[CONFIRMATION LB713 LB730 LB738 LB797]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, January 23, 2008, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on gubernatorial appointments, LB713, LB730, LB738, and LB797. Senators present: Joel Johnson, Chairperson; Tim Gay, Vice Chairperson; Philip Erdman; Tom Hansen; Gwen Howard; Dave Pankonin; and Arnie Stuthman. Senators absent: None. []

SENATOR JOHNSON: Thanks very much. Well, let's go ahead and start here this afternoon. I'm Senator Joel Johnson, head of the Health and Human Services Committee, and I don't know whether it was an accident or not, but someone put on my desk up here happy retirement," and this is the last go-round for a few of us around this table. But let's make it a real good session and try and make the world a little bit better for our having been here. Senator Gay, to my right here, is the Vice Chair; beyond him is Senator Pankonin; and then starting off to the left is Senator Howard, Senator Hansen, and Senator Stuthman. We've got Erin Mack and Jeff with us here, who serve as our counsel. And one of the things that we have heard from many people is that we have the best office staff in the building, and I think that's exactly right. So with that, let's go through a few of our ground rules, and they're the same ones as we had before. And basically we would ask that you immediately turn off your cell phones and if they go off we hope that you have written your will clearly and...(laughter) but if you would. And then there's a couple of ground rules when you do come up to testify. Even though we may have called you by name when you come up, would you not only give your name but spell it. And then one little thing: We have a glass-top desk and people have a little tendency to take a pen or something like that and nervously tap the top of the table, and if there's anything that drives our transcribers crazy, that's it. So kind of watch yourself on that. Jeff, can you think of anything else that we haven't gone over? Generally speaking, again, what we do is we have an introducer and then those in favor of the bill would testify, then those against, and then there are also neutral people who have constructive comments as well. So basically that's the order that we go in. What we're going to do first off here today is go through about a half a dozen gubernatorial appointments and, as you could tell, we have somebody on the phone who this person is from far western Nebraska and, so rather them make an 800- or 900-mile trip down here and back, we've made arrangements to interview this person via telephone. So with that, let's proceed. Judy Meyer (sic), are you on the phone? []

JUDY METER: Yes, I am. [CONFIRMATION]

SENATOR JOHNSON: Okay. Your appointment is to the Foster Care Review Board. Do you want to just tell...take a minute or two and tell us a little bit about yourself and then your interest in being a part of this group? [CONFIRMATION]

JUDY METER: (Exhibit 1) Okay. I am Judy Meter from Gering, Nebraska. I was born and raised in Nebraska. I have 4 daughters by stork, I have 1 by airmail, which is a foreign exchange daughter that lives with us for a year; and I have 12 grandchildren by stork and 2 by airmail. And therein lies my interest in the children. I feel very committed to the foster care system. I feel that the children desperately need our oversight and I just have the desire to serve and do what's best that I possibly can for the children in foster care. I feel that it's important that we have someone representing the 3rd District, and even though it is a distance for me to go, I do try to make just about every meeting. There's been a few that I've had to do via videoconference out here at the local station, but basically, I try to get to all of the meetings that I possibly can and so far it hasn't been too much of a problem or of an imposition. My job is very receptive to what I do and they are very supportive, and that is a very big help. So this would be my second term on the State Foster Care Review Board. I have also sat on the local board for probably, I'm going to say, about the last eight or nine years. [CONFIRMATION]

SENATOR JOHNSON: Okay. Thank you. One of the things, let me say to you that Senator Erdman just walked into the room, who you may know as well, being from Bayard... [CONFIRMATION]

JUDY METER: Yes. Uh-huh. [CONFIRMATION]

SENATOR JOHNSON: ...not...almost within sight of you out there. One of the things, Judy, that I want to mention to both you and the other people that we're going to visit with today about the Foster Care Review Board is this: I'm sure that all of you take your job seriously and it does take quite a time commitment on your part to do this. Now I look at it this way. We can be friends with our people in other branches of the government, and in your case most likely that's going to be our people in Department of Health and Human Services, but I think we should encourage the belief that you, when it says Foster Care Review Board, that means that you have a responsibility as part of this board, almost an adversarial relationship to the system, so that we do have the checks and balances that the Foster Care Review Board was created for. So, yes, be thorough; be equal in your treatment; but your responsibility is to the children, not to the Legislature itself or to any of the divisions of government. So with that, we have any questions around the table here? [CONFIRMATION]

JUDY METER: I have no questions. [CONFIRMATION]

SENATOR JOHNSON: Judy, I think you're scot-free here. [CONFIRMATION]

JUDY METER: Okay. [CONFIRMATION]

SENATOR JOHNSON: Thank you very much for being on the telephone with us today. I appreciate your efforts in doing it. And what's the weather like out there, by the way?

[CONFIRMATION]

JUDY METER: Actually, it's pretty cold today. I think it's about 15-16 degrees. We do have some sunshine and hopefully it will warm up here in the next few days and we can get rid of a little bit of this snow we have. But otherwise, we're doing just fine. [CONFIRMATION]

SENATOR JOHNSON: Well, I've got to fly outstate a little bit here myself later in the afternoon, so I just kind of wanted to make sure that...what was going on, so... [CONFIRMATION]

JUDY METER: It will be a little chilly, but dress warm and you'll be fine. We'll enjoy having you. [CONFIRMATION]

SENATOR JOHNSON: All right. Thank you very much. [CONFIRMATION]

JUDY METER: Thank you. Have a good day. [CONFIRMATION]

SENATOR JOHNSON: You bet. Bye-bye. [CONFIRMATION]

JUDY METER: Bye. [CONFIRMATION]

SENATOR JOHNSON: Okay. Well, Christine Peterson. Welcome, Chris. [CONFIRMATION]

CHRISTINE PETERSON: Good afternoon, Senators. Thank you. [CONFIRMATION]

SENATOR JOHNSON: You've had an eventful year, haven't you? (Laugh) [CONFIRMATION]

CHRISTINE PETERSON: (Exhibit 2) Yes. (Laugh) Yes, it has been. Good afternoon, Chairman Johnson and members of the Health and Human Services Committee. My name is Christine Peterson, C-h-r-i-s-t-i-n-e, Peterson, P-e-t-e-r-s-o-n. I'm honored that Governor Heineman has shown his trust in my abilities to continue in a leadership role as chief executive officer of the Department of Health and Human Services. I served as the CAO of the Health and Human Services System during the first half of 2007, and previous to that I was the Policy Secretary for the HHS System, I held from 1999. In these positions, I facilitated initiatives that spanned across the three agencies. In addition, I directed all legislative activities, coordinated budget research and data collection efforts with agency directors, and was directly responsible for human resources, communications, and support functions such as the mail, leases, and purchasing. From 1996 to 1999, I was a Nebraska State Senator representing District 35 and I have held leadership development positions in Grand Island in Hall County and

taught school. On a personal note, my husband Ernie and I have one son, a daughter and a son-in-law, and, the most important sentence, our first grandchild was born the day after Christmas. During the last legislative session, LB296 created the Department of Health and Human Services to restructure the three former agencies into one department to bring greater clarity, transparency, and accountability to the work of the state's largest agency. We will be more accessible, easier to understand, and more efficient and effective for the people we serve. We have already taken significant steps. The department's leadership team is in place and you will hear from each of the Governor's six division director appointees this week, and I have provided a handout of the organizational structure, complete with the division descriptions and photos. Overall, the varied skills and experiences these people bring to the department provide new energy, views, and ideas which are necessary to meet the expectations of the Governor and the members of the Legislature. Dr. Schaefer, who continues in her position as chief medical officer and is now the director of Public Health, and John Hilgert, director of Veterans' Homes, both have experience within Nebraska state government. Scot Adams, director of Behavioral Health, and Todd Landry, director of Children and Family Services, come from the private, nonprofit sector, and Todd also brings private sector business experience. Vivianne Chaumont, director of Medicaid and Long-Term Care, and John Wyvill, director of Developmental Disabilities, bring with them experiences in state government from other states. In addition, this summer In addition, this summer I hired Bob Zagozda as the chief operating officer to oversee all agency operations. We have already found that his business and accounting experience is beneficial as we retool many of our procedures. Several of the directors have already restructured their divisions and, in addition, six of our ten 24-hour facilities have new administrators, and three of our five service area administrators are new. This fall, through our discussions with Governor Heineman, ten top priorities for the department for 2007 and 2008 were identified. I've provided these to you. These priorities touch on every division within the agency and provide a clear direction for our focus. They've been shared with staff in our employee newsletter and posters have been distributed to our offices. I've also provided you with a snapshot of some of the successes that the divisions have already achieved within these priority areas. The division directors have used these priorities to develop more detailed goals and action steps and they will address these, as well as major challenges and policy shifts that have taken place during these past six months. Since they will address those, I would like to move on to provide information about changes we're making in the operations of the agency. The department has never had a departmentwide performance evaluation requirement, and this is going to change. I'll be implementing performance evaluations for all employees that will be consistently applied. The training will be completed in May and we'll start those March 1. This is a key to our goal of being accountable, and knowing when we are and aren't, so actions for improvement can be made. The department has never had an internal, centralized, comprehensive service contract management process. This is not good business practice and has caused problems. We're implementing an electronic service contract approval process that, in addition to division director approval, will include review and

sign-off by finance, human resources, support services, and legal sections. This procedure ensures key review, oversight, and monitoring features. Operations will coordinate the training and implementation of this process through the Nebraska Information System, or NIS. We will soon pilot it within one of the divisions and it will then become a departmentwide operating expectation, hopefully by March 1. In December 2007, we processed an estimated 800 service contracts through NIS. Right now we do it by paper. We actually have a green slip that follows the contract around as it goes through the system. This will be electronic. Specific people in each division will be trained. They will be the only ones who could enter the contract. Everything will have to be signed off by those departments, such as HR, to make sure that we're following the correct DAS hiring policies; by finance, to make sure that we're within the other DAS guidelines in terms of the amount of the contract; and by legal, to make sure that we're following all of the policies and procedures we have in place. The department now has a unit that collects overpayments for aid programs. In recent years, their work has grown to include overpayment collections for food stamps; Aid to Dependent Children; Aid to the Aged, Blind and Disabled; childcare; and foster care. As this activity grows, we must ensure that we have processes in place to support the collection of these funds. I am moving this unit under the direct oversight of Bob Zagozda, chief operating officer. Bob has private sector experience with collection processes and can provide the attention it needs in order to be successful. And last, I'd like to address the State Auditor's December report that was critical of accounts receivable procedures for several facilities--specifically the regional centers and BSDC, and community-based developmental disability services. Before I continue, I want you to know that I appreciate the work of State Auditor Foley throughout this process. His staff identified concerns in their Attestation Report for the fiscal year that ended June 30, 2006. They did additional work in that area which resulted in the December report. They have been helpful in their recommendations. Bob Zagozda has developed a good working relationship with the Auditor and fully understands their roles and responsibilities. Clients receiving services through these programs are liable for their cost of care, support, maintenance and treatment. We have not been doing a good job with that. Since the Auditor's report, we have changed procedures to make sure accounting adjustments and write-offs are done appropriately and according to our policies and state law. We have also taken disciplinary action because policies clearly were not followed. And I'd like to explain the breakout in the Auditor's findings. During fiscal year 2006, the department identified, as we do through our CAFR, $49.8 million in accounts receivable. In essence, what we say is we book them to work them. If there's an accounts receivable, we have to enter it so that then we have the ability to go back and work that to see if there's an overpayment or an adjustment we can make. Of that, $22 million was identified as unposted cash. We had collected; we did not post it. It has since been assigned to the appropriate account. This left $27 million in question. Of the $27 million remaining, estimated adjustments and uncollectible amounts account for $16 million. What this means is we're going to go through the process of applying to a third party insurer, we're going to check to see if they have income. If they're still receiving benefits from us, they're not

able to pay it now, but if they go off and their income increases then we'll go back and collect from them. So it's an ongoing, working process. The way we close these is if there's a death, a bankruptcy, people simply have no assets, or they're still receiving state aid and we go past the statute of limitations. We will always have accounts that cannot be collected. This leaves $11 million that we believe we should and can collect. We're assuming that those are debts...that those are overpayments or services that were provided that we will be able to collect on. But the important thing is we are working on collecting them all. In the past, the department has billed; we have not collected. We now are in the process of collecting. Monthly billing statements will continue to go out. A demand for payment is now sent from the department, followed by a legal demand letter, and these actions will result in some payments. We have now contracted with a debt collection agency to pursue money owed to the state that we have not been able to collect, and we are also reporting people to a credit agency. In addition, we have hired a private accounting firm--Seim, Johnson, Sestak and Quist--to review our internal accounting procedures to ensure that what we have in place is adequate. The department was restructured to achieve significant change. While we've made strides, we have a long way to go and I look forward to continuing to update you on our progress. And I'd be happy to answer any questions you may have at this time. [CONFIRMATION]

SENATOR JOHNSON: Thank you, Chris. Yes, Senator Hansen. [CONFIRMATION]

SENATOR HANSEN: Thank you, Senator Johnson. Good to have you here again, Chris. [CONFIRMATION]

CHRISTINE PETERSON: Thank you. [CONFIRMATION]

SENATOR HANSEN: This past year, being a new senator, I was very impressed with your accessibility. [CONFIRMATION]

CHRISTINE PETERSON: Oh, thank you. [CONFIRMATION]

SENATOR HANSEN: We could always call you or any of your department heads and get our questions answered, I think, in a timely manner. I appreciate your business attempt at looking at this as a business and your billing and having a COO and I think you're on the right track. I'm glad we had this opportunity to reconfirm you, I guess, so... [CONFIRMATION]

CHRISTINE PETERSON: Oh, thank you. [CONFIRMATION]

SENATOR HANSEN: ...and I'll plan on doing that. [CONFIRMATION]

CHRISTINE PETERSON: Thank you very much. [CONFIRMATION]

SENATOR HANSEN: Thank you. [CONFIRMATION]

CHRISTINE PETERSON: I appreciate that. [CONFIRMATION]

SENATOR JOHNSON: Senator Howard. [CONFIRMATION]

SENATOR HOWARD: Thank you, Mr. Chairman. Chris, welcome back. [CONFIRMATION]

CHRISTINE PETERSON: (Laugh) Thanks. [CONFIRMATION]

SENATOR HOWARD: Yeah. And I agree with Senator Hansen. There is a more positive feeling that things are moving and a more open direction that really includes the public much more than it did in the past. One of the things that I think is fair to say that you and I have both been committed to is improving the new worker training. [CONFIRMATION]

CHRISTINE PETERSON: Yep. [CONFIRMATION]

SENATOR HOWARD: And I just would appreciate having any update information you could give me on how that continues to move along and to involve the college, the graduate schools of social work. [CONFIRMATION]

CHRISTINE PETERSON: Right, I appreciate that, and I especially appreciated the opportunity we had that Senator Johnson gave so that we could all get together and be on the same page. I think we're all wanting to go in the right direction as soon as we have that one hurdle jumped through. As soon as we find out anything, we'll let you know. [CONFIRMATION]

SENATOR HOWARD: Anything new on the time frame with that? [CONFIRMATION]

CHRISTINE PETERSON: Not yet. [CONFIRMATION]

SENATOR JOHNSON: Chris, would you kind of explain to the group what... [CONFIRMATION]

CHRISTINE PETERSON: Oh, sure. [CONFIRMATION]

SENATOR JOHNSON: ...in about two sentences, what the problem is. [CONFIRMATION]

CHRISTINE PETERSON: Senator, we don't do anything in two sentences. (Laughter)

[CONFIRMATION]

SENATOR HOWARD: Or more. [CONFIRMATION]

SENATOR JOHNSON: (Laugh) There's the challenge. [CONFIRMATION]

CHRISTINE PETERSON: Actually, we have...we work with one of the universities to provide our training for our protection and safety workers and Senator Howard and I, over the last year, have talked about what we would like to see, improvements in that training. And Todd Landry, who's the new director of the Children and Families Division, has that one of his goals too. There was a bill introduced last year that would work with one of the other universities and create an internship program, and one of the things that is on the table that we have to be concerned with is right now we are in a legal situation with the feds regarding how we have calculated our training costs for our IV-E dollars. We have gone through many years of legality on that and we're at the point now where we have won, up until the end. And so for us to talk about training at this point, I have not...I do not have any ability to talk about any future plans for training at all. [CONFIRMATION]

SENATOR JOHNSON: What's the dollar figure involved? [CONFIRMATION]

CHRISTINE PETERSON: I'd have to get back to you on that because I think there's interest involved. It's in several different pots. It's in double-digits. [CONFIRMATION]

SENATOR JOHNSON: I thought it was in terms of $30 million or something like that. [CONFIRMATION]

CHRISTINE PETERSON: It's in double-digits, there's no doubt about it. [CONFIRMATION]

SENATOR JOHNSON: So I know there is a lot of money that is on the table and... [CONFIRMATION]

CHRISTINE PETERSON: Uh-huh. We have had disallowances for each of the years and, on top of that, there's the issue of interest being involved. And so I think the suit has been going on since 1999. [CONFIRMATION]

SENATOR JOHNSON: Yeah. Yeah, the suit has been going on for over eight years and about $30 million involved. So it's an interesting process. Any other questions? Senator Gay. [CONFIRMATION]

SENATOR GAY: Chris, I'd echo the sentiments that were said earlier, and I'm going to say this quickly because we have other things to do. But your staff I think you've

assembled, the Governor and yourself, have a great staff and expect great things out of you. [CONFIRMATION]

CHRISTINE PETERSON: Yeah. [CONFIRMATION]

SENATOR GAY: I did want to say...Senator Hansen brought up and Senator Howard, I agree with that, but one thing I do admire and I hope you keep this up is when you see a problem you address it, and keep doing that. There's tough decisions need to be made and I know your staff is doing that. Sometimes they aren't the things we want to hear but they're things we need to address. So commend you on that and continue to do that, and so... [CONFIRMATION]

CHRISTINE PETERSON: Yep. Right. I don't sometimes learn fast, but once I learn, I learn, so we'll keep you informed just as quickly as we find out, so I hope we won't drop the ball on anything. [CONFIRMATION]

SENATOR GAY: Thank you very much. [CONFIRMATION]

SENATOR JOHNSON: Any other questions around the table? [CONFIRMATION]

CHRISTINE PETERSON: Thanks. [CONFIRMATION]

SENATOR JOHNSON: Well, let me say just one thing. [CONFIRMATION]

CHRISTINE PETERSON: Okay. [CONFIRMATION]

SENATOR JOHNSON: When you think that...the people in the room, when you think you've had a hard day, let me tell you this. A couple months back now I met with Chris regarding all of the problems down at Beatrice State Home and most of these were there before she came on board, and it's a longstanding problem with many facets and very difficult, and the federal people had just come down with some very bad news. So we had a long conversation about that, and then I went up to the university hospital and as I walked in the door I heard the buzz of several people being brought in from Von Maur. So that's what Chris Peterson had to face the rest of the day after I left her with such a distressful morning, and so on. So can you top that? [CONFIRMATION]

CHRISTINE PETERSON: I tell you what, we've got good people, though. That's what gets us through it. [CONFIRMATION]

SENATOR JOHNSON: Yeah, that's right. You bet. So thank you very much. [CONFIRMATION]

CHRISTINE PETERSON: Thank you, Senators. [CONFIRMATION]

SENATOR JOHNSON: Next, Dr. Schaefer. Welcome. [CONFIRMATION]

JOANN SCHAEFER: (Exhibit 3) Thank you. Good afternoon, Chairman Johnson, members of the Health and Human Services Committee. My name is Dr. Joann Schaefer, J-o-a-n-n S-c-h-a-e-f-e-r. I am honored that Governor Heineman has shown his trust in my abilities, as well, to continue in my role as chief medical officer and to take on the new role of the director of the Division of Public Health. By way of background, I received my M.D. degree from Creighton University and I am board certified in family practice. I practiced family medicine in Omaha, delivering babies and caring for nursing home patients and having a practice while teaching. During that time, I became tenured and I achieved the rank of associate professor in the Department of Family Medicine at Creighton, the highest rank ever achieved by a female in that department. In 2002, I became the deputy chief medical officer for the Nebraska Health and Human Services System. For the three years that I served in this role, I was responsible for coordinating the state's bioterrorism grant and for chairing the Child Death Review Team, while continuing part-time in my practice up in Omaha. In 2005, the Governor asked me to be Nebraska's chief medical officer and the director of HHS's Department of Regulation and Licensure, at the time, to which position I was appointed and confirmed in 2006. The Governor, in his top priorities for the Department of Health and Human Services, made realigning public health programs a priority. For the first step in that process, we undertook the division's restructuring and at that, you've seen an org. chart, we have one side that's completely dedicated pretty much to just the regulation. That's the health licensing/investigation side and environmental health issues. And the other side of the division is dedicated to community health and within that we have health promotion, community health planning and wellness, and a variety of other programs that I won't get into at this time. I'm asking you to confirm my appointment because I hope that you have seen that it's obvious that I have a lot of passion for my job and the passion to improve Nebraska's public health. To do so, I've selected five division priorities that will be to refocus our current work and our resources to address the important health issues for Nebraskans. Not in any particular order, but first I want to talk about our division becoming a trusted source of health data. Data is most useful when it's analyzed and shared. The division generates and has access to many sources of data, such as birth and death records, crash outcomes and injury data, disease data which is...includes current, ongoing and past disease data. We also have cancer registries, trauma data, and much more, many more sets of data that I can get into. I want the Division of Public Health to be the most important source of health data that Nebraska uses in meeting the highest standards of data and reporting completeness and accuracy. In some cases, we meet and surpass all of those standards, but not in all of them. Another priority in the Division of Public Health is to create a culture of wellness. Our leading causes of death are heart disease, cancer, and stroke. All have largely preventable aspects to them. Limiting our caloric intake, eating the right foods, exercising, and not smoking will have a great impact on our health and

longevity. In fact, you probably have seen a recent study that showed a 14-year increase in our life expectancy if we just take those simple steps. Healthcare has long be focused on treating you, as an individual, when you're sick, not on prevention and not on keeping the focus on being well. To create a culture of wellness, it must surround us everywhere. It must be in our schools, it must be in our jobs, and it must be in our communities. It plays an important role in healthcare reform and it plays an important role in each and every life and every Nebraskan. Another priority in the division is to address health disparities. Unfortunately, in our state, if you are black, you experience 85 percent more premature death than if you are white. Deaths from cancer are also 41 percent more preventable...or, I'm sorry, more prevalent among blacks than among whites, even though the incidents are approximately equal. That means that even if you...even if you're black or white, you get the cancer rate at the same amount, but you die 41 percent more often, if you are black, prematurely. This is a sad situation and we need to take a better look and reflect on our statistics. It takes an organized, strategic approach that must be accomplished, because so far what we've done has not had an impact. These are just two disparate challenges that we have in this state and it's going to take a long, strategic look or plan to address it. Another priority in the division is to devise a media and education plan. This plan will provide the basis for outreach to Nebraskans and focus on public health messages that are important, that can be life changing if they reach the right people that need to hear them. A good media and education plan will help us promote wellness and achieve our public health goals. It must be more rich than just awareness months and more than just a fear of the week that we do to educate people. Another division priority is to provide meaningful budget transparency. In government, it's important to see where our dollars go, whether they are federal, general, or cash. The division as a whole receives cash funds--birth and death certificates and from licensing healthcare professionals, for example. We also receive funding from federal grants, such as the Preventative Health Services Block Grant, and we get limited General Funds for programs like the drinking water program. But I want the Division of Public Health to have more than just a spreadsheet when you tabulate all those dollars. It needs to have an overlay in the organization...of the organizational chart so that every dollar can be tracked, whether it's general, federal or cash, and you can actually see, as a taxpayer, where those dollars go and where it's tracked down to which program and what those dollars buy you as a citizen. In closing, I would like to express my appreciation for your support of public health and say that I'd be happy and honored to be confirmed in the position of the director of the Division of Public Health. And thank you. [CONFIRMATION]

SENATOR JOHNSON: Any questions? Senator Stuthman. [CONFIRMATION]

