shortage for that specialty
* indicates county is not eligible by definition for that specialty
X indicates shortage area for that specialty
X** indicates only part of the county is a shortage area for that specialty (see Lincoln & Omaha radius map)
Numbered footnotes are on page 4

COUNTY NUMBER	COUNTY NAME	2016 FAMILY PRACTICE see footnote (1)	2016 GENERAL INTERNAL MEDICINE see footnote (2)	2016 GENERAL PEDIATRICS see footnote (3)	2016 OB/GYN see footnote (4)	2016 GENERAL SURGERY see footnote (5)	2016 PSYCHIATRY & MENTAL HEALTH see footnote (6)

(4) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "Obstetrics & Gynecology" in one of the state-designated OB/GYN medicine shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in OB/GYN in one of the OB/GYN shortage areas to be eligible for financial incentives under the Act.

(5) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "general surgery" in one of the state-designated general surgery shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in general surgery in one of the general surgery shortage areas to be eligible for financial incentives under the Act.

(6) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a physician must be board eligible or board certified in and practice "psychiatry" in one of the state-designated psychiatry shortage areas. A physician assistant must be practicing under the supervision of a physician who is board eligible or board certified in psychiatry in one of the psychiatry shortage areas to be eligible for financial incentives under the Act.

(7) For purposes of the financial incentive programs under the Rural Health Systems and Professional Incentive Act (the Act), a nurse practitioner's training and supervision will be taken into consideration to determine the appropriate shortage area. The Rural Health Advisory Commission will review individual cases.

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