SENATOR STUTHMAN: Thank you, Senator Johnson. Dr. Schaefer, first of all, I want to thank you for all of the work you've done. And the thing that really impresses me, and I did not comment when Christine Peterson was up here, but it is, to me, the situation that we have such open group of people for us to work with in situations that deal with

HHS. And I have never had that experience prior to Christine being the head and working with you. If I have a concern, you know, you're more than willing to try to address it and give me an answer, and I just feel so comfortable about that, and that is because I can help my constituents at home with the response that I get from you. You don't run a closed-door operation. You run a very open-door operation, and I really respect all of you for that. Thank you. [CONFIRMATION]

JOANN SCHAEFER: Thank you. [CONFIRMATION]

SENATOR JOHNSON: Any other questions or comments? Well, I can't let you off without saying one thing to you as well. Years ago, I used to think that public health was one of the more boring things that there was. I have completely done an about-face with that and I think it is the way that we have to go now. We cannot afford to let people get sick and then try and get them back to health. It has to be public health measures that does the preventative maintenance ahead of time. So I'm delighted that you're going in that direction. [CONFIRMATION]

JOANN SCHAEFER: Thank you. Me too. [CONFIRMATION]

SENATOR JOHNSON: Thank you very much. All right, John Wyvill. Welcome, John. [CONFIRMATION]

JOHN WYVILL: (Exhibit 4) Good afternoon, Senator Johnson, members of the Health and Human Services Committee. My name is John Wyvill, W-y-v-i-l-l. I began as director of the Division of Developmental Disabilities for the Department of Health and Human Services on September 17, 2007. I am honored that Governor Heineman appointed me to this position, and will appreciate your confirmation of his appointment. Let me share a little background...about my background. Before coming to Nebraska, I served as vice president and general counsel for AMS Consulting, Inc., in Little Rock, Arkansas. I also served for nearly 18 months as director of the Arkansas Department of Workforce Education, which is responsible for addressing the changing workforce training needs of adults and young people. Prior to that, I was commissioner of Arkansas Rehabilitation Services from 1999 to 2005, overseeing an agency with 19 field offices, as well as a 24/7 rehabilitation hospital and training facility. I managed programs designed to provide vocational and independent living services to individuals with physical, sensory and mental disabilities. The work focused on helping find jobs for people with disabilities. My previous experience also includes practicing law in the private sector and serving as assistant legal counsel in the Arkansas Governor's Office from 1996 to 1999. My professional affiliations include being appointed by President Bush as a member of the United States Access Board in Washington, D.C., and being appointed by the U.S. Education Secretary to the National Technical Institute for the Deaf National Advisory Group in Rochester, New York. I received a bachelor of arts degree in political science, with distinction, from Hendrix College in Conway, Arkansas,

and a law degree in 1991 from the University of Arkansas at Little Rock School of Law. On a personal note, my wife Andrea Schultheis, a social worker, and I have two children. Sophie is five and learning to play soccer, and Mike turned three last week. My experiences in state government have developed my skills in facilitating collaboration, strategic planning, and building and strengthening partnerships. I can think of nothing more satisfying than to draw from that experience to help carry out our mission of helping people live better lives. As the director of the Division of Developmental Disabilities, I've had responsibilities for both community-based programs and the Beatrice State Developmental Center, or BSDC. My vision for the developmental disabilities is that through quality enhancement we support effective services that build on a person's strengths and maximizes independence. I would like to share some of the successes of the Developmental Disabilities Division. This month the Center for Medicare and Medicaid approved BSDC's plan of correction after the November survey. We are making progress in rightsizing BSDC by moving clients, who can be served in community-based settings, to the community. We are maximizing federal funds for community-based developmental disability services, an increase of 12 percent in participation rate from 2003 to 2007. From 2003 to 2007, there was also a 12.9 percent growth in community-based services without corresponding growth at BSDC. We are implementing a fifth Medicaid waiver choice--the community support waiver, a self-directed approach to service delivery. And we are refining the community-based developmental disabilities quality services improvement plan. This plan includes 100 percent monitoring by service coordination, and 100 percent provider agency monitoring by the DHSS Community-based Services Unit. We are also experiences challenges in several areas: hiring and retaining adequate staffing at BSDC, although reducing the census at BSDC will assist in improving the staff ratio; stretching available resources to address new challenges, while maintaining services to individuals currently served in the community; addressing the registry of unmet needs; distributing financial resources equitably across all people receiving community-based developmental services; keeping up with the community-based services, providing more choices to people served, increase in monitoring of service choices and providers; communicating expectations for drawing on available resources to deliver quality services that address the behavioral needs of the people served; and translating quality improvement monitoring data into action plans for improved services. In the short time that I have been division director, I have set the following priorities: improving the quality of services for the people who live at the Beatrice State Developmental Center; meeting the goals outlined in the three-year plan; improving the services...quality of services for people with developmental disabilities; and supporting activities that maximize the use of financial resources. I'll be happy to answer any questions at this time from the committee. [CONFIRMATION]

SENATOR JOHNSON: Okay, John. Any questions? I see none, but I can't help but again comment. You have a very interesting thing, particularly at Beatrice State Home, because there you've got the problem of all kinds of federal regulations coming into play

which tell you to do different things in taking care of the people that are in that facility, including almost direct orders to ship some of these people to a different facility. And what we are seeing, of course, is the relatives, guardians and so on of these various people that the federal regulations say you have to move out, that these relatives and guardians are saying we're very satisfied with the care that they've been receiving and please don't move them out. So you're kind of in an impossible situation. Do your best. [CONFIRMATION]

JOHN WYVILL: It's a very challenging environment, Senator,... [CONFIRMATION]

SENATOR JOHNSON: Yes, it is. [CONFIRMATION]

JOHN WYVILL: ...but we're very blessed to have a good team. [CONFIRMATION]

SENATOR JOHNSON: Any other questions? Yeah, Senator Gay. [CONFIRMATION]

SENATOR FULTON: John, I just wanted to say, too--I said of Chris and then Dr. Schaefer as well--tough decisions that you're making. You kind of got thrown into the fire in your new role here, but I think you're doing a great job and we all appreciate your daily efforts and the tough decisions that are being made by you. So I just want to say that publicly while you're here. [CONFIRMATION]

JOHN WYVILL: Thank you, Senator Gay. [CONFIRMATION]

SENATOR GAY: Thank you. [CONFIRMATION]

SENATOR JOHNSON: Any other questions or comments? See none, John. Thank you very much. [CONFIRMATION]

JOHN WYVILL: Thank you. [CONFIRMATION]

SENATOR JOHNSON: All right. Now we have three people from Foster Care Review Board. The first one I have is Ronald Albin. Ron, welcome. [CONFIRMATION]

RONALD ALBIN: (Exhibit 5) Good afternoon, Senator Johnson, members of the committee. My name is Ronald J. Albin, R-o-n-a-l-d, Albin, A-l-b-i-n. I'm from Norfolk, Nebraska. I'd like to tell you a little about myself. I'm basically a Norfolk, Nebraska, boy, even though I graduated from high school in Platte Center, Nebraska. I got my bachelor's degree from Wayne State College here in Nebraska in 1973 with highest honors; then went on and was accepted and graduated from the University of Nebraska Law School in 1976. I am a practicing attorney right now in Norfolk, Nebraska, and my cases involve juvenile court. For the last 30 years, I've been a guardian ad litem. I've represented parents, both sides. I've been the attorney for the child. I do criminal

matters so I understand the involvement of youth in criminal matters. Unfortunately, I'm involved in a lot of divorces so I also see how that affects families. I do bankruptcies so I understand how that affects families. I do other things involving contracts. I am at the working level of where the Foster Care Review Board is looking down at. I'm actually in the trenches. And so I really appreciate the Governor nominating me for this position because I bring on hands experience. They talk about what happens and I'm actually doing it, and I'm curious how I can contribute toward making things work better and see if some changes can be made. But not only do I bring experience to the table, but I have a great deal of common sense and a sense of integrity of what is right and wrong, and so I do plan to speak up if I see something that's not right. I am an outsider. I don't know, except for the other nominee, Alfredo Ramirez, I don't know anyone, and I didn't come down here to develop friendships. I came along down here to be part of the team to make things work, make things improve. And, quite frankly, if the proposed changes don't pass my muster test, I'm going to object and scream to high heaven because I, like I said, I actually have to deal with the department on a level where we actually need things done and I know where some of the problems are. And it would be interesting to see what they think the problems are and how they can help. But if they actually are going to come up with notions that interfere with what we do, I'm going to oppose them. So that's all I can tell you. I don't...I don't know a whole lot about all the functions of the Foster Care Review Board. I'm going to come up to speed real quickly, but I'm enthused and I'm willing to put the time in to do it. I care about the kids and I appreciate what the Governor wants done. Improvements need to be made. [CONFIRMATION]

SENATOR JOHNSON: Senator Hansen. [CONFIRMATION]

SENATOR HANSEN: Thank you, Senator Johnson. Welcome today. I have a two-part question. How many, as a guardian ad litem, how many cases do you have? And secondly, how many cases should a guardian ad litem be exposed to in the course of a year? [CONFIRMATION]

RONALD ALBIN: Well, that's interesting, at any one time. How many do I have right now? I probably have about...probably about 10 to 12 cases. How many should an attorney have? I would say probably no more than 15, as a general rule. The thing about...the only thing about picking a number is it all depends on how active they are, because some of them are really...there's not a whole lot that needs to be done, just an experienced eye needs to look at them. But if you've got some active cases, you really need to pull back. You can't handle probably more than five or six really, really active cases, especially where you're headed for a possible termination. We do have week-long termination trials up in Madison County and that takes time, but you don't get those that often. But I think that's what I would have to tell you, my opinion. [CONFIRMATION]

SENATOR HANSEN: Okay. Thank you. [CONFIRMATION]

SENATOR JOHNSON: Senator Stuthman. [CONFIRMATION]

SENATOR STUTHMAN: Thank you, Senator Johnson. John (sic), thank you for, you know, your willingness to serve on this Foster Care Review Board. And just by your comments earlier it seems like you're a very aggressive person; you want to make a change if there's a change needed. [CONFIRMATION]

RONALD ALBIN: That's right. [CONFIRMATION]

SENATOR STUTHMAN: And I think that possibly comes from the fact that you did graduate from Platte Center, Nebraska, (laughter) and that's very important. Did the school go many years after that? [CONFIRMATION]

RONALD ALBIN: The school was knocked down probably about '69. Somewhere after '69 it was knocked down. I would have graduated from there in '65. [CONFIRMATION]

SENATOR STUTHMAN: So thank you, and thank you for your willingness to serve. Thank you very much. [CONFIRMATION]

SENATOR JOHNSON: Senator Pankonin. [CONFIRMATION]

SENATOR PANKONIN: Senator Stuthman, I won't tell you what Senator Erdman wanted me to say about Platte Center, (laughter) something about it's a good thing somebody good came out of there. (Laughter) Mr. Albin, thanks for your willingness to serve but also I think for your vigor in trying to make the system better. And obviously you've had the real world experience and from being on this committee this past year and being exposed, visiting a local foster care review board and close by and knowing the problems in this area, I really to appreciate your experience and knowing that you are going to pursue excellence in this area the best we can, knowing it's a very, very tough area with a lot at stake. And so we wish you well and we hope you do, as Senator Johnson questioned earlier of being independent, trying to do the best for the kids is an important responsibility. You've been doing it, so we look forward to your service. [CONFIRMATION]

RONALD ALBIN: Thank you. [CONFIRMATION]

SENATOR JOHNSON: Any other questions? I've got one for you too. [CONFIRMATION]

RONALD ALBIN: Yes, sir. [CONFIRMATION]

SENATOR JOHNSON: Who was the World War II general from Platte Center?

[CONFIRMATION]

RONALD ALBIN: Gruenther. [CONFIRMATION]

SENATOR JOHNSON: Very good. (Laughter) Thank you very much. Alfred Gruenther, as a matter of fact. [CONFIRMATION]

SENATOR ERDMAN: See? Two good people came out of Platte Center. (Laughter) [CONFIRMATION]

SENATOR JOHNSON: Okay. Who we have next on the list? Gene Klein. Gene, welcome. [CONFIRMATION]

GENE KLEIN: (Exhibit 6) Good afternoon. I'm Gene Klein, G-e-n-e, Klein is K-l-e-i-n, and I'm the executive director of Project Harmony, which is a child advocacy center in Omaha, Nebraska. My background: I graduated in 1988 from Creighton University with a degree in social work; in 1993 with a master's degree in social work from the University of Nebraska at Omaha. My first job in 1988 was with Senator Howard as a child protective service worker, and all 20 years of my career have been in child welfare or children and families issues. The last six years have been at Project Harmony, which is a nonprofit agency that ensures that kids who are going through a child abuse investigation aren't further traumatized by the system that's intended to protect them. I have been on the Foster Care Review Board for the last two years and am asking for your consideration for another appointment to that term. [CONFIRMATION]

SENATOR JOHNSON: Senator Howard. [CONFIRMATION]

SENATOR HOWARD: Thank you, Mr. Chairman. Thank you, Gene. I can't resist the opportunity to express how grateful I am that you made this commitment and, yes, you and I worked together a number of years ago and I have the greatest respect for you and the work that you've done in our field, so thank you so much. [CONFIRMATION]

GENE KLEIN: Thank you. [CONFIRMATION]

SENATOR JOHNSON: Any other questions? Senator Gay. [CONFIRMATION]

SENATOR GAY: Yeah, just real quick, I agree with Senator Howard. Constituent, I've known you a long time, but your commitment to the kids and view that's tremendous. Just looking at your resume here as I was waiting for you to come up speaks for itself. So thank you for serving. [CONFIRMATION]

GENE KLEIN: Thanks. Sure. [CONFIRMATION]

SENATOR JOHNSON: Yeah. I just want to say, yeah, going to your home within this last year was one of the great things I have done in the past year. It's a marvelous facility that we all can learn from, so... [CONFIRMATION]

GENE KLEIN: Thank you. [CONFIRMATION]

SENATOR JOHNSON: ...bring some of that with you. Thank you very much. Oh, Senator Hansen. [CONFIRMATION]

SENATOR HANSEN: Thank you, Senator Johnson. Good to have you here today. Would you be considered a provider in the childcare system? And can you explain what that is and your connection between that and HHS or the department. [CONFIRMATION]

GENE KLEIN: Sure. Yeah. Yeah, in 2004, Governor Johanns and the Legislature appropriated funds to provide coordination of the LB1184 teams, which are investigative and treatment teams. A number of you were a part of that. And in that role the Health and Human Services...actually, the Legislature identified the child advocacy centers as the place where that business needs to be conducted. So, in essence, we do receive funding through Health and Human Services for...specifically for coordination of the LB1184 investigative and treatment teams. So, yes. [CONFIRMATION]

SENATOR HANSEN: Do you see that as a conflict of interest at all? [CONFIRMATION]

GENE KLEIN: With regard to...? [CONFIRMATION]

SENATOR HANSEN: Foster care, sitting on the Foster Care Review Board at the same time. [CONFIRMATION]

GENE KLEIN: I don't. I don't see that. The statute requires that a representative from child advocacy centers be on the Foster Care Review Board and that's the role that I'm here. Our role in those cases in that contract is to provide...to make sure that the police and law enforcement and child protective services and the prosecution are all talking about these cases and really to make sure that kids aren't falling through the cracks, very similar to what the Foster Care Review Board is doing. Ensuring that kids' needs are getting addressed while they're in that...in the investigation is our primary role, but also throughout the foster care system. So I don't see that as a conflict of interest. [CONFIRMATION]

SENATOR HANSEN: Do you think that the Foster Care Review Board needs reorganized in any way, any shape or form? [CONFIRMATION]

GENE KLEIN: I know that there's an audit that's coming up, the Performance Audit

Committee has issued or requested that an audit be conducted to make sure that the organization...actually, the scope hasn't even been defined. But in terms of reorganization, I don't know anything about that. [CONFIRMATION]

SENATOR HANSEN: Okay. Thank you. [CONFIRMATION]

GENE KLEIN: Sure. [CONFIRMATION]

SENATOR JOHNSON: Okay. [CONFIRMATION]

GENE KLEIN: Okay. [CONFIRMATION]

SENATOR JOHNSON: Thank you very much. [CONFIRMATION]

GENE KLEIN: All right. Thanks. [CONFIRMATION]

SENATOR JOHNSON: And we've got Alfredo Ramirez will have the chair. I just love your first name. [CONFIRMATION]

ALFREDO RAMIREZ: Thank you. Some people refer to it as chicken, so...(laughter). (Exhibit 7) My name is Alfredo Ramirez, A-l-f-r-e-d-o, Ramirez, R-a-m-i-r-e-z, no middle name. I think I was kind of cheated on that, but I don't know why, so. [CONFIRMATION]

SENATOR JOHNSON: So was Harry Truman. [CONFIRMATION]

ALFREDO RAMIREZ: I'm originally from Texas, so I want to give you just a little bit of background in terms of who I am, not necessarily to boast or anything but it's a part of my history and part of why I do what I do. I was actually...I'm actually a Texan. I was born and raised in San Antonio, Texas, and I'm an 8th grade dropout. I was involved in a lot of gang warfare in San Antonio when I was young, and reached a point that I needed to leave so I did, so I left with an 8th grade education and joined the Air Force. When I was in the Air Force, things didn't calm down and, consequently, I was relieved of my duties early but had a good discharge. So that's a whole story in itself and it's somewhere for a book someplace. But as an 8th grade dropout, my dreams have always been that I wanted to be involved in some type of work involving children, so it kind of goes like this. I graduated from West Texas State University, which is now a part of Texas A&M, with my bachelor's in social work. I have a master's in social work from UNO and, matter of fact, I went to school about the same time that Carol Stitt also did. I have been a therapist or involved with children and families for the past 37 years and it has been in all facets. It has been in community work, has been in office, has been on the streets, and just every facet that you can think of has been my involvement. Actually, I started out, still as an 8th grade dropout, and received my GED and worked for a hospital district in Amarillo, Texas, where I actually worked on the streets with a lot

of young people and sometimes picking them up and throwing them in my Volkswagon car and taking them home and dropping them off at home with paint and stuff all over their faces because they had been huffing. That in itself really piqued my interest in terms of young people and at some point I decided that I wanted to give back. There's a long story there just in terms of my involvement because a lot of my history caught up with me at some point and I went back to San Antonio and came very close to losing my life to old rivals and so forth, so I was stabbed several times and came within about ten minutes of dying. That is part of my history and it's important because it's pretty well what has formed me into who I am now. Getting to the present, I have been a local board for 20 years now. As a matter of fact, I tried to add up the amount of cases that I have reviewed with the local board over the past 20 years and it really did scare me. I had several feelings. One of them was sadness and one of them was there's some who have made it and there's others who are not going to make it. But in all of it what I found was that it was extremely important in the story of the starfish that we can take one and save it then we're changing some generations, and I don't say that lightly. I say that very committed to that. I have previously been appointed by the Governor to the Nebraska Coalition for Juvenile Justice, where I served for over seven years, and also was appointed to the National Coalition for Juvenile Justice out of Washington, D.C., where I served also as chair for several committees and also locally. So I was able to really get my hands into a lot of the policies and Washington, D.C., things that we needed to do. At this point, I also have been serving on the Norfolk school board for the past ten years and, without saying so...wanting to say so, I'm probably the first person of color that has ever served on that board, and I'm running again for another four years so I hope that works out okay. I've been involved in the local community in Norfolk...well, not just in Norfolk, in the 20-some counties since I've lived there, since 1982, and also about two years ago was responsible for a group of people that launched a methamphetamine conference that was very successful and that Senator Flood also participated in at that time. As a matter of fact, the Native American population was very good with this and gave Senator Flood a star blanket at that time. I've also, in terms of my practice, my practice is known as Odyssey III Counseling Services. I've been in private practice 19 years, but have served as a therapist in the Norfolk area for over 20 years. So I decided to go private primarily for one reason--I didn't have to deal with a lot of red tape that was not necessary to get things done. In all the history that I have and that I can give you, and I would be more than glad someday to have a conversation about that because it would take awhile, I don't consider this to be my job and I don't consider it to be my career, and I don't consider it anything else other than it is my vocation. And I've had people over the years ask me, don't I get tired, don't I burn out, don't I get tired of listening to people either fighting or kids that run off. And in terms of children, I work with them from ages five years old all the way up, and even with children who have killed other people, as well as children who have been mutilated, who have gone through ritualistic abuse, who have gone through trauma. You name anything that a child can go through, I think I pretty well have worked with it. Nothing is a surprise to me at this point anymore. I hold my passion very close to my heart and it stays there because it keeps

me focused. I always look at the idea that I never allow my emotions to cloud my discipline because if my emotions get involved in doing the work that I need to do I may lose focus. And so I tend to that very carefully. But in terms of it being a vocation and the question that people ask me of if I ever get tired, the question is very simple and the answer is also simple. No, you can't ever get tired of a vocation, because that's what you're supposed to do. It's not something that you're told to do, it's not anything else, but it is something you're supposed to do and that's what you do. So I also look at the idea that any decisions that I make in regard to children or families I have to ask myself the very first question--is it good for the children? And if its not, then I can become controversial with that also. I don't have any problems in holding accountability. I don't have any problems with...even though I do work with Department of Health and Human Services, I work with them rather well. I prefer to collaborate and negotiate and do whatever we need to in order to provide the focus on the children, which is the most important thing. So I do...I think I do a very good job with that. And that's about what I have; otherwise, I could go on and on, so I prefer not to do that. [CONFIRMATION]

SENATOR JOHNSON: Any questions? Yes, Senator Hansen. [CONFIRMATION]

SENATOR HANSEN: Thank you, Senator Johnson. Just one comment, that I think you have your priorities right. I think we need to ask that question more--what's the best interests of the child? Thank you for that. Thank you for your story. Thank you for being here. [CONFIRMATION]

ALFREDO RAMIREZ: May I add to that? [CONFIRMATION]

SENATOR HANSEN: Certainly. [CONFIRMATION]

ALFREDO RAMIREZ: Probably what I would add to that is that I do have some concerns in regard of the work the Foster Care...the Foster Care Review Board does, and not only statewide but also locally. There are some concerns that I have that a majority of the cases that we review anymore, a lot of...at least 90 percent, if not more sometimes, have methamphetamine involved in them. That is very tragic to me because it keeps families from being able to come together. The other concern that I have is that there needs to be more work done in regard to holistic kinds of approach with families. It takes too long to get children back into their homes. A lot of the bonding is sometimes lost. We need to work on that. And I think those are very important things. We have children that attach very easily sometimes to foster parents and find it very hard to move on to their own families. The issue that we have with methamphetamine and some of the other drugs are really destroying families considerably, and you see into...you look into the eyes of the young children and you see a lot of pain there that sometimes all of us tend to forget. We just...we're focused a lot of times on the adults and we forget the pain of the children. Any other questions? [CONFIRMATION]

SENATOR JOHNSON: As you were talking an old saying came to mind: Success breeds success. I think we're awfully glad that you're here. Thank you. [CONFIRMATION]

ALFREDO RAMIREZ: Thank you very much. [CONFIRMATION]

SENATOR JOHNSON: All right. I believe that takes care of all of our appointments. Jeff, I haven't missed any here, have I? So thank you all very much for coming and we'll proceed on. I think I saw Senator Pahls back there. Let's kind of take a minute and stretch our legs as you're coming up. [CONFIRMATION]

SENATOR PAHLS: (Exhibit 1) Thank you, Senator Johnson and members of the committee. My name is Rich Pahls, P-a-h-l-s. I represent District 31, the Millard of Omaha. Right now one of the pages is handing out two documents that I think would be quite interesting for you to have the opportunity read at one time. One is from our state department. They have not taken a position on the bill, but at least there's...I think, some important information in both of those documents. One is from the state of Kansas. I'm speaking to you today on LB713. One of the important health issues facing our society today is obesity. Unfortunately, in our hurry to address this concern, a questionable medical practice has arisen. The verdict about the safety and effectiveness of using Lipodissolve to reduce fact is still out. LB713 prohibits the use of Lipodissolve to reduce or eliminate fat under the skin unless the FDA approves its use for this purpose. The FDA will not approve this procedure until safe, medically controlled studies have been performed. We are a leader on this issue. Last year the Kansas State Board of Healing Arts adopted a regulation very similar to this bill. Later, a Kansas state court suspended the regulation on a technical basis. But I do think if you read some of that information there, they are still working on this. My office has checked with NCSL. We are the first state with this legislation on...with legislation on this topic, but an NCSL health researcher anticipates that this topic will come up in other states, based on the reports in the media. I introduced LB713 on behalf of Dr. Joel Schlessinger, a leading physician in Omaha. He operates a clinic and skin research center located in my legislative district. He enjoys a national reputation for his leadership in health issues. And Dr. Schlessinger is here today to provide you with more information. [LB713]

SENATOR JOHNSON: Caught me with a cookie halfway down. [LB713]

SENATOR PAHLS: That's exactly what I was aiming for. I just... [LB713]

SENATOR JOHNSON: I figured as much. (Laughter) [LB713]

SENATOR PAHLS: I was looking at you and keeping my pace at a certain direction. [LB713]

SENATOR JOHNSON: But you know, we have a very good person in this building that brings cookies to us on a regular basis and, you know, I feel I have to eat them. [LB713]

SENATOR PAHLS: I agree. You know, you have my support. You have my vote on that. [LB713]

SENATOR JOHNSON: (Laugh) Any questions of Senator Pahls? [LB713]

SENATOR GAY: I've got a question. [LB713]

SENATOR JOHNSON: Senator Gay. [LB713]

SENATOR GAY: On this, they would have insurance and some of those things covering all the procedures they do, right? So why wouldn't a doctor...why would they go ahead and do this if it could be a liability or something else? Won't it police itself? [LB713]

SENATOR PAHLS: To be honest with you, that question probably would be better to be answered by a physician. Yes, they have insurance because there are, it's my understanding, we do have some physicians in the state using this right now. The concern is that it has not been approved, FDA, and I can't answer the question about the insurance. [LB713]

SENATOR GAY: Oh, okay. Thanks, Rich. [LB713]

SENATOR JOHNSON: Senator, I don't see anyone else. Will you be able to stay? [LB713]

SENATOR PAHLS: I'm going to stay. [LB713]

SENATOR JOHNSON: Okay. Great. [LB713]

SENATOR PAHLS: We finished ours. [LB713]

SENATOR JOHNSON: All right. [LB713]

SENATOR PAHLS: Government is done. [LB713]

SENATOR JOHNSON: Yeah, Matt can help you out there. Welcome. [LB713]

JOEL SCHLESSINGER: (Exhibit 2) Thank you, Senator Johnson. My name is Joel Schlessinger, and it's J-o-e-l S-c-h-l-e-s-s-i-n-g-e-r, and I'm testifying on the proponent part of this issue. Thank you so much, Senator Pahls, for introducing this, and thank you so much for this committee considering this bill. This is a bill which, as Senator Pahls

has mentioned, is quite important in my mind because we are in an area and in an arena at this point that is allowing essentially unapproved medications to be prescribed or injected, even worse, into unsuspecting patients, and this is something that is probably a dilemma that has happened more and more as the field of cosmetic surgery has evolved and people have come into that field that are outside the typical pattern of delivery of that healthcare; i.e., they are not in specialities that are what we would consider the core specialties of cosmetic surgery, that being plastic surgery, dermatology, facial plastics, and opthalmology plastic surgery, ENT. So there are people that are going into this field and there's been an explosion in medicine that is being provided by these people, sometimes with somewhat disastrous consequences. It's because of this that I, about three or four years ago, I started to realize that there were many things, including Lipodissolve, that were being done in our area by people with little or no training who had never completed a course of any substance in this field, let alone in the field that they were professing, such as administering Lipodissolve. And I started speaking out at that point, including the Omaha World-Herald about two or three years ago, Channel 7 about two or three years ago, and it was then that I became aware of the magnitude of this problem that subsequently I was brought to the forefront in Kansas when, in the past year, they introduced a bill to ban this substance in Kansas. For whatever reason, we here in the Midwest have been the epicenter of this development because a company called fig. in St. Louis developed a great marketing mechanism for this and a great term--Lipodissolve--and set up clinics around the Midwest and then subsequently spread to the coasts. That's rather unusual because most of the time the cosmetic procedures and trends start on the coasts and move inward. But because of this company, fig., f-i-g., it occurred in the Midwest and that's why we have about eight or nine facilities in Omaha alone that are providing this procedure. What I come to you today for is to inform you of this and hopefully stop this procedure, and I will present in as brief a manner the presentation that I was going to give to you. It's in essentially a PowerPoint, but you can follow along. And we don't have a PowerPoint with us so I'll explain that. First of all, Lipodissolve is an unapproved, injectable drug. It has two components, which are phosphatidylcholine and deoxycholate, and the sodium deoxycholate is made from cow bile, the phosphatidylcholine is made from a soy product. Now the soy product is probably not the active ingredient. The active ingredient in it is probably the sodium deoxycholate, the cow bile, and it's an American copy of a drug that was introduced in Europe, Germany, many years ago for stroke, embolism-related issues after a stroke, and was soundly told not to be injected anywhere but in IV, and it not really very used...much used in Europe anyway. It's marketed by many clinics as this thing called Lipodissolve or Mesotherapy, and it's meant to be an alternative to liposuction or something that people who are looking to lose weight can do. It typically costs about $2,000 per body part and this fig., when they were interviewed prior to going bankrupt in St. Louis, said that they had done 155,000 treatments or more. Going on, the reason that I consider it a drug, and the FDA, I believe, will be in that part of the argument, is that it is something that is meant to affect the structure or function of body of man, and that's what it's doing.

They have issued a warning letter back in 2003 to Ayoula Dublin demanding he (sic) cease the distribution of Lipostabil, which he (sic) did, and at that point it was taken on by a number of shadowy networks of people who distribute this stuff. They haven't...these places that are distributing this, and it's from a variety of places across the United States, Brazil and in Europe, have never actually gone forth and asked for a new drug application from the FDA. One company at one point decided that they were going to look into it and, when they found out that it was going to be millions and millions of dollars to develop this, they withdrew the...or they didn't do anything with the application, let it lapse, and just went ahead and developed this role model of clinics by presenting this product as an approved product. One company is working on a new drug application and is in the middle of studies on a process that is like this and it looks like it will be years before that is ready or available. FDA recognizes this problem. There's, on page 3 of your handout, there's a statement by the FDA Office of Public Affairs, Karen Riley, and she says that she realizes that this is not FDA approved and she cannot assure the safety and the efficacy of these types of drugs, and consumers need to know that this is a buyer beware situation; these are unapproved drugs for unapproved uses and we can't guarantee consumers' safety. Going onward, just to explain, these drugs are being commercialized by various clinics, including Lipodissolve clinics, and there have been no adequate, well-controlled clinical trials providing safety and efficacy on these drugs. The FDA has not been involved and the companies that actually have popularized them have as much stated in the point on page 4 that they never intended to go to the FDA because it is very expensive and they thought it would be much more money than they wish to spend to get this drug approved. Unfortunately, the FDA is sometimes slow to act and they have a lot more on their plate than regulating this. There are people that are doing other things that they are very well aware of and they're trying to do their best, but this is one of those things that the FDA hasn't caught up with what is actually happening in clinical practice. Here in Nebraska, going to page 5, in just Omaha alone there are some Lipodissolve centers, one called Devenu, which on its web site says that Lipodissolve is a nonsurgical treatment that permanently dissolves fat and cellulite, the safety and efficacy is supported by several clinical studies published in Europe and the United States. Now these are clinical studies that were done by people who introduced Lipodissolve, so these are studies that were not adequately controlled, were not published in recognized journals that are ones that practitioners would look at, and most of these were...most, if not all, of them were funded by the industry that is producing this product. So there's actually a very great deal of self-interest in this and a conflict of interest. Now going on to Body Enhancement MedSpa, also in Omaha I think: guaranteed permanent results, proven track record, safe, hundreds of thousands of successful treatments given worldwide. Another clinic, Fountain, run by an ER doc: Lipodissolve injections reduce the size of localized fat deposits and cause skin retraction; supported by clinical studies and research in South America, Europe and U.S. What he fails to note is that it has been banned in Brazil, in Canada, and parts of Europe it's been strongly regulated against. They have another statement that was in today's Omaha World-Herald by Dr. Julie Waddell, who is a family

physician and now runs Devenu, that she's done Lipodissolve on patients and has had no problems whatsoever. They don't have a reason to report and there's no regulation that they must report any problems with this, since it is not an approved drug. If it were an approved drug, it would go through a process where any problems had to be reported. She goes on to state the procedure is safe and effective as long as it is done properly and those performing the procedure have proper training. Later on at the end I'll tell you what the proper training apparently is for this procedure. Going onward, we have a cite from the Better Business Bureau of St. Louis which, when 36 months of data were tabulated, they had 102 complaints about the companies performing Lipodissolve, regulating that they had false advertising, a pattern of complaints, they had people that alleged the procedure was ineffective, caused swelling and pain, improper billing was performed, and they had difficulty obtaining refunds from the companies. Those people are totally out of luck now because the companies have gone bankrupt and they've invested thousands of dollars in a procedure that was probably not good to begin with, but especially not good since they are out their money. Commercialization of an unapproved drug is something that we are worried about. Thalidomide is the first thing that I think comes to my mind when I think of a drug that wasn't approved for a particular indication and went ahead and caused severe problems when it was used without adequate testing. We also are very concerned about other drugs that have been used and are unapproved for their conditions or, in this case, any condition. The FDA has received complaints from Physicians Coalition for Injectable Safety saying that this is not a medically proven treatment and it has severe risks. There are many things that can happen if this is done and causes problems, including skin infection, which has occurred, disfigurement, severe cramping, bloating, dehydration. There is a recent case wherein a girl from Lincoln was injected with this material and developed severe irregularities on her skin and had to go to the Mayo Clinic to try and find an answer or solution for this. She was recently seen at the Mayo Clinic and they are in the process of trying to figure out what they can do for her, but apparently there's really nothing that they can do at this time. They are probably going to issue a case report on it and look for other people that can try and figure out what has happened to her. Because of the substance and the fact that it's not put together in a federally approved way and that there's no manufacturing process for it, they really don't even know that she was injected with a correct strength. Maybe she was injected with something that was ten times, a hundred times, a thousand times as strong. But there's some concern about it. She was involved in the Kansas legislation as well. There are no mandatory adverse event reports for these companies, so as a result many of these companies just gloss over the people that have problems. There are, however, quite a few people that are very interested in it. We've seen quite a few stories in the public press about problems with it, including articles that I was quoted on in the L.A. Times and The Wall Street Journal, and other articles in The New York Times, Washington Post, and other publications. Let there be no doubt this is an unapproved drug. It is not being used correctly and it really should be regulated. The ads are giving every indication that this is a safe drug, and there's no substance behind that. The growth is unsafe, in my mind,

and it can harm people in our state, and that's something that I'm very interested in stopping. And I go into a few more slides about what the actual process is to get an approved drug through the FDA and it's quite a big of time, effort and money. These companies have not and will not do that. Lastly, on the last three pages, I am enclosing a statement of what it takes to be trained in these procedures and apparently what it takes to be trained in these procedures is one day at a course that you pay money for. They don't even state if you have to have any credentials whatsoever, but what they do say is that you have to spend, see the last page, Mesotherapy, which is what we are talking about for this, February 11 is the day that they address it with...during this six-day course for the Esthetic Skin Institute. So you can be trained and accordingly, apparently, certified--hands-on certification training in this one course in one day whether or not you're a doctor, whether or not you have medical credentials. Apparently, this Leigh Giordano, who's an R.N., was trained in one day so, you know, she can go out and perform Lipodissolve, and that's about what we're seeing. The problem that we're seeing is the people that have gravitated to this field are interested in a profit-making motive and they are selling this and doing very well with it, and potentially harming people. The only other thing I'll mention, and this is a follow-up to what you had asked to Senator Pahls, is that currently it is not an FDA approved procedure so, technically, there is no malpractice coverage for it. In California, the three largest malpractice insurers refuse to cover any problems that occur after Lipodissolve administration because it is not an FDA approved procedure. I have that data if you need that, and it's a clear statement that this product, this process is unsafe and should not be performed. Thank you very much. [LB713]

SENATOR JOHNSON: Senator Erdman. [LB713]

SENATOR ERDMAN: Joel, thanks for coming. I have no knowledge of cosmetic surgery or Lipodissolve, but I would like to think I understand the way that bills are introduced. This bill does not prohibit Lipodissolve from being used in Nebraska. It only says that it is grounds for disciplinary action for an individual who is licensed, should they use it and it not be approved by the FDA. Your last...your closing comments there led me to believe that nonmedical professionals, those who aren't licensed, could somehow have access to this drug as it's not an FDA approved drug. I imagine there's a different process for access to those that are and those that aren't, but walk me through that. Because if what you're telling me is, is that nonmedical professionals can still...could have access to the training or could possibly hold themselves out at a salon to be able to provide this, I don't think the bill addresses them at all. And so I'm just trying to understand the logic, because we can fix that if that's what we choose to pursue. But I'm just trying to understand. If it's beyond the medical professionals that can have access to this or apply this, the bill has to be corrected to address that issue. [LB713]

JOEL SCHLESSINGER: That's an excellent point. I guess we probably phrased it that it should be regulated from medical professional. But that's absolutely correct, if it doesn't

state that really nobody should do it, and it would be a real shame if the bill went from having medical professionals doing it to having less than medical professionals doing it and getting away without being punished. [LB713]

SENATOR ERDMAN: So explain to me the process that somebody would get if...this substance is called Lipodissolve, how do you go about receiving that? [LB713]

JOEL SCHLESSINGER: It's a rather, as I say, shadowy network of pharmacies, compounding pharmacies, some of which are in Europe, some of which are in Brazil, some are in the United States, and they just basically write to these companies. They send them the... [LB713]

SENATOR ERDMAN: And "they" being...? [LB713]

JOEL SCHLESSINGER: The clinic, whoever is administering it, they send them a bottle of this Lipodissolve or PC/DC, and they then can administer it. Many of the vials are really rather large and so they can essentially treat many people and that's another area where we think problems have occurred. Because they are multiuse vials, they can become contaminated, and most of the people that are doing this procedure are not medically trained or, if they are medically trained, they're very weak on their sterility. So the vials are becoming contaminated and people are having infections from it. [LB713]

SENATOR ERDMAN: And again, I think going back to the earlier observation--and, Senator Pahls, if I'm not reading this right you're more than welcome to correct me--but even under that scenario, again, there's no administrative license. I mean there may be other criminal potential solutions to that, but I'm just trying to understand. So if I wanted to set up a spa in Bayard, Nebraska, for all 1,200 people that live there, I find the contact number for somebody or whatever and I just send away for a vial and...? I mean, I've got to think that it's more involved than that, but maybe it's not. Maybe because it's not FDA approved or hasn't gone through that process, that if I get access to it, I can have it, and if it's any other drug I've got to get a doctor or somebody that's going to write a prescription for me to receive that. [LB713]

JOEL SCHLESSINGER: Most of the compounding pharmacies, I believe, will insist on having a doctor's name on the prescription. But if you go onto the Internet, you can actually purchase this on the Internet without an M.D. license. They just ship the stuff to you. You could conceivably even do this in your own back...in your own home. It is that unregulated on the Internet. But in general, what we're seeing is that these clinics are going through a network of compounding pharmacies to get it and most of them, although I wouldn't say all of them, have a physician associated with it that orders the product. [LB713]

SENATOR ERDMAN: Okay. Thank you. [LB713]

JOEL SCHLESSINGER: But that's an excellent point. Thank you so much, Senator Erdman. [LB713]

SENATOR JOHNSON: Senator Gay. [LB713]

SENATOR GAY: I've got a...is it...is this common? Are there other drugs that are not FDA approved that are being used in the industry? And I know your industry is probably much different than what you're describing here. Is there other non-FDA drugs, though, that are kind of going to be coming to our attention? [LB713]

JOEL SCHLESSINGER: I can't think of any that are available, you know, certainly none in my practice that are being used. And it's a rather scary thing if they are, indeed, being used in an unapproved manner. For example, it would be just as if we decided that there was a new antibiotic that was maybe available, hadn't gone through all the testing, and we just wanted to use it and we got it from Europe and imported it and just started using it on people. That would be inappropriate and the FDA would certainly, you know, have an issue with that. But to my knowledge, no, I'm not aware of any unapproved FDA...FDA unapproved drugs that are being used in common practice. [LB713]

SENATOR JOHNSON: Let me just kind of ask a question here first. How many people do we have that will be on the pro side, or supporting what Doctor is? And those opposed? One? Okay. I'm just looking to manage our time. The question that comes to my mind is this; is...and I guess maybe it was answered a little bit, where...it seems a little odd for you to come to this committee first so have you talked to, you know, Society of Plastic Surgeons or whatever and what's their stand on this? And if that's the case, why aren't they here or some...you know, where you been before? [LB713]

JOEL SCHLESSINGER: Well, I'm the immediate past president of the American Society of Cosmetic Dermatology and Aesthetic Surgery, which is the leading society of 2,000 dermatologists from across the world. So I guess I would be, in some ways, a representative of that. During my work as the president of that society, I worked with many specialty societies and have the backing as well in this of the American Society of Plastic Surgeons. They have issued a statement. Many of these other societies have issued statements on this so it is on their radar screen, but they don't necessarily have the resources to come and testify at this meeting. And we actually do have the letter that you may have in your pamphlet from Mark Stafford from Kansas who is also a friend of this bill. There really aren't a large amount of people that are against this at this point, other than the people that are looking to make sure that it's safe for the patients, and that's one of the problems with it. There are probably more people who have a financial stake to be for it because they're making thousands and thousands of dollars on the procedure. And interestingly enough, the press has been fairly weighted in favor of this procedure because the mode of operation of these companies is to come into

town, like the fig. group would come into a town, they would saturate the airwaves--radio, television, newspaper with commercials regarding this and, in the process, would become friends with the media. And so when a story was done on this, almost invariably, until really we started making a concerted effort to bring this to the forefront, it would be a very positive story. I can point to stories in the World-Herald, as soon as two years ago, that were very positive. [LB713]

SENATOR JOHNSON: Yeah, but we're getting kind of... [LB713]

JOEL SCHLESSINGER: Yes. [LB713]

SENATOR JOHNSON: ...off the track here a little bit. See, what I'm trying to do is establish documentation for things. See, if you come before the committee and give, you know, I see it this way, well, then the opponent to it comes up and says, I see it the other way, how do we differentiate, you know, who's right and who's wrong and so on? And see, one of the concerns that I think comes up to everybody on this side of the table is we just got done spending several months on hearings with hepatitis C, which would be a concern with this and so on, and it's a very significant problem. But how scientifically can we go about this? Because you get up and say this, and the opponent will get up and say something else. Where is the scientific organization backing that we can go back to? [LB713]

JOEL SCHLESSINGER: Well, the onus of proof is on them. Basically, this is an unapproved procedure. If they can provide proof that it has been through FDA testing and is... [LB713]

SENATOR JOHNSON: Well, I understand you're saying that, but I mean why, if this is such a problem, where...how come the other groups aren't here and, you know, saying all these bad things about the procedure? See, I'm trying to get documentation, see, is what I'm saying, rather than your opinion. [LB713]

JOEL SCHLESSINGER: Well, I can certainly provide statements from three or four other society groups that are against this procedure and are on file, but the meeting was announced one week ago and...or the hearing was announced one week ago and most of these people are running practices. They have jobs that they are doing in their states, whether it be Oregon or elsewhere. So that probably is one of the reasons. I think that, you know, it's a difficult thing to prove that it's unsafe until the companies create problems, which we've seen many of these problems in people that have been harmed. I've spoken firsthand to people from California, Kansas, Nevada and other states about their problems. There are people here in Nebraska. Just about every article that you read on this has shown at least one or two people with problems. Additionally, there are web sites that are devoted just to the problems of this procedure. There's a web site called Real Self, which is a blog, there is one called... [LB713]

SENATOR JOHNSON: But again, see, that's just...you know, I don't have much use for blogs as an example. [LB713]

JOEL SCHLESSINGER: Uh-huh. [LB713]

SENATOR JOHNSON: That is an anonymous person hiding behind a screen, voicing an opinion. That's not very scientific. [LB713]

JOEL SCHLESSINGER: Uh-huh. [LB713]

SENATOR JOHNSON: And so I'm trying to sort this out, like I say, and you're not the first person (laugh) that I asked this question of, because we've got to make scientific, you know, as much as we can, is make the decisions by science, not just a person coming up and saying I see it this way, make a law. [LB713]

JOEL SCHLESSINGER: It's an incontrovertible fact that this product is not FDA approved and it's also a fact that we have an FDA to regulate these processes, because we don't want to just go around injecting unknown substances willy-nilly into people without it being tested thoroughly. So I think that there's absolutely no doubt that I come from the standpoint of having every bit of proof on my side and they come from the standpoint of having absolutely none of the proof and all the errors on their side. And so I guess it's hard to prove something that is, in my mind, so ingrained that we shouldn't administer drugs that are not FDA approved. It would be, in many ways, kind of like saying that you would have to go back and say that there's a reason that you have to go through medical school to become a doctor. You know, you could, you know if we had to prove you had to go through medical school to become a doctor, I guess it would take about three or four years to show, yeah, it's a bad thing if you practice medicine without being a doctor. But it is a fact that we have to go through medical school to practice medicine and we have to become certified and there are many rules that are surrounding it and this is just one of those rules, that if you don't go through the FDA you can't inject or administer a drug. That's the way it is. [LB713]

SENATOR JOHNSON: Okay. Any other questions? Okay. [LB713]

JOEL SCHLESSINGER: Thank you. [LB713]

SENATOR JOHNSON: Thank you very much. All right. Any other proponents? Did I miss anybody? Okay. Opponents? And just one? Come on forward, sir. [LB713]

DAVID GALE: (Exhibit 3) Hello, Senators. My name is David Gale. I am the proud owner of Devenu. [LB713]

SENATOR JOHNSON: I got to ask you this: spell your name, David. [LB713]

DAVID GALE: Oh, I'm sorry. D-a-v-i-d G-a-l-e. My wife, who is also here, Christine (phonetic) and I have three boys: nine, five, and two. We live in Fremont, Nebraska. We are the proud owners of Devenu Medical Rejuvenation Center in Omaha. I am involved in private equity in Nebraska. My dad refers to me as a recovering attorney, but I think private equity sounds more distinguished so we'll go with that. I have, to be handed out after my testimony, two packets from two societies in contravention to Dr. Schlessinger's testimony, with 50 footnotes as to studies talking about the positive effects of phosphatidylcholine, which I'll refer to, going forward, as Lipodissolve. So if those could be put into the record after I'm done and handed out after I'm done, that would be great. Nebraska Medical Aesthetics is the official name of my company and we run Devenu Rejuvenation Center in Omaha. It is a profit-making venture and was...and we're very proud of the eight jobs that we've created in Nebraska through starting this company 14 months ago. And I know the owners of the other medical spas in Omaha and Lincoln are also proud of their companies and the jobs that they've created in Nebraska. And I also know for a fact the money that is charged for Lipodissolve is sure less than the plastic surgeons are charging for liposuction, so I think Dr. Schlessinger is probably doing pretty well himself. Our senior medical advisor is a board certified dermatologist, a graduate of the University of Michigan Medical School. Our medical director is a board certified family practice doctor, graduate of the University of Iowa Medical School. They thought it was more...not more important, but they're with our patients today instead of here, so any errors in...oh, I'll try to answer the medical questions as best I can, but they're obviously more qualified than I would, which I am introducing the medical testimony into the record. I'm here today to testify in opposition to LB713. As a wise politician once told me, if they say it isn't about the money, well, then it usually is, and this bill, ladies and gentlemen, is about the money. Lipo...first, to answer a couple of the things that Dr. Schlessinger said, I think the largest mixed characterization in his testimony was that the FDA has not approved this drug. And to quote the Los Angeles Times article that he mentioned where he was quoted, there's two quotes I'd like to read. One: It's not illegal for doctors to administer drugs that are not FDA approved for a specific procedure. It's what is known as off-label use. Doctors may administer drugs that the FDA has approved for other uses. Though Lipodissolve is not approved for any use in the United States, doctors administer it through another FDA provision that does allow doctors, on an individual patient basis, to prescribe compounded drugs--a blend of approved drugs made by a licensed compounding pharmacy. And Lipodissolve is a compounded drug. We order it for specific patients, not through a shadowy network of distributors in Brazil and Europe. Kohll's in Omaha, our doctor calls for the patient, and Kohll's delivers Lipodissolve. So I don't see anything too shadowy about that. Also, you know, and Dr. Schlessinger also compared Lipodissolve to thalidomide, but I think a more practical and apples-to-apples comparison is to Botox. And in the same Los Angeles Times article, it's quoted saying not all drugs or devices have received, require or are used with FDA approval. Botox,

for example, was criticized by the FDA as an egregious example of off-label use before it was officially approved for cosmetic procedures in 2002. Last year it as the top nonsurgical cosmetic procedure in the United States. Nonsurgical procedures have increased 750 percent in the last decade. And, too...and that gets to the gist of my testimony today, is that what LB713 I think is really about is a turf war between the surgeons who are performing liposuction and other types of surgery, and dermatologists and doctors who are not. And the fact that nonsurgical cosmetic procedures have increased 750 percent over the last ten years is eating into the revenue of these surgeons and they are...you know, I think this is another in the long line of medical turf battles that seem to come and go. How Lipodissolve came to being in the Midwest or why Devenu offered Lipodissolve 14 months ago was to...it really filled a need to complement the performance of liposuction. And if you know anything about liposuction or have read about it, it's a procedure performed with general anesthetic. It is a pretty traumatic, invasive procedure that has a long list of complications, I think more extensive than Dr. Schlessinger read off for Lipodissolve. What...the gap that Lipodissolve filled was it's noninvasive, there's no anesthesia, and instead of surgery, it's an injection. And the phosphatidylcholine, or the Lipodissolve, is injected into the fat cells and actually blows the fat cells up--that's my layman phrase--and it's passed out through the waste of the body. It's not used for weight reduction. We have very rigid requirements as to the BMIs of people that can receive Lipodissolve, and only our medical...only M.D.s can prescribe it or do the procedure in our clinic. The R.N.s do not give Lipodissolve. Estheticians don't do Lipodissolve. Cosmetologists don't do Lipodissolve. If the committee were...if this is something they're interested in, I think limiting Lipodissolve by...to the...or only by administering it from physicians or PAs might be a common-sense way to look at it, but to just ban it flat I think may be kind of...is an absence of commonsense. Dr. Schlessinger talked about it's banned in Brazil and banned in Kansas, and that goes back to the point I was just making. In Brazil, Lipodissolve or the injection of Lipodissolve was unregulated as to who could give the compound, and in Kansas it was also becoming very prolific. And it wasn't that Lipodissolve was ineffective or was dangerous. It was just that M.D.s were not using it. So again, I think that would be a more appropriate constraint. Even though I think, you know, I could get up and say all the, you know, the horror stories about liposuction and the disfigurement and the deaths, Dr. Schlessinger can talk about, you know, the Mayo Clinic visits, I think liposuction and Lipodissolve are both appropriate quivers...or arrows in the quivers of doctors in Nebraska and in the country for dealing with, you know, some of the real health issues of obesity in the case of liposuction but also just some of the body contouring and the self-esteem issues of weight in America. I do not know of eight or nine medical clinics in Omaha prescribing Lipodissolve. I, of course, may be completely wrong about that. I think there are two or three. I think there are two or three in Lincoln. Before these medical spas...and the medical spas developed as doctors were looking for ways...they've been so kind of crunched by the insurance companies to increase the cash part of their business. And as drugs like Botox and Juvederm, laser or vein therapy and some other cosmetic procedures have increased, medical spas have

increased. Before medical spas came to Omaha and Lincoln, Dr. Schlessinger, which I don't fault him for, had the market pretty well to himself. I think we've all seen his ads and his billboards, and he has a great business and he still does. As he did have the field to himself, all of our patients and the patients from the other medical spas are, for the most part, former patients of his. I'm estimating, at least from the two clinic medical spas that I deal with, that we're probably hitting his monthly revenue to the tune of about $50,000 to $70,000 a month, which I'm sure, you know, was not something that he expected or nor did, I'm sure, he expect that we would still be here and still be treating our patients with care. Finally, it is my understanding that Dr. Schlessinger has recently sent out an e-mail to all of his past and present patients announcing the immanent closure of all medical spas in Omaha because the Nebraska Legislature was going to outlaw Lipodissolve, and called this a triumph of patient's safety. This brought to mind several thoughts. One, at the worst I thought this was kind of taking advantage of Senator Pahls' generosity and good nature in sponsoring this bill. At best, I thought it was putting the cart before the horse. I think it also ignores the fact that it's my understanding that Dr. Schlessinger is being paid to administer Lipodissolve in a study...in an ongoing study to see whether Lipodissolve is effective in the shrinking in lipomas. And three, I think it ignores the fact that Lipodissolve is already becoming an obsolete technology in the fast-moving world of cosmetic medicine, which I guess in my former lawyer life I'd call kind of a non sequitur. The medical spa, at least in our case, Lipodissolve is such an edge, we marketed it heavily and it was a big part of our practice in the beginning. Now it's probably about 20 percent of our practice, and shrinking. And in fact, over the next six months we're going to be moving to what's called laser lipolysis where a laser actually treats the area of fat and melts the fat, and the largest clinic in Lincoln that provided Lipodissolve has already switched to laser lipolysis. So this seems to be more of a marketing ploy on Dr. Schlessinger's part to generate bad publicity for his competition in the Omaha and Lincoln markets. I also think this is a little bit of a rush to judgment. As I said, this is not a treat...this...as Lipodissolve is not a drug, this is not something the FDA will approve or not approve. The administration of Lipodissolve is the proper use of a doctor's discretion and training, which he spoke about, in treating patients. And, you know, the Health and Human Services Department or the Board of Medicine or the FDA itself, I think, would be a more proper forum for this measure if the...but another avenue might be just limiting the administration of Lipodissolve, you know, for the time that it's still around, just to medical doctors and physician assistants. Thank you for your time. [LB713]

SENATOR JOHNSON: Any questions? Senator Stuthman. [LB713]

SENATOR STUTHMAN: Thank you, Senator Johnson. Mr. Gale, is there any record of anything as far as when this is injected and it dissolves...it breaks up the fat, fat organisms, how far out in the body does it go? Does it have an effect of...if you...you know, two inches, four inches, your whole body? What are the effects on a long-term basis or will you regain that fat at a amount greater than it was to start with? [LB713]

DAVID GALE: I will give you my understanding of what happens. My wife has been treated with Lipodissolve. Can I say that? [LB713]

CHRISTINE GALE: You already did. [LB713]

DAVID GALE: Oh man, I'm in trouble. (Laughter) Now I'm in trouble. But...and her experience was we've had...she's had three kids. She has a small area of kids that you can do a million sit-ups and it didn't go anywhere, so the Lipodissolve injection goes right into the area. There's some localized swelling and redness and it does swell because it's the fat cells increasing, but it does not, in her case, spread to the rest of the body. And since the cells are actually, you know, exploded, she lost three inches off of her waist. She didn't lose any weight, but that's...Lipodissolve is really a body sculpting tool, not a weight loss tool. And, you know, as we screen it very carefully to make sure people aren't using it for weight loss, one thing we have found, and I think the material or the studies would back this up, it's in about 2 to 5 percent of the people, they don't get...it's not that they get an adverse reaction but they just don't get a reaction, and in those cases, in our clinic, we have refunded their money, you know, happily and quickly. And that's just been a few people. [LB713]

SENATOR STUTHMAN: I have one more question, Mr. Gale. [LB713]

SENATOR JOHNSON: Go ahead. [LB713]

SENATOR STUTHMAN: How long has this Lipodissolve been in existence or is this a compound put together of different chemicals? [LB713]

DAVID GALE: For my understanding, again, it's...the compound or the use of phosphatidylcholine originated in Europe. Lipodissolve, as a trade name, was developed by the American Society of Nonsurgical Aesthetics and the American Society of Aesthetic Lipodissolve, and it's actually a protected name that has a very specific training course and treatment course for just M.D.s before they can administer Lipodissolve. And for the companies that use Lipodissolve without going through this course of training and following the ASAL protocol, they are sued and actually fig. was sued by ASAL for infringing on the trademark of using the name Lipodissolve. [LB713]

SENATOR STUTHMAN: Okay. Thank you for your information. [LB713]

DAVID GALE: Sure. [LB713]

SENATOR JOHNSON: Is Botox approved by the FDA? [LB713]

DAVID GALE: It is. It was in 2002. [LB713]

SENATOR JOHNSON: Okay. Prior to that it was not and it was being used? [LB713]

DAVID GALE: Yep. It...and it was approved for uses other than what it was being used for. I think it was...and I may, again...I think it was originally approved for hyperhidrosis, excessive sweating underneath the arm. Now it's approved for this area of the forehead, not for, you know, the crow's-feet, but, you know, some practitioners might still use Botox for crow's-feet. So it's an interesting area of medicine. [LB713]

SENATOR JOHNSON: Yeah. I think, if my memory serves me correctly, that the active ingredients in Botox is the most toxic compound in the world. [LB713]

DAVID GALE: Yeah, botulinum toxin, I believe. Yes, sir. [LB713]

SENATOR JOHNSON: Senator Pankonin. [LB713]

SENATOR PANKONIN: Thank you, Senator Johnson. Mr. Gale, thanks for coming today. A couple questions: You've indicated that in your clinic a doctor administers these injections, correct? [LB713]

DAVID GALE: Or a physician's assistant. [LB713]

SENATOR PANKONIN: Okay, or a physician's assistant. [LB713]

DAVID GALE: Correct. [LB713]

SENATOR PANKONIN: Do you think some of your other competitors' clinics, is that the case throughout Omaha, as far as you know, or...? [LB713]

DAVID GALE: I couldn't say. I believe The Fountain, Dr. Elliott administers Lipodissolve solely at that facility, but I would just be speculating as to anyone else, so... [LB713]

SENATOR PANKONIN: Okay. The other question would be have you had some folks...you obviously indicated you had some folks that maybe were not satisfied with the results and you've refunded their...but have you had any that have had adverse medical conditions, in your opinion, and that needed further treatment or that you know of? [LB713]

DAVID GALE: As far as I know, no one has needed further treatment. One woman that I know of thought the swelling was more intense than she thought it was going to be and that was represented to her, despite the fact that everyone that receives Lipodissolve has to go through a one-on-one consultation with a medical provider, a half an hour long, to talk them through the procedure, and we have a very extensive, you know,

disclosure statement that they sign telling them of the risks and some of the reactions. But for her, the swelling was more than she expected and we also refunded her money. But she did not require any follow-up care. [LB713]

SENATOR PANKONIN: Okay. As you've indicated, this industry is going through or treatment is going through rapid change and that this particular procedure might not even...might be a moot point down the road. But in your industry, do you see...how do you see patients or just the issue of regulation so that, you know, from our standpoint, from the state of Nebraska, that people are being treated safely? What do you think is the key? [LB713]

DAVID GALE: Well, I think the key is to require all medical spas have a medical director that's a board certified practitioner in family practice or dermatology or surgery. And also the medical...oh, this...the medical malpractice companies require that. We actually are covered for the administration of Lipodissolve in our clinic. General Star Insurance from Seattle wrote our coverage and didn't have a problem with it. And we put it through a broker in California actually. But I think the key is to have a medical director and have...make sure that the malpractice insurance requirements for medical spas somehow don't fall through a crack so they somehow can't have the same coverage that maybe a doctor's clinic has. And I'm not...I don't know the technical details of that, but that would be, you know, what...we're very highly insured and I would hope that the other clinics would be also, but I don't know that to be true. [LB713]

SENATOR PANKONIN: Okay. Thank you for your testimony. [LB713]

DAVID GALE: Thank you. [LB713]

SENATOR JOHNSON: Okay. Any other questions? I see none. Thank you, sir. Any other opponents? Any neutral testimony? Senator Pahls, I believe that you're batting cleanup or some such thing. [LB713]

SENATOR PAHLS: Yes. Let me bat cleanup just for a little bit. [LB713]

SENATOR JOHNSON: All right. [LB713]

SENATOR PAHLS: I know this is the first bill, I think, of this session for you guys. Here are a couple things: I was listening to people testifying on both sides of the issue. It does appear that we need to make sure we give you a little bit more information. What I'm going to ask you, to be sure you read the two pieces of information that I did provide because one is from our own department. Even though they've not come up or down on this bill, there's some interesting information in there. And also the one from Kansas, I think they are...they're going to make some significant changes down there. I don't know all the ramifications of this particular procedure, but it does sound like we have some

issues. And I was listening to you, Senator Erdman. We do need to take a look at the bill and make it a little clearer, make it more effective by adding some of the dimensions to the questions that you had in front of you. The one thing I just want to point out is, as I'm listening, I'm almost saying, and I'm taking a quote from the Kansas...about third paragraph from the bottom--buyer beware, until we get this resolved. Thank you. [LB713]

SENATOR JOHNSON: Okay. Thank you, sir. All right, that closes the hearing on LB713. Thank you all. And let's move right head. Is Senator Flood here or a representative? Okay, you're the pinch hitter, huh? All right. Let's just take about 30 seconds and let the room clear. [LB713]

MATT BOEVER: Members of the Health and Human Services Committee, my name is Matt Boever, that's B-o-e-v-e-r, and I'm here on behalf of Senator Flood, who's at a Government Affairs Committee (sic) hearing right now. Senator Flood represents the 19th Legislative District, which includes all of Madison County, and his testimony is, to introduced LB730, is as follows. As you know, only EMTs, licensed physicians, registered nurses, licensed physician assistants, and licensed practical nurses can transport a patient in an ambulance. The problem is that in many rural communities across our state there are simply not enough medical personnel to operate ambulance service during the daytime hours. Patients in need of emergency care are needlessly waiting for transportation at the hospital. LB730 isn't Senator Flood's first attempt to find an answer to this problem. And over the last several years, he's met with many members of the EMS Board and the EMS community. In the interim, some members of the EMS community came up with the idea that became LB730, which he thinks is a step in the right direction. Under LB730, the EMS board would establish a curriculum for EMTs that would include a "skills competency tests." This skills competency test would be a hands-on or oral test of a person's ability to be an EMT. Senator Flood's thought was that this would attract more qualified people to become EMTs and in that way our rural areas of the state would be better served. Is LB730 perfect? I'd say the answer is no. But the answer is not to simply sit idly by. There's a real problem with lack of qualified emergency medical personnel in the rural areas of the state and the hope is that...to bring the medical and EMS leadership to the table to figure out an answer. Thanks for your consideration of LB730 and I'd be happy to answer any questions if I can. [LB730]

SENATOR JOHNSON: Any questions? Could I ask you to do this? And I realize you're a pinch hitter and maybe got notified ten minutes ago that you were, but can you summarize in two or three sentences what you would like...changes you'd like to make? [LB730]

MATT BOEVER: Well, LB730 would, instead of the national test for EMTs, would change it to a hands-on skills competency test that would be overseen by the EMS

Board. [LB730]

SENATOR JOHNSON: Okay. No other...I mean, that's basically the summary. [LB730]

MATT BOEVER: Right. [LB730]

SENATOR JOHNSON: That's fine. [LB730]

MATT BOEVER: That's the substance. [LB730]

SENATOR JOHNSON: Okay. Thank you. Okay. Thank you very much. How many people do we have who wish to speak on the pro side on this issue? May I see a show of hands? All right. How many would we have that will speak opposed to? Significant number. All right. Let's go ahead and proceed, and the...perhaps I've been a little bit slovenly here in not moving things along here fast enough, but let's try and move with all reasonable speed. Jerry. [LB730]

JERRY STILMOCK: Thank you, Senator. My name is Jerry Stilmock, S-t-i-l-m-o-c-k, registered lobbyist on behalf of my client, the Nebraska State Volunteer Firefighters Association, even though the title of the name is firefighters, it...the association represents statewide EMS at the volunteer level as well. Our association is opposed to the measure in LB730 and going away from a written test. Years ago, Senator Johnson is well aware of and perhaps others as well, there was a state test. That state test was prepared by Nebraska. It was issued and tested by Nebraskans and the stories somewhat go that if the person was close in passing the test but they had a couple of mistakes or misses that would prohibit them from passing the test, there was a sidebar, if you will, and the instructor said, you know, if you only did this you would pass--and at least those are the stories that are handed down--and therefore it was somewhat result in the failure of the Nebraska authored test. Lo and behold, we have the national registry test. National registry is located in Ohio. There are 44 states, I'm told, in the country that use the national registry. The question is why the national registry. The biggest reason seems to be for transferability between the states. The backdrop of what's happening at the national level is the standards are being rewritten. They're being retooled. This has been a process that started since the year 2000. When September 11 struck in 2001, and then subsequently Katrina, the educational experience by those in EMS was that the commonality, that's the goal of...in a terroristic or a natural disaster where several entities are coming from throughout the country, they weren't speaking the same language, they weren't trained the same, they didn't act the same, they didn't look the same, and they didn't respond the same. And so that emphasized at the national level, the federal level, maybe we need to get some common ground. So the process started in 2000 and, lo and behold, these two catastrophic events occurred and the focus had shifted then to what we need to do at the national level to assure that people are being well trained and, most importantly, that

the citizenry is receiving the best emergency medical care possible. To fast-forward, it's anticipated that the standards that have been circulated now in the past couple of years, those will be finalized in the year...this year, latter part of the fall, and it will take about two years in order to implement. So in the fall of 2010, the national registry expects that they'll be able to begin testing of the new protocol. So what's the problem with Nebraska? Nebraska, I'm told by the national registry, is in the upper one-third of passing the national test. It has a passing grade of about 73 percent as of the calendar year 2007. But to leave and go to an oral type of testing, I think it just opens up Nebraska to exposure. When I completed my conversation with the executive director of the national registry, and I posed the question that brought about the history of what this committee has been doing with first responders being able to transport, and I said, okay, I'm not in Cincinnati, Ohio, I'm not in Phoenix, I'm not in Chicago, I'm in a small rural setting in Nebraska. We have a first responder out there. As Mr. Boever testified to at the beginning, this bill was brought about because of the issue of first responders' inability to transport a patient. And so I posed the question to him and the history, of which you know: there's a catastrophic event, there's only a first responder, first responder is not able to transport under the protocol and under the curriculum of which they study. But the sequence of events that happened after that first responder is on the call prohibits them, even though there's nobody else on the way, even though there's no mutual aid on the way and even though that patient may need immediate care, that first responder, receiving the lowest level of training education, is strapped with two issues, one legal and one moral: If I do not act I'm going to have consequences; and how can I let the neighboring rancher or the neighboring farmer be in critical condition without taking action? If I do act, then I act outside the scope of practice of what I'm trained for. What's going to happen to me and my home and everything else because I'm a volunteer? As I listened to the gentleman's response, he said we have to remain flexible, you have to be flexible. So I outlined for him some of the different ideas that we've talked about and I don't think what is being proposed at the national level...that's pretty much being crammed down our throat. Why is it being crammed down our throat? Because if, for example, we would say we would go to a Nebraska authored written test, and because of the involvement of the terroristic and the catastrophic events and Homeland Security jumping into play, it's my understanding, from what others in my discussion and research have told me, that if you run a Nebraska-only test then Homeland Security, when it's doling out federal grants and dollars, is going to look at that grant application by the state of Nebraska or some organization as a EMT service in Nebraska and how are you certified under your training. Well, we have our own authored test. It's administrated by a provider, XYZ. It is a part of the national registry? No, it's not. What I'm told anyway is that that will have an impact negatively on the ability of Nebraska to obtain federal funding. So the carrot out in front of us is to maintain the national registry in its revamped and its format that it's changing that's occurring the next couple of years. But the backdrop is we still have the same problem with a rural setting and the ability to have people serve in their communities when we rely on 90-95 percent of the task...the working force out there in EMS services are

volunteers. For all of those reasons, it's a tremendously important issue, but for the reasons as I've outlined that our association opposes LB730. [LB730]

SENATOR JOHNSON: Any questions of Mr. Stilmock? Yes, sir. [LB730]

SENATOR STUTHMAN: Thank you, Senator Johnson. Mr. Stilmock, you gave the situation of the rural rancher, an accident, and a first responder out there. And you had the one situation wasn't good, and the other situation, because they couldn't transport, you couldn't really take him. What would be a reasonable answer to that question? [LB730]

JERRY STILMOCK: On one side of the table is... [LB730]

SENATOR STUTHMAN: I don't want to hear the one side of the table or the other side of the table. [LB730]

JERRY STILMOCK: Okay. [LB730]

SENATOR STUTHMAN: I want to hear what should be done when that rancher is laying there with a broken neck and he's the only one within 50 miles to transport him to a hospital? [LB730]

JERRY STILMOCK: My opinion is that you establish a protocol with your health director. Your health director has to be a physician. And that protocol established ahead of time is you have checkoffs. Number one, is the group that you belong to, is that licensed to transport? The answer is yes. Number two is, have you checked with mutual aid through dialing 911 or through your dispatch? Have you communicated with them? Is there anybody with a higher level of training on their way? No, they are not. What's the nearest location that you might receive backup? It's an hour away. What's the critical nature of the patient? It is critical. How do you know that? Because I've been taught, as a first responder, to do assessment. Dispatch, you have my medical director's cell phone number; you have means to communicate with him. Dispatch, you get that medical director on the phone and you tell him the circumstances and the protocol that have been established ahead of time. What's the nearest mutual aid? Is there anybody available? Is there anybody on their way? Because I know in Platte Center if everybody commutes into Columbus, and in Platte Center the circumstances which you described, you're going to say...I would think one would say, don't leave me here, get me there. So with the protocol set up in advance of have you done this, have you done this, have you done...and so we get to an extreme bottom level circumstance that this is what we've prepared for, then the physician would direct dispatch to say, yes, transport. And at the same time, you would have that company, that volunteer, whether it's private, whether it's paid or volunteer staff, coming from the opposite direction to be able to meet and intercept and jump on...jump on, to enter the ambulance and then continue on. But

without that protocol established ahead of time...and the most important thing, as we heard in the 1990s, that this had to be...EMS had to be flexible for all different areas of Nebraska, and that's why the idea of an advanced protocol that involves direct communication by dispatch going to the emergency or to the medical director of that particular service, of that particular volunteer department in answering and also, most importantly, to answer the question of what's the condition of the patient. [LB730]

SENATOR STUTHMAN: What if this injured person is in a valley or something where there is no access to cell phone coverage? And there are a lot of those areas, I'll tell you that, a lot of those areas. [LB730]

JERRY STILMOCK: Yeah. [LB730]

SENATOR STUTHMAN: And you don't have to answer that, but that's a real concern. [LB730]

JERRY STILMOCK: Good. I'm going to sit back then. (Laugh) [LB730]

SENATOR STUTHMAN: That's a real concern of mine. What I think this bill is trying to address is that with some training that would give another person, you know, the opportunity that he could transport somebody in there because he would have taken the test, and the fact is the time involvement to be an EMT in the rural areas, the commitment of hours of training and everything and to get volunteers to do is almost impossible. [LB730]

JERRY STILMOCK: It is unbelievable. [LB730]

SENATOR STUTHMAN: Almost impossible to do. [LB730]

JERRY STILMOCK: I like your words better--unbelievable and impossible. The national registry is geared on 120 hours. [LB730]

SENATOR STUTHMAN: Uh-huh. [LB730]

JERRY STILMOCK: What's coming at Nebraska, along with all the other states, is 150 hours and that you're going to take at least six months of time, two to three evenings or perhaps a Saturday in that six months to say good-bye from 6:00 p.m. to 10:00 p.m. and obtain the training. [LB730]

SENATOR JOHNSON: Jerry, what was it in the original? Was it 60 hours or...remember what it was? [LB730]

JERRY STILMOCK: I don't, but that was...you know, in the reading that I've done with

the standard, I think, you know, we go back to the seventies. I think that's probably right, 1970s. [LB730]

SENATOR JOHNSON: It might even have been as low as 40. I can't remember, but it was a relatively small number which, you know, putting in an evening a week for three months or four months, why, you would have it taken care of, and now it's almost a freshman course,... [LB730]

JERRY STILMOCK: True. Very... [LB730]

SENATOR JOHNSON: ...in fact. Yeah. [LB730]

JERRY STILMOCK: I capsulized. In response, Senator, don't tell me one side or the other, tell me; so I said my opinion. That's my opinion, not of that of my association because my association is split on what to do. So I came up...now I'm going to back up. I represent my association. My association is not square on in support of what I outlined for you in protocols. That was just one solution, in attempt to be courteous to answer your question, Senator. [LB730]

SENATOR STUTHMAN: Thank you, and I appreciate that. [LB730]

JERRY STILMOCK: Yes, sir. [LB730]

SENATOR JOHNSON: Well, Senator Stuthman, and the other thing about it, and the unfortunately, so many people that are the head of these organizations are from Chicago, St. Louis, San Francisco and so on, and they just don't get it when you tell them that it's 300 miles to this type of physician or this type of care or whatever, and they just don't understand that and that we're talking all volunteers instead of all paid personnel. And so it's a difficult thing. [LB730]

JERRY STILMOCK: It is. It is very different. If I may, senators, two additional comments? Senator Stuthman, the protocols and so forth, those would only occur, in the conversations that we've had with Senator Flood, those would only occur after the medical director has signed off on that first responder and only after the first responder has demonstrated to that medical...the physician in charge of that volunteer service, only after the physician has signed off on that volunteer that they have done additional training to allow them to do the additional items it would take to be...to transport. It's not the best solution. EMTs are not trained in a lot of different areas. They're not trained to put on a simple C-collar. Well, how important is that? As a layperson, I don't know, but I'd tell you if you have a...I would imagine if you have a broken vertebrae and you're messing around with it, you go from bad to worse. And I know...I have a feeling the folks behind me are biting at the bit to say exactly that, and as a routine of a task as it may appear to me or perhaps to you to place somebody onto a cot and load them into the

ambulance, it becomes very critical depending on the nature of the injury. And if a person would vomit and a person as a first responder doesn't have training for clearing that air passage, what to do, that's a huge concern to everybody. But I tried to answer your question, Senator. The second point and final point that I would have, please, for the senators, in my conversations and research, I spoke with as many other people as I could get to wrap our hands around this issue because I cannot believe it's Nebraska only. I spoke to the state of Idaho and the medical person in charge of that and he described a situation in which first responders don't transport. But because first responders are the only type of unit that has four-wheel drive vehicles that can make it up into a mountain to retrieve a patient and then bring them down the mountain in order to pass them off, it's not transporting but yet that's what they're doing in Idaho, at least one other state, to try to deal with the issue of they don't have EMTs, as explained to me, they don't have EMTs with the vehicles in order to access the mountains. Somebody has to bring them down to the mountains. Those are first responders that have four-wheel drive vehicles. And some other state is making it work I guess, senators. I stopped twice and then there was questions and I got started again. I better quit. [LB730]

SENATOR JOHNSON: Well, no, and good comments and kind of reminds me that about 40 years ago now the national head, who started the EMTs, was from Sargent, Nebraska. So kind of an interesting little thing that we've evolved now to the point where it's difficult for Sargent to have a unit. All right. Any other questions? Jerry, thank you very much. [LB730]

JERRY STILMOCK: Thank you. [LB730]

SENATOR JOHNSON: Next, please. [LB730]

BRUCE BEINS: Good afternoon, senators. My name is Bruce Beins, it's B-r-u-c-e B-e-i-n-s. I'm an EMT from the small village of Republican City, Nebraska, in south central, a town of about 190. I also am here representing the Nebraska EMS Association, which represents over 2,000 EMS providers in the state. Jerry kind of took some of my thunder on some things, but it seems like we got off and started discussing the first responder bill instead of LB730. LB730 does three things. One thing it does, it changes some of our titles. Calls our first responders emergency medical responders. EMT stays the same. Our intermediates go to advanced EMTs. And paramedics go from being emergency medical technician paramedics to paramedics. That's all fine and dandy. I like to say I don't care what you call me, just call me. But the second two parts of this bill really make the first part moot. The second part does away with any references to our national standard, which is the Department of Transportation curriculum. The Department of Transportation curriculum has evolved over the years. As Senator Johnson knows, that's where Jerry took some of my thunder because I also keep archives for EMS and can see Senator Johnson's name pop up now and then,

including on the Kearney Volunteer Fire Department's web site. Talks about how Senator Johnson helped teach the first EMT classes in the state of Nebraska, which was at Kearney Fire, was one of the first go-round. I believe that would have been in the early seventies. Dr. Kenneth Kimball (phonetic), which was also from Kearney, was on the national boards that helped establish a standard after the Highway Safety...Highway Traffic Safety Act of 1966 that recognized that we needed a standard. We needed some sort of standard to train people to because every state was doing their own thing. Funeral homes were picking people up. So we established a national standard and, like I say, that has evolved a little bit over the years. If we go away from that standard, if we lose that we lose the textbooks, because the textbooks obviously are going to follow the national standard, so we lose any ability to have textbooks, audiovisuals, lesson plans, so forth. It would all have to be developed on our own. The way the statute currently reads is, is that we accept the DOT standard until modified by rule and regulation. The EMS Board has done that. They've modified the national standard to suit Nebraska, to give us the practices and procedures and skills that the people in our communities wanted us to have. So we have been able to do that with the traditional or the existing national standard. Yes, that standard is going to change. I sit on a committee for the National Association of EMTs looking at the new educational guidelines and, as Jerry said, it's still in a draft form but they did put out a 150-hour estimate of a minimum amount of hours. When you really break that down it's really not much different than what we're doing now because that 150 hours would bring into the class CPR training, which is now outside the class. It would also bring in hazardous materials training, and NIMS training, which is national incident management which all cities, villages, so forth have to have in order to be able to get federal funding now, too, through Homeland Security. So that brings all of this into the class. So going from what is a 120- to 130-hour course now to what will be maybe 150-hour course is really no different than what these same providers have to take in training now. They just don't get it all in the EMT class. They do the EMT class. They got to have CPR first. Then they have to make sure they have HAZMAT training. They have to make sure they get their NIMS training. So the training hours aren't really changing that much. The second thing that this bill would do would be to say that we had to create a skills- or oral-based testing for first responders and EMTs only, doesn't address the advanced providers at all. I don't want to say that that's not an intriguing idea, but to say that we're no longer going to test knowledge at all is really kind of scary, because one of the things we want to do is protect the public. So not testing somebody's knowledge, I can teach you a skill on how to put on a neck collar, but without knowing whether you have the knowledge to be able to apply that when you need to apply it is kind of a scary proposition, and that's the first thing they taught us in EMT class is the same thing I think they teach the doctors, too, is first off, do no harm. So you have to have the knowledge and we have to have someway of addressing whether or not this person has the knowledge and the skills to become an EMT. As Jerry said, and I had a little different number than he did but I liked what he said about that we're in the top one-third in the nation passing the national registry, so we don't have a problem right now testing. I had 83 percent, is where

Nebraska is passing the national registry. I want to kind of slip back now and talk a little bit from Bruce the EMT from the town of 190 people, because we do have a recruitment and retention problem. I mean, this problem hasn't gone away and we're shooting arrows all the way around it, but it seems like we can't get people to look at some of the true issues. In some of our rural squads, our number one thought is need to provide care to our people in our town. We don't have any egos about that. We also don't have any bodies. Making a simpler test, degrading or downgrading the testing or the training isn't going to help towns like Republican City because we don't have any bodies there. So we need to look at some other things that's going to help be able to provide that safety net for these services that maybe are struggling. And that's what concerns us, is if Republican City gets to the point to where nobody answers our call, then what can we do to protect our citizens? Yes, we have mutual aid agreements to where towns surrounding us will come to our aid if nobody can answer the call. But some of those same towns aren't much better off than we are. And so if we give it up, that puts more burden on them. They're in trouble. Who eventually is going to be responsible for making sure the citizens do have that care? There's nothing in statute that says anybody has to take care of EMS. It's in statute that you have to have a fire department. Most of our fire departments are doing 90 percent EMS and a small amount that's fire. Thank goodness. Thank goodness. But we need something in statute that says we need to make sure that EMS is provided in some way, shape or form, some controlling authority. To make these changes in this bill, I applaud Senator Flood for bringing this forward, we need to have more discussion and more talk about a lot of these issues. I've been coming before you guys for about ten years now talking about the problems of recruitment/retention. Yes, it would be a risk that we would lose federal grant money if we didn't follow the standard. The cost of maintaining...of developing a curriculum, a test, maintaining that test, keeping it secure, trying to protect the public is fairly high. The fiscal note I believe you have in front of you, you know, looks pretty big to me--$219,000, $185,000. That's about as much money as we get from the Legislature now just to train people. So to put that much more out just to test them, I think the money would be way better spent on some other recruitment and retention ideas. Other things that have been brought forward in the past, the EMS Board does their five-year report to the Legislature, 2004, and it listed out the things that the board was doing on these problems and the things that they felt that the Legislature could also help with. The only one that really I've seen come forward was killed last year, is back this year, is to provide some sort of a benefit to volunteers that are active in their rural communities and that would be to give a $500 tax credit. It was killed fairly quickly last year, it's back again this year, but the idea has some merit. In my area, we have people that have been EMTs for 25 years that have let their certificates lapse, have got off the services because they just, you know, they were tired; they, you know, felt like they couldn't do it anymore or didn't want to do it anymore. We need to find something to keep those people there, and maybe $500 would be enough to recruit some of them, to keep some of them on service, or some other type of benefit or break for the thousands and thousands of dollars of service they're providing their communities. So with that, I

appreciate you giving me your time here. I would like to answer Senator Stuthman's question, if he'd allow me to. [LB730]

SENATOR STUTHMAN: Should I give you the question right now? [LB730]

BRUCE BEINS: You can or I want to answer the one you gave Jerry. [LB730]

SENATOR STUTHMAN: Oh. Yes, you may, and then I'll ask you another one. [LB730]

BRUCE BEINS: Jerry answered it--and let me poke fun at Jerry a little bit--he answered it like a lawyer. I'm going to answer it like Bruce EMT from Republican City. And if I'm down in that gully with somebody that's hurt and there's no way that I can get, you know, anybody to me or whatever, what am I going to do? We're going to do the right thing. We have that ethical decision that we have to make and, number one, we always make our decisions in what's the best interest to the patient. That's what we're taught from the first and that's what we're going to do. And if I violate a rule and regulation, I guess then, you know, somebody is going to slap my hands or shake their finger at me, tell me not to do it again. But as long as I can, in my own heart, say that I'm doing that for the best interest of the patient, then we're not going to worry a lot about the protocols and the rules and regulations. Now it would be great if I could get a hold of my medical director and that way he could take some of the liability off my back by telling me to go ahead and do this, but if I can't, we're going to do what we did back in the fifties and the early sixties, is we're going to throw them in the pickup and we're going to haul them to the hospital. [LB730]

SENATOR STUTHMAN: Thank you. [LB730]

BRUCE BEINS: That's my answer. [LB730]

SENATOR STUTHMAN: Thank you, because that's what I would do also. [LB730]

BRUCE BEINS: Yeah. [LB730]

SENATOR STUTHMAN: The question that I had for... [LB730]

SENATOR JOHNSON: Go ahead, sir. [LB730]

SENATOR STUTHMAN: Thank you, Senator Johnson. [LB730]

SENATOR JOHNSON: We're waiting. [LB730]

SENATOR STUTHMAN: You made the statement that was as a legislative body should make sure that, you know, all of these areas have EMT or EMS, emergency medical

service, or an EMT... [LB730]

BRUCE BEINS: Have coverage. [LB730]

SENATOR STUTHMAN: ...coverage in their area. How are we going to do that? [LB730]

BRUCE BEINS: I don't know, but I think you could look at some of the surrounding states, and Kansas comes to mind. Kansas, I believe, leaves it up to the authority of the county board. Now I think they exempt their larger class cities, like what we would with Lincoln and Omaha, but the county board can either tax money to support the volunteers, they can hire a third party service to come in and do it, or they can start their own service with county personnel as EMTs, so forth. Maybe they would also support a hospital-based service that would come out of a hospital. We have a lot of services in this state. In my area, every 10 or 15 miles we have another ambulance service and they're all struggling. If we could band together countywide, we wouldn't necessarily have to lose our little squads in our little towns but at least we would have the backup and some taxing authority to buy ambulances that are now $100,000. It would sure take a lot of pressure off of these small towns and then maybe that would also help the recruitment and retention somewhat too. Because as county employees, you have benefits. But then there again, where are we going to get the money in our counties? [LB730]

SENATOR STUTHMAN: Property tax. Thank you. [LB730]

SENATOR JOHNSON: Any other questions? Yes, Senator Erdman. [LB730]

SENATOR ERDMAN: Bruce, good to see you again. Three parts of this bill. I think two of them are probably innocuous, and one of them is the fact that the board could adopt the federal standards. Could they not? [LB730]

BRUCE BEINS: The new federal standards? [LB730]

SENATOR ERDMAN: Well, whatever standards are in place. [LB730]

BRUCE BEINS: Yes. [LB730]

SENATOR ERDMAN: You could adopt that by the board. [LB730]

BRUCE BEINS: Until modified by rule and regulation, yes. [LB730]

SENATOR ERDMAN: You could maintain...you could change the language that the Legislature is adopting in statute to leaving it up to the board if we wanted to. [LB730]

BRUCE BEINS: Exactly. [LB730]

SENATOR ERDMAN: And there's nothing that says that the board couldn't adopt the existing standards or the new standards. They would still be the national standards. [LB730]

BRUCE BEINS: Exactly. [LB730]

SENATOR ERDMAN: The real rub is on the oral-based or skills-based test. [LB730]

BRUCE BEINS: That, to me, yeah, that's the two big problems. [LB730]

SENATOR ERDMAN: Help me understand why that...what issue that solves in practice. Is it not the first responder issue that we're trying to address by changing this process? [LB730]

BRUCE BEINS: I don't see that this changes the first responder issue at all, because it says nowhere in that bill that a first responder can transport patients. [LB730]

SENATOR ERDMAN: Because that section is in LB244... [LB730]

BRUCE BEINS: Exactly. [LB730]

SENATOR ERDMAN: ...which we've yet to hear what the resolution is on that. And based on your last comments, has there been any resolution on that? [LB730]

BRUCE BEINS: There has not. As the way...I'm not part of the focus group, but as the way I understand the focus group's discussions with Senator Flood, he kind of latched onto this idea of getting away...getting around or getting away from a national registry test and testing people with skills, thinking that that would bring more people into the ranks of EMTs. [LB730]

SENATOR ERDMAN: So it's a matter of adding instead of retraining, adding new folks instead of retraining the ones we have or possibly providing a variance for those to transport that may not have the training now. [LB730]

BRUCE BEINS: Exactly. Exactly. [LB730]

SENATOR ERDMAN: And I am very interesting in resolving some of these issues that appear to be coming from northeast Nebraska from Senator Flood. And I got an e-mail, and I'll have to go reread this because I may have misread it, but I've got constituents or people in western Nebraska that support LB730, and they're EMTs, and I'm trying to

figure out what they're missing. Or I have to go, like I said, reread their e-mail, but I just...I find this amazing that we keep coming back to this discussion and your example appears to be logical. Your situation is we're going to take the person in the LB244...LB244 provision and say we're going to transport them; we're going to provide that opportunity. Jerry's comments were we have an obligation morally and in some states they have a physical limitation of being able to go to places and bring those individuals, to be met in an intercept, to be able to be delivered to the location. I'm wondering why it is that if it's that obvious, sitting here today in front of the committee, why it hasn't been that obvious for the last however many years that Senator Flood has been working on this. And I...maybe I'm just not connecting the dots, but if it's that obvious sitting here today, why do we still have bills laying around and why don't we have a resolution in front of the EMS Board and the focus group to try to resolve that issue? I'm trying to figure out where LB730 fits into that because I've got to think that if we would resolve LB244, LB730 wouldn't be here. So I'm just...I'm just thinking out loud and, you know, last year the Speaker wanted to advance LB244 to the floor and I said, no, we'll send a letter and we will say if you don't resolve this we will pursue it. Because I am tired of sitting here every year and listening to the same discussion, as I'm sure you are. We need to be beyond these discussions and get to the ones that you're talking about, about how do we keep people in these occupations, how do we provide the right opportunities for rural communities to have volunteers or services that we all need to make sure that we have the types of opportunities for our citizens to be taken care of medically and provide the opportunity for them to receive those services. So I'm just interested or curious or you pick the... [LB730]

BRUCE BEINS: Can I give you just a... [LB730]

SENATOR ERDMAN: Yeah, you can... [LB730]

BRUCE BEINS: ...a real short answer? [LB730]

SENATOR ERDMAN: ...you can have the soapbox, because I've been monopolizing it. [LB730]

BRUCE BEINS: And this is something that I almost hate to say in a hearing. It appears that there are those that have the senator's ear that want to do away...or I should back up, that want anybody that wants to be an EMT should be able to be an EMT, period. Right now we're losing two out of ten because they can't successfully complete the training and the testing, and a lot of us would like to have those two people. I mean, we need those two people, but should they really be EMTs, is the question. And we all know in all professions not everybody is cut out to do every single thing and it's unfortunate and I feel sorry because I am in a small town that has critical needs for EMS people. But also, my service doesn't want to put people out there taking care of our public that aren't qualified to do it, that don't have the knowledge and the skills to do it.

We don't want to do that. That's, you know, that's downgrading. It can be dangerous. So we don't want to take that step backwards with the level of care we provide. We want help to be able to provide the standard, and the standard is a minimal standard. We're not making people experts in EMS. We're training them and testing them to a minimal standard and then hoping, through continuing education, that they hone those skills and they get better at the things that they're going to use and improve from there. But one thing I want to tell you, too: I don't know that it's possible--and I'll talk about my town here--that the little town of Republican City is always going to be able to keep an ambulance. It's unfortunate, but society is changing. People are moving from rural to urban and does every little town deserve an ambulance? Well, yeah, if their public wants to pay for it they probably do. But can we make that happen? The way the system is set up right now I'm not sure that's possible. I think we're going to have to eventually move to more regionalized, maybe a higher level of care, but if you want to live in a little town like Republican City you're going to have to get used to waiting 15 minutes for the ambulance because it's going to come from the county seat or from the local hospital or something. I mean we're talking something that's probably going to happen in the future, but unfortunately some of the issues that were brought up with LB244 and with this are issues that probably can't be fixed, probably shouldn't be fixed. Because I'm afraid by doing something like this we won't be fixing them; what we'll be creating is a monster that could be worse than them taking the written test. If we have to try to assure that these people are competent through skills and oral testing versus sitting down to a computer and taking a written test, you may be four hours in front of a board getting grilled on your knowledge to determine whether or not we can trust you to go out and treat people. So I, like I say, this is not the answer. [LB730]

SENATOR ERDMAN: You know what they call... [LB730]

BRUCE BEINS: I mean, the question is still is out there, but this isn't the answer. [LB730]

SENATOR ERDMAN: You know what they call the individual who graduates last in his medical class? [LB730]

BRUCE BEINS: Doctor. Yes. (Laugh) [LB730]

SENATOR ERDMAN: At least he graduated though, right, he or she? [LB730]

BRUCE BEINS: Yes, that's right. That's right. [LB730]

SENATOR ERDMAN: Okay. [LB730]

SENATOR JOHNSON: Quick question: If there's 40,000 people that show up on the 4th of July to go on Harlan County lake, who's going to take care of them? [LB730]

BRUCE BEINS: Right now? [LB730]

SENATOR JOHNSON: Yes. [LB730]

BRUCE BEINS: That would be me. (Laugh) Honestly, Senator,... [LB730]

SENATOR JOHNSON: Just wanted to point that out. (Laugh) [LB730]

BRUCE BEINS: ...one of the recruitment and retention issues is mutual aid, and there's nothing really in statutes or anything that says we have to have strong mutual aid agreements. Most of us do in some way, shape or form, but those need to be strengthened, either through regulation, or legislation if not regulation, to where that would be one way of assuring that the people of Republic City are covered; is that it was mandated that if Republican City didn't answer that somebody else was going to, so that somebody was going to cover that call. [LB730]

SENATOR JOHNSON: Well, you know, I think we better move on. But, you know, I guess I can't help but think that somewhere here, and probably pretty soon, we better be thinking of the stimulus packages that we can come up with to get people to become EMTs and so on. We're asking an awful lot of these people. And as the demographics change out there, here's a change of 145 taking care of 40,000 people. And so there's a lot more to it than sometimes we think, so... [LB730]

BRUCE BEINS: And in 85 percent of the state, the only thing they get for that is the warm feeling in their heart... [LB730]

SENATOR JOHNSON: Yeah. [LB730]

BRUCE BEINS: ...and that's not enough for the young people coming up. [LB730]

SENATOR JOHNSON: Well, and maybe it shouldn't be. Thank you very much. Next, please. [LB730]

MIKE BUSCHER: (Exhibit 1) Afternoon, senators. My name is Mike Buscher. I'm a current member of the EMS Board and I will be back next week or next week, yes, to...I've been reappointed by the Governor. My last name is Buscher, B-u-s-c-h-e-r. The EMS Board met and voted to oppose this bill and to clarify, most of the stuff is on the handouts but I won't read it all the way through because Bruce covered most of it. So in just little point...and I want to be clear that the board looked at the bill, you know, and what problems we seen and how to, if the bill would pass today or during this legislative session, what burden it would put on us. So that's a lot of it, and the problems we seen with the bill, so...and that's where that I believe that why we voted to oppose the bill.

Just starting from the top, the bill didn't address existing EMS personnel. You know, it added some. What do we do with the first responders we have? Do we change their names? Do we make them emergency technicians of what sort? It didn't...it didn't clarify that. In the second paragraph, if we go through that real quick, looking at it, it talks about the DOT and Bruce kind of covered that, that we do have the power right now. If we want to stay with the DOT we can, so we don't see no reason to change the bill. So down at the bottom part, one of the parts of this new bill is it says license sections and adopt. It appears that regulation change to adopt current every year. If we have to look at this and adopt new changes every year, it takes a year and a half to get any changes in by the time we do public hearings, form a committee to draft the changes, and do that. Then it comes back. It goes to the legal and then it goes to the department head. To go through all that procedure takes us a year and a half. It would be almost impossible to do this on a yearly basis. The skills, I think we talked about that to go to a skill-based testing. There would be a lot of, you know, somebody sitting down, taking oral exams might be harder than actually if they had to sit down and take a multiple choice test, so looking at that part of it. And basically as a board, and I sit on the board, my biggest concern is the safety of the citizens of Nebraska. You know, that's what we're looking at. We know there's big problems in having people. Is nobody coming or, you know, is somebody there that's not qualified? Could do more harm than good, so we have to look at that. And then the last part it talks about that this...the bill states that it would go in effect December 1, 2008. Going back to the year and a half thing, and then also writing up new curriculum, none of us on the board would be able to sit down and maybe write up these curriculums. You know, this takes expertise person to do that and, you know, the board is made up mostly of EMTs, paramedics, EMS instructors that most of them don't have teaching degrees, so this would create a big problem. And then same as before, we'd have to get it approved, have to have public hearings, have to get approved by the legal department and department head. So would just, you know, be a big burden on it. [LB730]

SENATOR JOHNSON: All right. Any questions? [LB730]

SENATOR STUTHMAN: Thank you, Senator Johnson. Mike, you serve on the EMS Board? [LB730]

MIKE BUSCHER: Yes. [LB730]

SENATOR STUTHMAN: The members of the board, are they from the state of Nebraska? [LB730]

MIKE BUSCHER: Yes, all, all members. [LB730]

SENATOR STUTHMAN: Are there any from a real small community or town like 50 miles away from the next small town? [LB730]

MIKE BUSCHER: Oh yes. The board is made up...they made the board up, it's a 17-member board. At least five people come from each Congressional district. That's how the board was originally made up so there would be a representation from all across the state, so no area would be left out. [LB730]

SENATOR STUTHMAN: Okay. Thank you. [LB730]

SENATOR JOHNSON: All right. Any other questions? Sir, thank you very much. [LB730]

MIKE BUSCHER: Thank you. [LB730]

SENATOR JOHNSON: Let me make note...and come right up, sir...a letter from Warren E. Shaulis, and I hope I pronounce it correctly, S-h-a-u-l-i-s, and we'll enter that into the record as well. (Exhibit 2) It's from the Mitchell Volunteer Fire Department. [LB730]

GENE BRADLEY: (Exhibit 3) My name is Gene Bradley, G-e-n-e B-r-a-d-l-e-y. Senator Johnson, members of the Health and Human Services Committee, I am the director of Pro-Med EMS in Falls City, and we provide advanced level...advanced life support transports and critical care transports in southeast Nebraska, and our service was formed by the need to provide those transports to the city. Today I am here as a representative for four separate organizations: the Professional Ambulance Association of Nebraska, which I am the current president of; Nemaha County Hospital in Auburn; Community Medical Center in Falls City; and the Nebraska Hospital Association. And on behalf of those organizations, I ask that you oppose LB730 as it pertains to right now. While we greatly appreciate Senator Flood's ongoing efforts related to EMS recruitment and applaud his continued focus on the EMS areas of concern, LB730 is not the best avenue for Nebraska's EMS system. I will now highlight why I feel some of that...some of the parts of the bill are all right. LB730 eliminates the written test that ensures competency for EMT-Bs and the first responders. We have used numbers here today for the national registry of 44. I have 35 in mine, because the national registry, you can, as states, can choose at what levels they want to test. Not all states test every level with the national registry. Some only test the paramedic level, so my number is different than some of those been given before. But there is all 44 states require some form of written testing that use the national registry. There is no state in the nation that does not have a written test to provide competency for that. Since the national registry has just recently went to computer-based testing for the written test, we have seen those pass rates actually go up, and they have also gone up in Nebraska. The Legislature has the ability to compromise the high quality of patient care provided to Nebraskans. While the skills test demonstrates that a person can perform the skills, the written test is the mechanism designed to ensure that they understand why they are doing the test...or why they're doing the skill, and without that knowledge there can be life or death consequences.

The root of the issue, as Bruce mentioned, is that there is no one agency that is responsible for EMS in the state right now. If the volunteer squad in Falls City decided today that they were no longer going to be able to provide service, there is no backup for that. There is no one responsible for providing EMS in the city. If squads were just held accountable to the established emergency medical services regulations already in place, every community would have some form of coverage and there would be a backup plan if that primary coverage was not able to respond. EMTs and paramedics are also being integrated more and more into the hospitals in the state. My service is one where we're not transporting on ambulances. We're manning the emergency room and helping care for patients on the floor and in the surgery suites, and helping deliver babies. Hospitals trust in our skills and our knowledge base. There is no group better at triage and initial patient stabilization than EMTs and paramedics. The lack of a formal testing process could have far-reaching implications, and hospitals need to know that caregivers have the ability to meet the needs of their patients and the communities. Leaders of the EMS community must join together and work with Senator Flood to find a resolution to recruitment and retention that does not lower the standard of care for the citizens of Nebraska. Senator Flood's proposed changes to the EMT basic licensure and the first responders may have some merits, but this bill puts the proverbial cart before the horse and we need time to research this and figure out what will work that won't endanger the citizens. We have faith in Nebraska's EMS system and we believe we can work together to achieve this. And I'd like to answer your question, Senator Erdman, earlier. I was on the focus group that worked with Senator Flood. We met with him in December. He had said at that time that he would put LB244 on hold because the real crux of that issue was the fact that there was not enough EMTs in his area to answer the calls, and the reason that there wasn't enough is that they were unsuccessful in passing the test. And the...was that they could get through the course and they would pass the course successfully, but then they couldn't pass that national registry test at the end of that. So the issue with the first responders was let's let them transport, but with this, he thought maybe this would be a mechanism that would allow more people to receive their EMT license and build those numbers. So it was trying to fix LB244 without requiring Legislature to allow first responders to transport. Some of the questions that were brought up earlier, I'd just like to address a couple of those, is... [LB730]

SENATOR GAY: Gene,... [LB730]

GENE BRADLEY: Yes. [LB730]

SENATOR GAY: ...unless a question is directed at you, don't...let's don't answer those other questions, okay? [LB730]

GENE BRADLEY: Right. Okay. [LB730]

SENATOR GAY: It's getting late in here. Okay. Thanks. [LB730]

GENE BRADLEY: I appreciate that. I'm sorry. The big...one of the big issues is services won't tier with the other services in their area. There's egos involved. Our service provides advanced level care for five counties in southeast Nebraska and there are services right now that won't call for ALS intervention when we could make a difference. One area, too, that is working is Pawnee County, which we serve on the ALS side, combined five town services into one countywide service and are working together, and they're also entered into an ALS intercept agreement with us where we will respond with them if they request that and need the advanced level. So those are my comments today. In closing, the Professional Ambulance Association, Nemaha County Hospital, Community Medical Center, and the Nebraska Hospital Association all urge you to oppose this bill in its current form. Instead, we need to work together and develop a plan that will maintain high-quality patient care while improving the EMS system. Thank you for your time and consideration. I'll answer any questions you might have. [LB730]

SENATOR GAY: Thank you, Mr. Bradley. Are there any questions from the committee? I don't see any. Thank you. [LB730]

GENE BRADLEY: Thank you. [LB730]

SENATOR GAY: Are there any other opponents? [LB730]

JOANN SCHAEFER: (Exhibit 4) Good afternoon. Dr. Joann Schaefer, S-c-h-a-e-f-e-r, M.D., chief medical officer and the director of the Division of Public Health within the Department of Health and Human Services. I'm here to testify in opposition of LB730. There's not a thing that's been said here today that is not already in my testimony, so in the interest of time I will trim it down. [LB730]

SENATOR GAY: Okay, thank you. Thank you, Dr. Schaefer. [LB730]

JOANN SCHAEFER: The department doesn't take any issue with the name changes; however, because of the name changes that are in there, there are some technical issues with the language as to what part is referring to which part. So we could solve that issue. However, one of the things that wasn't mentioned is that many of our first responders cross borders and many are...in disaster preparedness. It's a huge issue and Lincoln Fire and Rescue's urban search and rescue team did deliver services in 9-11. And if we don't have some sort of uniform test, uniform registry that allows that to occur, our people can't go other places and they're vital in our plans. So that's an issue I just wanted to make sure. The fiscal note you'll have on file to this, it is significant to the department. And one thing that hasn't been mentioned is this test currently is computerized. It's on demand 24/7. There's no way the department can meet that demand in that kind of a...it is a little bit different mechanism of what we'd have to do

and go out and give the test to certify folks. So it does wind up being a challenge for us to get out to get people to do that. And then the rule and reg challenge, to actually have a rule and reg go through every year, yearly, to approve the curriculum would be onerous. What I'd like to just say is that I have talked with Senator Flood about this and if he will allow me to take some ownership and work with him, I would be very happy to do that and get the parties involved and address this issue kind of head on and solve both of these issues. [LB730]

SENATOR GAY: Okay. Thank you, Dr. Schaefer. Are there any questions for Dr. Schaefer from the committee? I don't see any. Thank you. [LB730]

JOANN SCHAEFER: Thanks. [LB730]

SENATOR STUTHMAN: Thank you, Doctor. [LB730]

JIMM MURRAY: Good afternoon, members of the committee. My name is Jimm Murray, J-i-m-m M-u-r-r-a-y. I live south of Papillion in Sarpy County, and I am here simply as a private citizen. No one asked me to be here, no one is paying my expenses to be here. I'm not a lobbyist. In fact, as an ordinary citizen, we don't even have lobbyists. There's not an organization that represents the common citizen, so I guess I'm here representing myself and my family unit. I have elderly parents that live in Denver. As a result, we travel across the state tremendously to see them. My son travels the state from Wyoming at least twice a month to visit his children in the Omaha area. My daughter and her husband traverse the northern part of the state to his folks in Spencer, Iowa. So I am interested and concerned about the emergency medical services system in some part because my fear is that my family unit someday could have to use it. Emergency medical services, to me, is not simple. It should not be embroiled in politics. It is complex. It is a system where people are treating citizens in their greatest moment of need. They're treating them in a challenging, uncontrolled and unsupervised setting. If you think of any other healthcare setting such as in a hospital emergency room, if you need additional staff they are brought in. You have people there, you have cameras in some cases, you have audio setting, you have someone taking notes. If an event goes bad, someone is going to know about it. How many of us have seen an ambulance going down the interstate the other direction and wondered what is going on inside? I certainly have, and you know what? Nobody knows what's going on in the back of that ambulance save that attendant and that patient in need. My belief is that government has an absolute responsibility to protect the public and to safeguard us in those areas that are appropriate. This bill, from my perspective, takes a system that is working, a testing system that is working--which is a written exam and a practical skills exam--and it decides that the least trained people no longer have to represent their acceptability or their credentials, and allows those that are the highest trained to continue a system of written and practical testing. Now to me, a written exam is a cognitive testing exam. It's the exam that says why do you do something, and when do you do something? The

skills testing portion, the psychomotor testing, simply says how do you do something? An analogy would be if you simply want to test a physician or a surgeon in his ability to open up your abdomen, that's psychomotor, that's skills testing. You now know that he can open up your abdomen with a scalpel. Well, I want my surgeon to know when to do that and why to do that, and under what circumstances. That takes a written examination, a cognitive examination of skills. With regards to the testing component of this bill, I think this is simply a solution that is desperately in search of a problem. If in the last ten years Nebraska has successfully trained and certified 7,200 basic EMTs and today you still have 6,200 of those EMTs in practice, to me that doesn't necessarily point out a problem whatsoever. This bill, again, will take away the requirement from written testing for the first responders and the EMTs. Those with about 60 hours or training and perhaps 110 hour training. It says to the 1,000-hour paramedic, you still have to go through written and practical testing. Well, to me, that doesn't make any sense. A barber probably has to have 1,500 hours to be certified to take a written exam and be deemed competent in the state. Now who would you rather cut your hair? The 100-hour barber or the 1,000-hour barber? I likewise believe that the 100-hour EMT likely needs the same kind of validation for public protection as does that person with 1,000 hours. Now it seems to me that we here in Nebraska test every single health profession, both written and practical--physicians, nurses, occupational therapists like my daughter, nurses' aides. We even make people on a one-time basis in their lifetime, take a driver's written exam. When you first want to get a driver's license, we even demand a written exam and a practical exam of skills. [LB730]

SENATOR GAY: Mr. Murray, can you stick this bill and this... [LB730]

JIMM MURRAY: Okay, I will. I certainly will. The analogy is that a written exam for an EMT is, again, a once-in-a-lifetime experience. So I would believe that taking away the written examination mandate in this bill is probably poor public policy. If in fact 80 percent of the ambulance services in Nebraska are at the basic level, what you've now done is discriminate against the citizens in 80 percent of the state by potentially allowing their new EMTs to only know how to do something, not when or why to do something. Since you have this bill open, and if you work the bill, I would simply offer two other minor suggestions to you. There are two types of ambulance services. There are ground ambulances and there are air ambulances. There's a makeup of a 17-member committee in there. There's no allowance right now for air ambulances to be represented, and yet from my perspective, they have the higher-level personnel, they have the more sophisticated machinery, that helicopter, that fixed wing. I would think you may want to have the other half, or the other component, of ambulance services in your state have at least some representation on the committee. A final point I have to make is, many, many years ago in the early seventies I took a basic EMT exam. I still hold that certification, although I don't practice. I'm not riding with anybody. But the way I read this bill and the rules right now, if I do not have an affiliation with an ambulance service, and were I to stop and render aid to the level of my ability as a basic EMT, I

think I am in violation of parameters within that bill. So it would discourage me from acting. It could potentially, likewise, not provide the best care to citizens in the state. Thank you very much. [LB730]

SENATOR GAY: Thank you, Mr. Murray. Are there any questions from the committee? I don't see any. Thank you. Are there any other opponents would like to speak on this bill? All right. Anybody in a neutral capacity would like to speak on this bill? All right, Matt. Do you want to close for Senator Flood? [LB730]

MATT BOEVER: No, thank you. [LB730]

SENATOR GAY: Okay, waive closing. All right, with that, I'll close LB730. LB738, Senator Fulton, change brain injury registry notification and reporting requirements. Is Senator Fulton here? Thank you, Senator Fulton. Senator Fulton, what we're going to do, time wise, you can have as much time as you want on the opening and close, but any proponents or opponents we're going to limit to about five minutes each. So if anyone is here to speak on Senator Fulton's bill, you just need to work with us--five minutes, not be repetitive. Go ahead, Senator Fulton. [LB738]

SENATOR FULTON: Thank you, Senator Gay. Good afternoon. My name is Tony Fulton, T-o-n-y F-u-l-t-o-n. I represent Legislative District 29 in Nebraska. It's southeast Lincoln. This is LB738. This bill provides a means of improving the lives of those affected by a traumatic brain injury. In 1992 the Legislature created Nebraska's Brain Injury Registry for the purpose of providing an essential databank of statistical information to be used for the planning of treatment and rehabilitation of those afflicted with a traumatic brain injury. In recent years, this registry has become underutilized, in my opinion. Upon learning this fact and investigating, only recently have I become assured that this registry is actually being attended to. During the 2006 Session, the Health and Human Services Committee received a report by the Traumatic Brain Injury Council in response to an interim study, LR401, on improving services to persons with traumatic brain injury. LB738 implements one of the findings of this report. First, LB738 amends the current Brain Injury Registry to require notification to persons with brain injury regarding available resources in Nebraska within 30 days of the department's receipt of a brain injury report. And second, the current statutory requirement for hospitals to report on an annual basis a brain or head injury that results in admission or treatment is amended so as to occur within 30 days of such treatment or admission. This bill and the amendments to the existing statute will dramatically improve the effectiveness of the brain injury registry in terms of alleviating injuries and reducing the incidence of secondary problems associated with those injuries. According to a Baylor College of Medicine Study, within six months of a brain injury's occurrence, 20 percent of patients developed depression, and nearly 40 percent developed other secondary conditions, including post-traumatic stress disorder and concussion-like symptoms. In my opinion, this fact may be further exacerbated with the incidence of our Iraq War

veterans not reintegrating into society. Sadly, many traumatic brain injury victims are unaware of the ramifications of such injury and are likewise unaware of the resources available for treatment and counseling services. It seems, therefore, incumbent upon the Legislature to take some measure of proactivity in regard to reducing the secondary effects of brain injury, utilizing our existing Brain Injury Registry to provide brain injury victims and their families with necessary information regarding treatment, rehabilitation, and counseling. Concluding, victims of brain injury and their families possess an acute need for treatment and other services that are currently available. It is necessary that those afflicted be given the opportunity for rehabilitation within a short time, as the passage of time as been shown to be the greatest factor in the development of adverse secondary conditions. In the Brain Injury Registry we already possess, the framework for an effective tool to alleviate such secondary effects already exists. I propose that we use and implement this existing tool. That concludes my testimony. If there are any questions, I'll be glad to answer them. [LB738]

SENATOR GAY: Thank you, Senator Fulton. Are there any questions from the committee? Senator Erdman. [LB738]

SENATOR ERDMAN: Senator Fulton, page 3 of your bill, lines 7-9, refers to the time within 30 days after receiving a report of brain or head injury, it will notify the person with such injury of resources and services available in Nebraska. Two questions I have: It notifies the person. My experience with individuals with brain or head injuries is that it's probably not the person that will utilize that information. It's going to be a caregiver or someone else involved in that. I'm just curious if that's the right way to put that notification in this bill. The second question is, what are the resources and services? Are we going to...what would that look like? Do we send them a letter, do we send them a pamphlet? On page 2 we refer to all of the appropriate public and private entities that provide rehabilitative services. Are we going to...I'm just interested in the practical application of this. I'm not questioning the need; I'm just wondering how we carry this out. [LB738]

SENATOR FULTON: To answer your first question, whether or not it should be the person, I would be open to any proposals to send information to someone other than the person experiencing the injury, but it just...it seems to me that that is...if there is an appropriate caregiver or someone who has taken volitional responsibility for him or her who has been injured, that's going to be determined anyway. [LB738]

SENATOR ERDMAN: They'll likely receive that anyways, right. [LB738]

SENATOR FULTON: So it seems to me that if, you know, we're talking about the care of an individual, the person, and that person is the one who's going to be cared for or admitted. And so the first...I guess the first...logically, the first place that this identity will be verified will be during treatment, and the treatment is occurring to a person. So that's

why I would submit it's the person. [LB738]

SENATOR ERDMAN: Okay. [LB738]

SENATOR FULTON: Secondly, what does it look like? I'm not expert on this, but we have information--I'll call that x--which is not getting put into the hands of those who need it. What that information is presently would be informative, and so does it take the form of a pamphlet or a brochure? I don't know. I don't know that I'd want the law to say that. That information which exists is pertinent, so what form it takes, if we want to put that into the law, I'd certainly be open to that. I just chose not to because I'm not positive...there could be lots of forms that it could take place in. [LB738]

SENATOR ERDMAN: Well, this would be information regarding legislative bills, but I'm not sure if I got it in the mail that I would probably read through all of it. I'm just trying to think out loud. [LB738]

SENATOR FULTON: Yeah. [LB738]

SENATOR ERDMAN: The other question I just thought of, this is not specific to Nebraskans, right? If I have a situation where there's a car accident on I-80 between Bushnell, Nebraska, and Kimball, which is within 20 miles of the Nebraska border, the individual that receives the treatment, under Section 3, would then be notified of the services and resources available in Nebraska for their treatment? [LB738]

SENATOR FULTON: Are you're saying you're not clear whether the persons on the registry are Nebraskans? [LB738]

SENATOR ERDMAN: No, I'm just making sure that I'm clear as to who we're targeting. [LB738]

SENATOR FULTON: Okay. If you go to Section 1 on page 2, this is the existing language, so this isn't anything that I'm proposing, but... [LB738]

SENATOR ERDMAN: And it's again, occurs within the state. It doesn't refer to the residence of the individual. [LB738]

SENATOR FULTON: Yeah. Now that's a question... [LB738]

SENATOR ERDMAN: I'm just...and again, it's just an observation. [LB738]

SENATOR FULTON: Yeah. I'm not positive who falls under this category, whether it's one who is a citizen of Nebraska or not. That's really the meat of your question, right? [LB738]

SENATOR ERDMAN: Well, or resident, whether they're a citizen or not. [LB738]

SENATOR FULTON: Or...yeah, right, a resident of Nebraska. I'm not positive. There could be others who could answer that. [LB738]

SENATOR ERDMAN: Okay. [LB738]

SENATOR FULTON: My...I take the language out of...the head injury that occurs within the state, those who are presently on the registry. I'd like to get that information to those people that are on the registry right now, so. [LB738]

SENATOR ERDMAN: Okay, thanks. [LB738]

SENATOR GAY: All right. Senator Howard. [LB738]

SENATOR HOWARD: Thank you. Senator Fulton, I...in reading this I would suggest, being somewhat familiar with the HIPAA regulations, I would suggest that you are correct in wording this, the person with the injury, because medical professionals are so hesitant to give any information to anyone other than the individual, that I would suggest that you are correct with this. And if that individual is not capable of handling that information, I would think someone else would have been designated to handle that and would receive that information on their behalf. But as far as the wording goes, I would think that's correct. Hospitals are just so reluctant to give any information to anybody else. Thank you. [LB738]

SENATOR GAY: Thank you, Senator Howard. Are there any other questions for Senator Fulton? I don't see any. Are you going to hang around for closing? [LB738]

SENATOR FULTON: I will... [LB738]

SENATOR GAY: How many testifiers do we have, proponents of the...one, two, three...about five. Are there any opponents? One. Anybody neutral? Okay. Well, in the interest of everybody's time, you know, let's not be repetitive. I'm trying to limit it to five minutes, but you know, we won't hold you that accountable. If you want to come on up and start testifying. You can stay... [LB738]

SENATOR FULTON: I'll probably waive closing, but I'll get that to you as we get to near the end. [LB738]

SENATOR GAY: Okay. All right. Thank you. All right. [LB738]

SENATOR FULTON: Thank you. [LB738]

SENATOR GAY: You bet. Thank you. [LB738]

PEGGY REISHER: Good afternoon, almost good evening. And you're going to wish, as much as I did, that I had went through Toastmasters, but I didn't, so bear with me. [LB738]

SENATOR GAY: (Laugh) Do you want to state your name, too, for the record? [LB738]

PEGGY REISHER: (Exhibit 1) My name is Peggy Reisher, it's P-e-g-g-y. Reisher is R-e-i-s-h-e-r. And I'm just going to read. I'm here in support of LB738. I'm here today as a representative for the Nebraska Brain Injury Council, but I've also been a social worker on the brain injury team at Madonna Rehabilitation Hospital for the last 11 years. On behalf of the council, I'd like to say thank you to Senator Fulton for sponsoring LB738. I'd also like to thank you for your time today. In May 2002, the Nebraska Brain Injury Advisory Council did a statewide brain injury needs assessment. We found 53 percent of the individuals who received acute medical services were discharged back to their communities without services or support. There was a lack of awareness of what brain injury services existed in Nebraska for individuals and their families. In the needs assessment, families identified the need for early and ongoing information on brain injury as their greatest priority. As the Nebraska Brain Injury Advisory Council, we have made significant progress in developing information for those with brain injury. We now have a single point of contact for information on brain injury services. We have a web site listing resources, support groups, and upcoming educational opportunities. Last year we had our first brain injury conference with over 220 people in attendance. This year we are hoping for even a larger group, which the conference is being held in April. At the conference we had survivors, family members, as well as professionals learning more about brain injury. We have a network comprise of over 300 individuals with brain injury, family members, and service providers expanding across the state of Nebraska. The members of this Brain Injury Network provide information and support to families and individuals in their community. Although we feel we've made progress in having information and support available to Nebraskans, we feel LB738 would help us tremendously with the awareness piece as identified in the needs assessment. Many don't know where to turn for help after a newly identified brain injury. We find individuals with mild to moderate injuries, otherwise known as concussions, are sometimes the ones who have the hardest time finding out about brain injury services. They are often discharged from the ER or sent home from doctors' offices without written information or direction on where to turn for information, because their injuries seem mild in nature. However, this is one of the groups that we often find in the greatest need of information, because they don't understand that some of the problems they're experiencing, such as headaches, dizziness, light sensitivity, sleeping problems, memory problems, confusion, and irritability might be related to a brain injury. They just feel like they're going crazy. And there was an article in the Lincoln Journal Star last Friday that also highlighted the

fact that thousands of troops have been treated for brain injury, and it's commonly called the signature wound of this war. Although the military treatment facilities are trying to screen for brain injuries, we know this screening tool has been in effect for less than a year, and the only soldiers getting this screening are the ones that go to the military-based programs. Some of these soldiers who may go to their local doctors with symptoms of brain injury are not realizing that they got this while at war. It's important for them to be given information also about the brain injury services in Nebraska. As a council we are reaching out to the VA to learn more about how we can work together to help those soldiers returning. An example of what we're doing is, at our conference in April we have asked members of the local VA to do a presentation about how that screening is happening, as well as how they are evaluating and treating those veterans. Since Health and Human Services is already gathering information because of the existing registry, we hope that this bill would help us go one step further and directly inform those with brain injury of other services that Nebraska has to offer. We've researched what other states are doing and found that, for example, the Colorado Department of Public Health and Environment had done a pilot project where they selected a random sample of 750 persons in its registry and sent them information about a toll-free hot line to help them identify or find brain injury services. The call volume to that hot line quadrupled during the months the information was sent out. Here in Nebraska our hot line gets anywhere from four to nine people a month looking for brain injury services. We don't anticipate the cost of the screening information to be very high. From our understanding HHS is already getting funds to gather registry data. This bill would add an additional cost of sending information to those whose names are new on the registry. As the Brain Injury Advisory Council we're willing to help put together information which can be mailed out. We feel like we can do this simple and we can do it cheap. Examples of materials may be something as simple as...this is a brochure that the CDC puts out. It's given to us--whoever asks for it, free. And it's just some facts and information about brain injury. That would be one example of what we could give them. The other thing is, our advisory council has developed a little brochure that just talks about the hot line and a web site to turn to, to get more information about brain injury. Again--simple, cheap, and in some cases, free, except for our federal government is paying for that. And although we feel like we're making progress in getting information and awareness out to Nebraskans, we feel like with the help of LB738 we can make a larger impact for those who know firsthand how devastating a brain injury can be. And they oftentimes don't know where to turn. Thank you for your time. [LB738]

SENATOR GAY: Questions? Hold on. Senator Stuthman. [LB738]

SENATOR STUTHMAN: Thank you, Senator Gay. Peggy, thanks for your testimony. It was very good. And the examples of your two brochures that you had, is there any possibility that, you know, that those brochures could be put at like the Madonna Center that deals with the brain injury and rehabilitation of those? I don't know if there's many other agencies that deal with brain injury patients other than Madonna. They specialize

in that also. [LB738]

PEGGY REISHER: Right. It is our specialty, and Lord only knows, I give people a lot more than just this when they come in to our doors. But we do find that the mild concussions are the ones that are being seen by their family doctors, and people are not finding out about that information. There was a time when we developed a little tote bag of information that we were giving to some of the larger hospitals here in town--or not in town, but in the state, and asked them to distribute some of the information. Honestly, we found that to not be real successful. We'd have a change in staff member and they wouldn't think to give out that information. It was just hard to get people--you know, the front-line people--to remember to hand out information about brain injury. That's why we're thinking of, they're already...you know, it's been identified that they have a brain injury and it's being sent to the registry. It would be just simple and easy, in our words, to be able to pop some information in the mail to them. [LB738]

SENATOR STUTHMAN: And you would like to concentrate more on the mild concussions and those people that, you know, aren't traumatic brain injury? [LB738]

PEGGY REISHER: Well, honestly, I find if they've got a real severe injury, they're going to show up at places like our facility, and they're going to be inundated with information. I mean, that's...if they spend one month there, they're learning a ton about brain injury, and as professionals, we're giving them a lot of information. But it's those who, as Senator Fulton also talked about, is the ones that have the concussions. I think of some of the patients we've had that have had a concussion, went out and played sports or whatever, got a second concussion, a more severe brain injury, and then they're at our place for a longer period of time. So it's in some ways a preventative, or just more information about secondary impact. [LB738]

SENATOR STUTHMAN Thank you. [LB738]

PEGGY REISHER: Um-hum. [LB738]

SENATOR GAY: Thank you. Are there any other questions? I don't see any. Thank you. [LB738]

PEGGY REISHER: Thank you. [LB738]

SENATOR GAY: Other proponents? And while you're coming up here, I just want...for the record, there are two letters that were entered, Linda Walker Gardels, from the Nebraska Planned Council on Developmental Disabilities, and Brad Meurrens with the Nebraska Advocacy Services, that submitted letters of support on this. (See Exhibits 8 and 9) Go ahead and state your name. [LB738]

DALE JOHANNES: (Exhibit 2) Hello, senators. My name is Dale Johannes, D-a-l-e J-o-h-a-n-n-e-s, and I'm here as a representative of the Nebraska Brain Injury Advisory Council. I'm a member of this group because I suffered a head injury in 1988, which was my junior year of high school. I was a passenger in a small pickup that was hit directly on the passenger door by a full-sized pickup going 46 miles an hour. In the accident I broke most of my ribs, I punctured both my lungs, I scattered my jaw, cracked my pelvis, and a couple of other things. But the worst injury that I suffered was the head injury. Because of the head injury I was unable to speak for six weeks, and when I could speak again I had the maturity level of a second grader, and I was 17 at the time. I was in the hospital for three months and during that time I lost 60 pounds. I was fortunate that I was able to start my senior year with the rest of my class and graduate the following spring. I started college the following fall here at UNL, and it took me six-and-a-half years, but I was able to graduate from UNL. During my second year here I developed two goals for myself: One, I needed to graduate from college because in my eyes that would prove that I had not let the accident beat me; and two, I had to use what I had gone through to help one person with a head injury, to make my experience mean something. In other to achieve that second goal I began working at QLI in Omaha. Quality Living was opened with the intent of assisting young adults with head injuries. I started working there in June of 1998 and it took me until March of 2003, 15 years after the accident, to reach my second goal. After achieving that goal, I felt that I needed to stay involved with brain injury in some manner, so I became involved with the Nebraska Brain Injury Advisory Council. I've been very fortunate along the road of my recovery because I've had the support of many people along the way. First and foremost was my family. They've supported me through all that I have done. However, more often than not, the strain a brain injury puts on a family causes them to break apart. I saw this countless times while at while at QLI as well as other settings where I've gone to offer my support to individuals who have suffered a brain injury. I see this bill as a vital first step in assisting families who are dealing with this trauma. The first part of the bill would allow for an accurate accounting of the number of individuals with head injuries in the state. This part of the bill is important, but it is the second part of the bill that I'm excited about, because it will have an immediate positive effect on families dealing with a brain injury. The second part of the bill will set up a central contact point who a person with a brain injury or their family member could contact to give them an idea as to whom to turn to in their community for assistance. Brain injury is a very isolating experience, both for the individual suffering the injury as well as for the family member or caregiver who cares for the brain-injured survivor. When my injury occurred 20 years ago, my family felt completely isolated. While medical technology has advanced the treatment of individuals with brain injuries exponentially in that time, the direction and support given to those dealing with the injury is still greatly lacking. This bill would be a great first step in addressing this issue. LB738 is important to me because of my life experiences. But objectively, it should also be important to the state of Nebraska. As medical technology advances, lives are being saved after brain injuries that only a few years ago would have been lost. But without some sort of direction given to these individuals, they often

just simply fall through the cracks and are a mere shell of the person they could become with the correct assistance. When this happens, these individuals often become dependent upon the government for their existence. Of more immediate concern are the returning veterans from Afghanistan and Iraq. USA Today reported in November that there have been at least 20,000 service members returning from combat that have been diagnosed with or shown signs of brain injury. Washington Senator Patty Murray pointed out that there is clearly a problem when the most common injury of the war is the least understood. This bill would be a fantastic step toward gaining some understanding in Nebraska. Currently there are 17 other states that have TBI specific registries, but only 8 that collect personal data such as name and address and use this information to link individuals with brain injuries to case management, service coordination, or other available services. By adopting this legislation, Nebraska would be well ahead of the curve in addressing the unique challenges that each individual and family affected with brain injury faces. [LB738]

SENATOR GAY: Thank you, Dale. Are there any questions from the committee? I don't see any. Thank you very much for your testimony. [LB738]

ANNE HUPKA: (Exhibit 3) Hello. My name is Anne Hupka, A-n-n-e H-u-p-k-a. Thank you, senators, for listening to my story. I am here today as a nurse, as an individual, but more importantly, as the mother of a 30-year-old man who has an anoxic brain injury--that being a brain injury from the lack of oxygen. On June 28, 2004, my son, Ken Hupka, had an electrical shock while working as an apprentice lineman for Omaha Public Power District. This electrical contact caused his heart to stop. As a result of this injury, Ken and his family are now faced with rehabilitation in a long-term care facility, frequent doctors' appointments, and behavior problems. I now fine myself as his caretaker, rather than enjoying him as my son. As a nursing professional, I do my best to ensure that every patient that I come in contact with has the proper education and resources available to them relating to their illness. It is the responsibility of the healthcare team to have patients and their families be an integral member of their treatment plan, including medications, consulting physicians, and therapies. They are given this information at discharge. If they are compliant with them, we all pray that everything will go well. It is very basic for the healthcare team to give advice to patients about what to do, but as close the door behind them, it's the first day of the rest of their life managing their illness. As I have witnessed first hand, it is not that clear-cut with brain injuries. Ken received excellent care from the intensive care unit to the rehab facilities, including Madonna and QLI. The medical teams did their job with expertise. As a family we were given all of the reading material anyone could possible imagine--so we thought. But three-and-a-half years later, I am still trying to work my way through the maze of the referrals and consults. In the middle of sleepless nights I pull the paperwork back out again and review it over and over again, hoping that I might find something. Did I miss anything? Ken's wife, Jen, searches the Internet, grasping for any new material that she can find. I find myself attending conferences hoping someone might

have a new treatment available. The most important information that I have received over the last three-and-a-half years was that there are no straightforward treatment plans for brain injury. Every brain injury is different and unique to that individual. There is not a predetermined, evidence-based outcome for a person with a brain injury. There is only a maze of referrals, a wait-and-see attitude, and a different behavior each day. I have been at health fair booths representing the Nebraska Brain Injury Network and have encountered several families who are searching for the right care, the right doctor, and the right answers for themselves or their loved one. One woman came to me and asked me how her husband could learn to read, write, and do math again. She had wanted to send him back to kindergarten. He had a master's degree in math and suffered a stroke during just a nonemergent surgery and can no longer do those simple things. Another family had problems taking their loved one out in public because of his crude language and crude behaviors. Another person came to me not knowing if he really had a brain injury but was experiencing short-term memory problems, headaches, extreme fatigue, and problems with just everyday activities, after an accident. He was told in the emergency room that there was not an injury associated with his head trauma. I have learned at these conferences that brain injured individuals are often found in our mental health wards due to their unpredictable behaviors. They are found homeless or in long-term care facilities, because they can't hold a job and their care is too difficult or too time-consuming for family members. They are often found in our judicial system because of their risky lifestyles and impulsive behaviors. I am here today to stress the importance that individuals and their families who are listed on the head and brain injury registry receive resource materials within the 30-day time frame. We need to help them find their way through the maze of consults in the healthcare system. Providing patients and their families access to critical resources reduces the burden of hours spent looking for answers and ultimately achieving the best outcome for themselves or their loved ones. Thank you for your time and consideration. [LB738]

SENATOR GAY: Thank you, Ms. Hupka. Hold on one minute. Are there any questions from the committee? I don't see any. Thank you for sharing that with us. [LB738]

ANNE HUPKA: Um-hum. [LB738]

SENATOR GAY: Any other proponents? [LB738]

RONALD RIDDER: (Exhibit 4) Good afternoon. I'm Ronald Ridder, Ph.D., R-o-n-a-l-d R-i-d-d-e-r, Ph.D. I'm a clinical psychologist in private practice in Kearney, Nebraska. I've provided neuropsychological services to central Nebraska for 17 years. I frequently evaluate individuals with brain injury. It is very important to identify that an individual has sustained an injury to the brain so that rehabilitation can begin in the acute phase of the recovery, to maximize return of function for that individual. For a mild brain injury, that acute recovery phase is the first three months after the injury. Typically, the cognitive skills impaired in a brain injury involve attention, memory, and executive functions. The

basic attention skills of focusing one's attention on a task and sustaining concentration to complete a task is typically disrupted. The ability to learn information and store it into memory is disrupted. Executive functions is a set of skills that involve self-regulation of behavior and complex problem solving, and that typically is disrupted. The self-regulation of behavior is the ability to modulate emotions and behaviors via appropriate inhibitory control and the ability to move flexibly among emotions and behaviors. Complete problem solving is the ability to initiate, plan, organize, implement, and sustain future-oriented problem solving. Typically, an individual with a brain injury is treated within a medical model that is problem oriented. The focus is on stopping the bleeding and mending the broken bones. It is only when the individual is not cooperating in physical therapy that the staff may be thinking about having a psych consult to address the patient's inappropriate behavior or disruptive behavior. The behaviors are frequently misdiagnosed as being psychiatric in nature rather than being a product of the brain injury. Most medications used to treat psychiatric illnesses will inhibit or suppress brain function. This results in a brain that has been compromised due to the injury being suppressed more to control the inappropriate behavior. In other situations the individual is discharged home because from the medical model, they are medically stable--you know, they can walk and talk and are doing fine medically. They are viewed as having a complete recovery to their functioning before the injury, but not looking at the psychosocial issues. Typically it's about a year or more after their injury that they're referred to me for a neuropsychological evaluation. This is due to two problems: The first problem is that the medical staff doesn't know how to identify the brain injury. The second problem is they don't understand that the treatment of the brain injury is an important part of the care of the patient. Early identification of brain injury will prevent many individuals from developing secondary behavior and emotional problems. It is common for individuals with brain injury to become depressed. It is common for individuals with brain injury to have poor anger control. It is common for individuals with brain injury to do and say things without thinking them through. It's common for individuals with brain injury to know what to do but lack the ability to carry it out. It's common for individuals with brain injury to self medicate with alcohol and drugs. These emotional and behavioral problems can be presented if treated early, but they are very hard to correct once they become chronic conditions. The lack of early treatment prevents many individuals with mild brain injury from returning to gainful employment. Instead, they're placed on social security disability. I would predict that many individuals with substance abuse have a history of brain injury prior to their substance abuse. And I'd predict that many individuals in the corrections system have a history of brain injury prior to their criminal acts. I am in support of the changes in the brain registry...that's LB738. The notification of the brain injury within 30 days is needed to prevent treatable conditions from becoming chronic burdens on society. It is not an undue burden on hospitals or healthcare staff to notify that a brain injury has occurred. Notification within one year is too long and denies individuals appropriate and timely treatment of their brain injury. [LB738]

SENATOR GAY: Thank you. Are there any questions from the committee? Senator Hansen. [LB738]

SENATOR HANSEN: Thank you, Senator Gay. Thank you for coming from Kearney today. Explain just briefly about the acute care immediately, or while they're recovering (inaudible). Why is that a stumbling block? It looks like if somebody has a brain injury, that you would be called in almost immediately. It's not true? [LB738]

RONALD RIDDER: It's not true. It's typically...I mean, they're, like I said, they're working on the, you know, the acute medical conditions and that, and you know, the implications of the brain injury itself are secondary to that, and so they're not focusing on those at the time. [LB738]

SENATOR HANSEN: But that needs to be done? [LB738]

RONALD RIDDER: With the...yes, it does, especially with mild injuries, ones that don't have as much, in terms of the medical conditions, where it may be a concussion and they come into the ER and they're given three or four hours' neuro checks and then discharged home. And it's only a few months later that they really start to develop symptoms and stuff that are problematic. [LB738]

SENATOR HANSEN: Do you think 100 percent of those people need your care, or your type of care? [LB738]

RONALD RIDDER: I wouldn't say 100 percent would, but I'd say a high percentage would. [LB738]

SENATOR HANSEN: Okay. Thank you. [LB738]

SENATOR GAY: Thank you, Senator Hansen. Any other questions? Senator Stuthman. [LB738]

SENATOR STUTHMAN: Thank you, Senator Gay. Ron, in this with the...like a severe brain concussion, do you feel that they need to be in a rehabilitation setting, or is the fact that they would go home in their environment and work together with the doctor and family members,...which situation do you feel would work better? [LB738]

RONALD RIDDER: Each individual, I mean, has individual situation and that, but typically with a severe injury, you're going to have a period of time where you're going to need to have, you know, occupational therapy, physical therapy, speech therapy, and neuropsych services to rehabilitate that individual, to get them to a point where they can then return home. [LB738]

SENATOR STUTHMAN: Okay, thank you. [LB738]

SENATOR GAY: All right. Thank you. Any other questions? I don't see any. Thank you. Other proponents? [LB738]

EILEEN CURRY: (Exhibit 5) Hi. I'm Eileen Curry, E-i-l-e-e-n C-u-r-r-y. Thank you for having me here. My name is Eileen Mazuran Curry, and I am the survivor of a brain injury that developed from a brain tumor, a meningioma, that was found in the left temporal area of my brain ten years ago. My family and I have survived the tumor, the 15.5 hours of surgery, the years of follow up and rehabilitation, the excruciating pain, the seizures, the financial loss, and the "refinding" of who I am and who we are. I owe my life and quality of life to the grace of God and the tremendous effort of family, friends, and many unique and creative professionals who help me find what all families facing brain injury must might--a new normal. That's why I'm here today, to ask for your help for others who will face the trauma of brain injuries that will result in destroying who they were and helping them gain a jump-start in finding who they might become. We brain injury survivors depend almost entirely on those around us, both initially and long term. I had to relearn how to speak, how to walk, how to think, and how to reason in new ways. Our memories, both long-term and short-term, evade us. Our personalities change and we struggle with marriage and parenting, because we just don't seem like the person we were before the injury. We view things differently. That which was familiar often no longer makes sense. That which was soothing or enjoyable no longer comforts. We can't figure out simple chores. I could not get through a shower or remember how to wash my hair, when to use the shampoo or the cream rinse, so I would have to do it over and over. I had to leave a stream of sticky notes--I thought about getting stock in them--and to remind myself what order to do. My strength as a professional instructor--my memory--was gone. Previously, in teaching at UNL I would remember the names of 300 students in a given semester. It was my goal to leave my students with a sense that they were remembered by name at the big university. Following the brain injury, I was teaching at Wesleyan and found myself unable to remember the names of my 15 students from day to day. That which I had honed and sharpened and in which I had taken so much pride was gone. I could not tolerate distraction or interruption, or maintain focus and concentration. I had to work hard to read papers and to follow what was being said. And the pain and the seizures continued. The inevitable was impossible to ignore and I tended my resignation. The financial stress continued, not uncommon for brain injury families. By this time two years had passed. The excruciating pain and seizures were increasing. As is typical among brain injury families, I learned of options through other brain injury families. EEG Neurofeedback Therapy was recommended to me by the mother of another brain injured young man who had found some relief through this innovative therapy. I was willing to go beyond the meds that made me so unreliable and spacy. Slowly I began to gain some control back, began to lessen the pain medications, and began to gain inroads over the frequency of the seizures. I began to search out whether I would

eligible to receive the training to become an EEG neurofeedback therapist. I was already working as a marriage and family therapist. I was, I did. I today, six years later, serve in that capacity. I seek to serve both the brain injured and the caregivers. I am rebuilding a practice in which I can serve and in which I can adjust to my disabilities. In 2006 I completed by Ph.D. in Human Science. My dissertation research focused on the caregivers of adult traumatic brain injury survivors, a phenomenal group of heroes. But what does that have to do with LB738? Several very important issues are involved. In telling my story I want you to note several things: Without help, both myself and my family would have had a much more difficult time. Brain injury does not go away; it leaves the survivor and the caregiver with long-term trauma, stress, and need for continued help. Local availability of assistance is essential, and getting the proper information as soon as possible is imperative. In examining these points more closely: Number one, brain injury is a family disease that keeps on taking. We are surviving the trauma to our family, ten years later, still trying to rebuild, thankfully celebrating that I am alive. It changed all of us, not just me. As I study the families in my dissertation research, it is alarmingly apparent that caregivers need continued help, contact, and resource referrals. Note that in my study, 84 percent of the participants in my study were caregivers in Nebraska. Two groups emerged--caregivers that were brain injured...parents of brain injured and spouses of brain injured--and you heard from several of them here--each with very unique needs. This must be identified and addressed. Forty-six percent of the caregivers that responded were from Lincoln and Omaha, but 54 percent that responded to me were throughout rural Nebraska, without resources, referrals, or options. And these stories were heartbreaking to me when I read them. Fifty-two percent of the brain injury survivors were forced onto disability, leaving caregivers struggling terribly financially. Thirteen percent became full-time caregivers following their loved ones leaving the hospital or rehab. LB738 will provide a uniform system of classification of brain injury, useful statewide for all medical, clinical and educational organizations. LB738 will help build a needed base to identify brain injured families across the state. This will help families here in Lincoln and Omaha, but even more so in outstate Nebraska. Immediate trauma is overwhelming. Information changes by the minute. Recommendations for help is often lose in the chaos, and caregivers are lost in a whirlwind of decisions, becoming an immediate provider, nurse, etcetera, and at the same time having lost the person that has either been their lifelong partner or their adult child. They often cannot remember where to go or what they are supposed to even ask. The registry will provide a base for follow-up help as loss, grieving, and needed assistance become more of a reality and more welcome to the caregiver. Each caregiver will have a different time line, and flexibility is needed. The registry will provide the needed information to enhance the current efforts of local brain injury support groups. We will have a means to obtain information regarding new families in our area and then contact them and offer support. There are eight such brain injury support groups that meet across the state. Our Lincoln group meets the second Tuesday of the month, and anybody is welcome to come. We meet at the First Methodist Church from 7-9 p.m. All are invited, both injury survivors and caregivers. We have another one that

meets with Dr. Karen Hux and Gina Simanek. That usually is for social work that they do. Currently, we depend on word-of-mouth referrals for people to find us. The registry will enable us to help contact persons going through the trauma of brain injury in our community at an earlier time in rehabilitation. Thank you for this opportunity to express my voice. I urge you to vote for LB738 to help us establish this solid base in the state of Nebraska. My family gained so much from those who reached out to us. We continue to reach out to others. Many never learn that there is help available. Help us to do so. Thank you. [LB738]

SENATOR GAY: Thank you. Are there any questions from the committee? Senator Stuthman. [LB738]

SENATOR STUTHMAN: Thank you, Senator Gay. I would just like to thank you for coming and testifying. [LB738]

EILEEN CURRY: Oh. [LB738]

SENATOR STUTHMAN: It really means a lot to me as a committee member, of a person that, you know, in that situation and gives me your life history and how things worked out, just as one of the other testifiers have done. [LB738]

EILEEN CURRY: I'm grateful to be here. [LB738]

SENATOR STUTHMAN: I really, really appreciate that, so thank you. [LB738]

EILEEN CURRY: Thank you. [LB738]

SENATOR GAY: I don't see any others. Thank you very much. Other proponents? Are there any other proponents after this one? Okay. [LB738]

BRUCE RIEKER: (Exhibit 6) I'll be short, sweet, to the point, and then I'll be gone. My name is Bruce Rieker, it's R-i-e-k-e-r. I'm Vice President of Advocacy from the Nebraska Hospital Association, here to testify on behalf of the association that we are in support of LB738. And to make my comments very brief, as you heard from the previous witnesses, especially from Dr. Ridder, the continuum of care exists. It's immediate, but it also exists long after the acute care is provided, and we believe that LB738 is a step in the right direction. It was not my, or our intent to testify in support of this for next thing I'm going to bring up, but we did look at the fiscal note with some degree of interest, because the Nebraska Hospital Association already collects a great deal of data from our hospitals, not from the physicians. But as we read the bill, where there is an estimated addition of one staff person to send out this information, not like I want to be here to say, we can name that tune cheaper or faster or anything, but if that's what is appropriate for this, the Hospital Association would be very interested in engaging in

conversations to contract for that kind of work. So I guess what I'm saying is, we believe that we could do it cheaper if that's something that you wanted to do. So with that, we do support the bill, but it's not our intent to be looking for work. But if we can help you out, we would engage in that conversation. [LB738]

SENATOR GAY: Thank you for that, Bruce. Are there any questions from the committee? I don't see any. Thank you. Are there any other proponents? Senator Stuthman said, but in behalf of the whole committee, we appreciate your patience today in sharing those stories with us, and thank you for coming and staying late. We do have...any opponents, come on up. There was no one in neutral on this issue? Okay. [LB738]

JOANN SCHAEFER: (Exhibit 7) Good afternoon. Members of the Health and Human Committee, my name is Joann Schaefer, S-c-h-a-e-f-e-r, M.D., chief medical officer and director of the Division of Public Health. I am here today to testify in opposition of LB738, and I just wanted to also acknowledge the fact that I very much appreciate everyone who was willing to come forward and tell their stories. As you can hear, the brain is incredibly complex, and multiple injuries can happen at any given time via a traumatic brain injury at the accident site to things...toxic injuries that cause encephalopathic changes in the brain, as well as strokes and anoxic injuries that can occur. So I just want to highlight the issues that...why the department has concerns. Our first concern is that rehabilitative services are not a reportable activity in Nebraska. We do not have an efficient way to determine what facilities or individuals perform rehabilitative services. We also believe that this is an expansion of government responsibilities that may not be appropriate. We question the need for this requirement to individually notify patients. Just for an example, a Google search for Nebraska brain injury rehab services yielded 38,000 web sites. If you remove the word "Nebraska," it yielded over 200,000. That's just one source of information, and obviously a person would need to correlate a lot of information. There are over 3,000 reportable brain and head injuries per year in Nebraska. Currently, we rely on the Hospital Discharge Database as the source of that information. The Hospital Discharge Databases report it to us once per year, about nine or ten months after the end of each calendar year, which makes the cases so far behind, as much as 22 months. The department rarely contacts patients with personal information in any of our diseases or injury or condition data bases or registry, so that's a step away from our policy to actually use the information, the data, that we have, and then go back and contact people individually. That would be a departure from our policy or preserving and respecting the privacy of Nebraska citizens. We suspect and have heard in the past that we would not...it would not be appreciated of our contact of individuals who want to be...remain...would want that information to be private, so there is that concern. The bill does not specify either location or type of rehab service. We presume the intent is to provide information only to agencies located in Nebraska and only on services of interest to the brain and head injury patients, but it is unclear of the bill language. We submit that the patient's own

physician or within the healthcare team would be a better, more welcome source of information. But as you've heard here today, there is certainly a difference of opinion there. I'm certainly willing to work on anything to make this (inaudible) an issue. There is no doubt that brain injury is a significant issue for our citizens. It's a public health concern and a complex problem. So with that, I'd be happy to answer any questions. [LB738]

SENATOR GAY: Thank you, Dr. Schaefer. Any questions from the committee? Senator Pankonin. [LB738]

SENATOR PANKONIN: Dr. Schaefer, thank you for your testimony, but I also appreciate your last comment, trying to work on this. And maybe there is some way to do it without a statute or whatever. So I'd be hopeful there is some mechanism maybe, that this can be worked out to help these folks that have had these real-life experiences (inaudible). [LB738]

JOANN SCHAEFER: Yeah. It sounds like there's a huge gap between those who have high service needs that are in the hospital, in a trauma, that they're surrounded by a lot of services, but maybe not getting some of the, you know, the information that they need for the long haul. And then the people that are seen in the ER for concussions and all of that, and the quick service, they may not be even aware that they need to look out for this stuff. And it seems like there are two different issues that we need to work on. [LB738]

SENATOR PANKONIN: Well, and I think what we heard today is, if we can help these folks from the onset, it may also save the state money in the long term,... [LB738]

JOANN SCHAEFER: Absolutely. [LB738]

SENATOR PANKONIN: ...or disability and those sort of things. [LB738]

JOANN SCHAEFER: It will certainly save the patients a lot of heartache, when they don't realize what they're experiencing is because of the brain injury and not, you know,...they're not, as someone put it, they're not going crazy. It's because their brain is playing some tricks on them, based on the injury. And they need to know that, and they need to know what services are available. There's no question. I just don't know if this is the right mechanism. [LB738]

SENATOR GAY: Dr. Schaefer, I have a question, follow up to Senator Pankonin's, in a way. I heard some, you know...we've got some real resources in this state--Madonna and Quality, you know. [LB738]

JOANN SCHAEFER: Absolutely outstanding resources. [LB738]

SENATOR GAY: But...and then the Hospital Association made that offer, I agree. Maybe there's some kind of, you know, situation...we could get together, and when you talked about so many Internet hits; well, there's probably a lot of garbage in that, too. [LB738]

JOANN SCHAEFER: Absolutely. [LB738]

SENATOR GAY: So to sort through all the nonsense... [LB738]

JOANN SCHAEFER: And that's... [LB738]

SENATOR GAY: ...so maybe we could get together as Nebraskans and try to come up with some workable solution here. Maybe it does not require legislation, but cooperation. So I agree with Senator Pankonin, and maybe we could do that. Senator Stuthman, you have a question? [LB738]

SENATOR STUTHMAN: Thank you, Senator Gay. Dr. Schaefer, in this registry would that just be a data base as far as services that are provided, or would this be the individuals' names that have had brain injury or anything like that? [LB738]

JOANN SCHAEFER: Well, the registry has a lot of information in it right now. The proposal is for us to contact them and then also have services information to give the people that are in the registry. [LB738]

SENATOR STUTHMAN: That are in the registry? [LB738]

JOANN SCHAEFER: Right, and you know, there's a lot of information that's gleaned from registry information. So... [LB738]

SENATOR STUTHMAN: How long has this registry been in place? [LB738]

JOANN SCHAEFER: Why, I couldn't...I'd have to follow up with you on that. I don't know the specifics. [LB738]

SENATOR STUTHMAN: I hope not 45 years, because I had brain injury 45 years ago. [LB738]

JOANN SCHAEFER: Did you really? [LB738]

SENATOR STUTHMAN: Don't say anything, Dave. (Laughter) I had a bad car accident. [LB738]

JOANN SCHAEFER: Oh, goodness! The brain is a pretty complex organism, organ, I should say. [LB738]

SENATOR GAY: Any other questions from the committee? I don't see any. With that,...thank you, Dr. Schaefer. With that, there is no one wanting to speak neutral. We'll call a close to the hearing on LB738, and open on LB797. Senator Pankonin will open that for Senator Johnson, and this is the change the provisions relating to Health and Human Services. Go ahead and get settled. Go ahead, Dave. [LB738 LB797]

SENATOR PANKONIN: Senator Gay, members of the committee, for the record my name is Senator Dave Pankonin, representing District 2. I'm here today to introduced LB797 on behalf of the Health and Human Services Committee. LB797 is the annual cleanup bill brought by the Department of Health and Human Services. This bill provides technical changes to HHS related statutes. LB797 deals with the following topics: References to federal law in Medicaid statutes, intentional program violations in Aid to Dependent Children Program, the re-release of cancer registry information, administrative references following the reorganization of HHS last year in LB296, the sharing of case-specific trauma data, the state mammography screening program, the state Breast and Cervical Cancer Advisory Committee, and references to nurse practitioners in the Rural Health Systems and Professional Incentive Act. Chris Peterson, chief executive officer of the Department of Health and Human Services, will follow me with testimony with more detail on the contents of the bill. That will conclude my opening testimony. Thank you, Senator Gay, and my colleagues. [LB797]

SENATOR GAY: Thank you, Senator Pankonin. Chris. [LB797]

CHRIS PETERSON: (Exhibit 1) Good afternoon, Senator Gay and members of the Health and Human Services Committee. I am Chris Peterson, chief executive officer of the Department of Health and Human Services, and I would like to thank the Health and Human Services Committee for introducing this bill on behalf of DHHS. I'm here to testify in support of LB797. Senator Pankonin has already gone through some of the parts of my testimony, so I will skip down to the specific information on the affected areas. References to the federal Social Security Act in state Medicaid statutes: This is something that we do every single year. Nebraska Revised Statutes, Section 68-1021.01 adopts by reference the federal Social Security Act as it existed on April 1, 2007. Nebraska case law provides that a statute may incorporate by reference a federal statute, but only as to the date such state statute became effective, and not all future changes in law. The statute needs to be updated every year, so any federal changes that have been made are incorporated by reference. DHHS administrative issues, Section 3 and Section 14: Language needs to be updated to reflect the administration and structure of DHHS. These are things that came to light after we had done the original huge bill that had been changed after that and so needed clarification. Specifically, the responsibility for licensure of child case agencies, child placing

agencies and group homes is changed from the Department of Health and Human Services to the Division of Public Health of the Department of Health and Human Services, since the responsibility for all licensing is with the Division of Public Health. It is used to be over under Children and Families, and it really shouldn't be there. It's a licensing duty, and it needs to be over into the licensing under Division of Public Health. Also, language relating to the membership of the Geographic Information System, the GIS Steering Committee, is updated. Currently, this language provides that the director of HHS is a member of the GIS Steering Committee. That language, which should be the CEO or designee of the Department of Health and Human Services, replaces the outdated language, director of the Department of Health and Human Services. Rural Health: The Nebraska Loan Repayment Program is open to "advanced practice registered nurses, the APRNs. This terms was defined prior to July 1, 2007, as those practicing one of the defined primary care specialties of family practice, general internal medicine, obstetrics and gynecology, general pediatrics, general surgery, and psychiatry. As a result of new legislation that became effective July 1, 2007, certified registered nurse anesthetists, CRNAs, certified nurse midwives, CNMs, clinic nurse specialists, CNSs, and nurse practitioners, NPs, will all be included under the title, advanced practice registered nurses. In order to keep the Nebraska Loan Repayment Program only to only nurse practitioners practicing one of the defined primary care specialties, the Rural Health Systems and Professional Incentive Act needs to have the term "advanced practice registered nurses" changed to nurse practitioners. And the reasoning behind that is the Rural Health Systems and Professional Incentive Act identified that the loan repayment would be just for the primary care specialties, not beyond that. Public Assistance Programs: In 2003, LB234 was passed into law, and this law enabled the Department of Health and Human Services to conduct administrative hearings on Intentional Program Violations of clients in the Aid to Dependent Children/Temporary Assistance for Needy Families, or ADC/TANF program, and child care subsidy programs. However, this law was inadvertently repealed by the passage of LB296 in 2007. And this bill put it back in. The reason we want it back in is it allows us to do an interim step between actually going after someone for fraud. We do this with our food stamps. If there's an intentional program violation, we can have an administrative hearing, and they are sanctioned for one year, (inaudible) they can't get the benefit. If they do it a second time, then they're sanctioned for two years. If they do it a third time, then they do not receive the benefits at all. This allows us to not have to prosecute for fraud. It's an interim step through an administrative process. The release of health information: The Nebraska Cancer Registry documents cases of cancer and provides background information about cancer cases in Nebraska. The NCR, administered and directed by DHHS, requests clarification of general release laws, Sections 81-663 to 81-675. A new section would specifically allow the US Centers for Disease Prevention and Control and the North American Association of Central Cancer Registries, the NAACCR, to re-release case specific information. This probably sounds familiar to the last year, because what we asked for last year was to allow the CDC and the NAACCR to release our information. What they would like to do now is, they have

given that only to aggregate publications for study and research by CDC employees or the members. And now they want to release that to non-CDC researchers. So as part of standard operations, the NCR releases case-specific but not patient-identifying information to both of these organizations. Then they have used this information to pass on. In 2007 the CDC chose to make it's restricted access file available to non-CDC researchers, and because of the way the law is written we had to prevent that from happening. So this would allow us to have them released to re-release the information they've had...have been available to release. Recipients of case-specific information from the NCR are prohibited from re-releasing that, the way it stands right now. Both CDC and NAACCR have researcher qualification processes that meet or exceed the requirements specified by Nebraska law and regulation. So we have no concerns about them re-releasing the information that we have given to them. By allowing CDC and the NAACCR to re-release this, the Nebraska Cancer Registry and the state of Nebraska can facilitate nationwide research or study of cancer without direct involvement of employees. This would enhance research opportunities and may reduce labor and equipment burden to the state of Nebraska. Researchers will be appropriately qualified by a formal and specific protocol required by the respective organizations, and again, these protocols are very similar to Nebraska's protocol, and compatible. The trauma registry: In 1997, LB626 resulted in the Nebraska Statewide Trauma Systems Act. This law, among other things, requires the department to improve the provision of emergency medical services and trauma care and requires trauma centers to evaluate trauma care delivery, trauma care qualify, patient case outcomes. We have a web-based data collection system which permits healthcare provides to electronically access health and medical data, and that's one step towards the legislative requirements. Changes to data laws will allow the department to fulfill more of its charge and to facilitate the statutory duties given trauma centers. This proposed update to current law would allow the department to release case-specific, but not patient-identifying trauma information to trauma quality assurance committees and regional trauma advisory boards. These groups advise DHHS on trauma matters. When these groups meet, they need case-specific information to discuss the improvement of trauma services, and both terms are defined by 81-664. This is a Class IV medical record data which will be confidential, with release of case-specific data to approved researches for specific projects. We have four classes of medical records. This would be one that would allow them to release information such as the location, the type of injury, the treatment and complications, which would then help the trauma centers be best able to come up with improvements in the care that they're providing. Mammography: This portion of the bill strikes obsolete provisions relating to the screening mammography program. The original statute was written in 1991 prior to the receipt of the state's breast and cervical cancer early detection grant, and it was created to put the state in a better position to seek funding from the CDC and to provide matching funds for the grant, should it be awarded. The statute also put in place a structure for the state mammography program and a Mammography Screening Advisory Committee. The state was successful in this, in applying for the breast and

cervical cancer grant in October of '91 and currently, these obsolete provisions are in conflict with the screening guidelines for the federal grant. Right now the screening guidelines are for both breast and cervical cancer. This statute refers only to mammography, so it's outdated with what the requirements of the federal grant are like now. The proposal updates language on the Breast and Cervical Cancer Advisory Committee. Specifically, obsolete provisions relating to the cash fund and confidentiality are deleted. And what these say is, you can only release information on mammography. We don't do just mammography anymore. It's breast and cervical cancer, so these are obsolete definitions. The membership requirements of the medical radiographer and radiologist are dropped. The role of this committee has changed to activities such as fund-raising, and so these two membership requirements are not necessary, because of the changing role. The Governor's Roundtable: In 1995, LB455, the welfare reform legislation, was passed into law. This law created the Governor's Roundtable. The roundtable was required to make recommendations relating to job training, job creation, tax incentives, unemployment compensation, child care and healthcare, to assist low income. However, the roundtable addressed these welfare concerns and has become obsolete, and this bill would eliminate that roundtable. Thank you. I'd be happy to answer any questions. [LB797]

SENATOR GAY: Thank you, Chris. Are there any questions from the committee? Senator Howard. [LB797]

SENATOR HOWARD: Thank you, Senator Gay. Good job with reading all of that! (Laugh) [LB797]

CHRIS PETERSON: (Laugh) Dry mouth. [LB797]

SENATOR HOWARD: If we can look at the section, Public Assistance Program, Sections 2 and 15. [LB797]

CHRIS PETERSON: Yep. [LB797]

SENATOR HOWARD: Just so I completely understand this, was this language as it's written in this paragraph, in the law prior to our enacting LB296 in '07? [LB797]

CHRIS PETERSON: Yes. [LB797]

SENATOR HOWARD: It was just...it was written this way. [LB797]

CHRIS PETERSON: It was left out. [LB797]

SENATOR HOWARD: There's not a change in this language? [LB797]

CHRIS PETERSON: No. It was simply left out. That law which passed in 2003 mirrored what we do for the Food Stamp Program, so that we're able to provide an interim level of sanction, as opposed to going forward with prosecution on fraud. And it was based upon administrative hearing, and it was simply inadvertently left out of the bill. [LB797]

SENATOR HOWARD: Okay, thank you. [LB797]

CHRIS PETERSON: Just dropped it. [LB797]

SENATOR GAY: Senator Erdman. [LB797]

SENATOR ERDMAN: Chris, I've got a couple questions after reading the bill. Section 1 updates the reference to the Medical Assistance Act, in Title XIX and Title XXI. The date is as they existed on April 1, 2008. That's a future date. [LB797]

CHRIS PETERSON: Um-hum, right. [LB797]

SENATOR ERDMAN: Congress is in session. [LB797]

CHRIS PETERSON: Right. [LB797]

SENATOR ERDMAN: They can do some pretty interesting things when they're in session. Do we know that there is something specific that we're targeting? Is that the right date? I mean, is that what we're required to do? [LB797]

CHRIS PETERSON: That's a good question, Senator. What I would tell you is that we've done this every year, because based upon what the federal law has told us, we have to update the law because we cannot be responsible for any change made after the date that's in the statute. And we've gotten called on it on the floor before, so we started this about four years ago, just updating that. Whether that's the right date, that's the one we've been using. I don't know why we've used April 1, but I can find out. [LB797]

SENATOR ERDMAN: But for example, if we know what is in existence today, we could say January 1, 2008, then we know what we're dealing with, and if we get into the middle of session and something major happens in federal legislation in these two areas, that may create some unintended consequences. And if we're trying to hold ourselves to an existing federal law or act, as we know it exists at a certain date, I'd like to know that we know what is in that law, as opposed to perspective. [LB797]

CHRIS PETERSON: Great. I can understand that, with the discussions that are going on at the federal level. [LB797]

SENATOR ERDMAN: On the...Section 4, dealing with the Rural Health Systems and Professional Incentive Act, we're changing the definition of advanced practice registered nurse to nurse practitioner? [LB797]

CHRIS PETERSON: Right. [LB797]

SENATOR ERDMAN: The logic behind that is the definition of an advanced practice nurse, APRN, has changed? [LB797]

CHRIS PETERSON: Yes. [LB797]

SENATOR ERDMAN: Is the intent here to restore a previous understanding or to limit those that are currently eligible? [LB797]

CHRIS PETERSON: It's to restore a previous understanding, which was that it was only the primary care specialties. [LB797]

SENATOR ERDMAN: But right now, any member of the certified registered nurse anesthetists, nurse midwives, clinic nurse specialists, as well as nurse practitioners, are eligible? [LB797]

CHRIS PETERSON: Only because the law caught us. We went forward, and then July 1, when we did the bill, the law was defined. The APRN was only for those specialties, I believe those five I mentioned. July 1, then, the language changed, and we knew we were at a kind of "tweener" definition there. There was never any indication on our part that would enlarge it beyond those primary care specialties, which were the original part of the rural health incentive law. This was simply to keep it status quo and take into account the change in the definition, and not enlarge the field of applicants for the loan repayment. There was never a request to do that. It was simply because of the way the laws passed each other that the definition was expanded. [LB797]

SENATOR ERDMAN: Do you have individuals now that fit into those other categories that are applicants under the plan? [LB797]

CHRIS PETERSON: No. No, the statute still says it's the primary care. That was the original understanding of the original bill. [LB797]

SENATOR ERDMAN: And the last question I have is on page 17. This deals with the administrative disqualification process for Aid to Dependent Children, and in specifically lines 2 through 6 it says the department may initiate an administrative disqualification proceeding when it has reason to believe, on the basis of sufficient documentary evidence, that an individual has committed an intentional program violation. Proceedings under this section shall be subject to the Administrative Procedures Act.

[LB797]

CHRIS PETERSON: Great. [LB797]

SENATOR ERDMAN: The word "sufficient" there is not found in any of the other provisions as far as information that is known. What is sufficient documentary evidence, and is the word "sufficient" necessary, or is it vague, that one may be able to restate that, that the department may initiate an administrative disqualification proceeding when it has reason to believe, on the basis of documentary evidence? [LB797]

CHRIS PETERSON: Let me find out for you, because I didn't realize it wasn't part. It would be a mirrored statute, similar to the other. [LB797]

SENATOR ERDMAN: Well, I just read through the language here, and it may be somewhere else, but I didn't see anywhere else in this section of law where it refers to sufficient evidence. It refers to a different...I'll find it here, if someone else has questions. If not, we can follow up later. But I just caught those three items. [LB797]

CHRIS PETERSON: I don't think the... [LB797]

SENATOR ERDMAN: Since we're here at 6 o'clock at the Chairman is not, we might as well make good use of our time. [LB797]

CHRIS PETERSON: I would say there's no intention to either create a new definition or limit what was already there. The idea is to allow us to do the APA, the Administrative Procedures Act, so people have the ability to appeal, once a departmental decision has been made. [LB797]

SENATOR ERDMAN: And like I said, maybe that's consistent with another act. It's just... [LB797]

CHRIS PETERSON: If it's not... [LB797]

SENATOR ERDMAN: When I read through here, I didn't see that... [LB797]

CHRIS PETERSON: If it's not, it's not to be any more onerous than what was there. [LB797]

SENATOR ERDMAN: Right. It just leaves a question as to what is sufficient. [LB797]

CHRIS PETERSON: Okay. [LB797]

SENATOR ERDMAN: And if you're going through an administrative procedure or

someone is going to review what it is you're doing, having the basis of sufficient document evidence is different than having a basis on documentary evidence,... [LB797]

CHRIS PETERSON: Okay,... [LB797]

SENATOR ERDMAN: ...because you're going to have to make a judgment on what is sufficient. [LB797]

CHRIS PETERSON: ...I will find out. [LB797]

SENATOR ERDMAN: That's all I'd have for the moment. [LB797]

CHRIS PETERSON: Okay. [LB797]

SENATOR GAY: Any other questions? I don't see any. Thanks, Chris. Are there any other opponents who are going to talk? Any opponents who would want to... [LB797]

HEATHER SWANSON: I would like to be neutral. [LB797]

SENATOR GAY: Neutral? Okay. Are there any...first of all, are they any opponents here yet to talk (inaudible)? Okay, neutral. [LB797]

HEATHER SWANSON: Hello, I'm Heather Swanson, S-w-a-n-s-o-n, and I'm from Wilcox, so I'm in District 37, Senator Johnson's district. And I want to be neutral because I think the rest of the bill I know really nothing about, but what I was concerned about was changing the language of APRN, from APRN to nurse practitioner only. And I am aware of why that language was changed. I was a part of the APRN coalition when that bill was drafted that put all advanced practice registered nurses under the APRN category. And I'm glad I didn't prepare written testimony, because I would have had to change it anyway. When she spoke about who qualified for the rural health specialties, actually I think nurse midwives would fall under that category fine, because she discussed or mentioned that women's health practitioners and primary care practitioners, those are the areas that are focused on. And as a nurse midwife, I provide all the same services that a women's health nurse practitioner does, only I can also attend deliveries. So I would meet the...I would also provide the same services that a women's health NP would already be providing, and they would qualify for loan repayment for service in rural areas. Also, certified nurse midwives are educated and credentialed to provide primary care services for women. We do annual exams, PAP smears, GYN care, colds, headaches, things like that. So I can see somebody in this state, under my license, for all those things. So I do believe nurse midwives would qualify for that category, so my request from you guys who are considering this is to also add certified nurse midwives, in addition to nurse practitioners. That's all I have.

[LB797]

SENATOR GAY: All right. Any questions? Senator Erdman. [LB797]

SENATOR ERDMAN: Of course, Heather, you couldn't attend a home birth in Nebraska, because we're one of two states that... [LB797]

HEATHER SWANSON: Yes, that still prohibits that. [LB797]

SENATOR ERDMAN: You would be violating your license by doing such. [LB797]

HEATHER SWANSON: Um-hum. [LB797]

SENATOR ERDMAN: The term that was defined prior to July 1, 2007, was those primary care specialties of family practice, general internal medicine, OB-GYN, general pediatrics, general surgery, and psychiatry. And you're making the point that certified nurse midwife technically would fall under some of those categories or would directly be eligible otherwise? [LB797]

HEATHER SWANSON: Yes. [LB797]

SENATOR ERDMAN: And just because you're a certified nurse midwife shouldn't disqualify you, because you're able to provide those services and should, therefore, be eligible for the same repayment as others that would, that would not have your title. [LB797]

HEATHER SWANSON: And I previous...I worked in a rural area that's considered underserved, and I was ineligible for this rural health service loan, and so I went and worked at a federal site for the Indian Health Service in Pine Ridge, South Dakota, to qualify for their loan repayment, and I would have gladly stayed in Nebraska and worked here. And so this won't affect me. I'm also a family nurse practitioner licensed in the state of Iowa. I still have a little bit of loan money to repay. I'm not going to ask that somebody else repay that. I can take care of that myself. But for other nurse midwives coming into the state that are providing services that fall under this category, it would be nice for them to be included on that. [LB797]

SENATOR ERDMAN: Okay. Thank you. [LB797]

HEATHER SWANSON: Um-hum. [LB797]

SENATOR GAY: Thank you. Any other questions? Thank you for your patience,... [LB797]

HEATHER SWANSON: Oh, you're welcome. [LB797]

SENATOR GAY: ...staying with us, appreciate it. Just for the record, too, we did have one letter from Nebraska Appleseed in opposition to LB797, so that will be included in the record. (See Exhibit 2) That will close the hearing on LB797. Thank you all for your patience. [LB797]

Disposition of Bills:

LB713 - Indefinitely postponed.
LB730 - Held in committee.
LB738 - Advanced to General File.
LB797 - Advanced to General File.

Chairperson

Committee Clerk