[LB141 LB230 LB250 LB394]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, January 29, 2009, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB141, LB250, LB230, and LB394. Senators present: Tim Gay, Chairperson; Dave Pankonin, Vice Chairperson; Kathy Campbell; Mike Gloor; Gwen Howard; Arnie Stuthman; and Norman Wallman. Senators absent: None. []

SENATOR GAY: All right. Thank you all for coming. Welcome to the Health and Human Services Committee. We'll get started today. We have four bills on the agenda. We'll get started. Before we get started, just want to go over a few ground rules. We have...if you're going to be testifying on any particular bill, we have testifier sheets over there that you need to fill out. If you can print those it would be helpful. And then also then when you come up to testify, if you can state your name and spell it out as well. It's all being recorded so the clerk can get that in the record. We have a light system here and that's for the benefit of the fourth person on the list, not the first. And what it is, we have a 5 minute...if you're opening on a bill, the Senators, you get as long as they want. If we ask any questions as well of you, that doesn't count towards your time, but there's a 5 minute time limit we'd like to have you follow. We won't cut you off right when that red light goes on, but it's time to start wrapping it up for sure. When the yellow light comes on you're at 4 minutes, so you'll kind of be able to see that. If...and like I say, the purpose of that is, we've had many hearings where the person at 5:30 or 6:00 p.m. at night even is not getting the same attention probably as the person at 1:30, so we've implemented that this year. We are on a streaming video as well that's broadcast. That's new this year. Just want to make you aware of that as well. If you have any handouts that you'd like to give the committee, we'd need 12 copies. If you don't have 12 copies, Justin or Blair, the pages, can make those copies for you. If you can get that ready before you come up even, they can start working on that if you have something to hand out. Other than that, my name is Senator Tim Gay. I'm the Chairman of the committee. We'll introduce ourselves starting to my right. []

SENATOR GLOOR: I'm Senator Mike Gloor, District 35, Grand Island. []

SENATOR PANKONIN: I'm Senator Dave Pankonin from District 2. I live in Louisville. []

JEFF SANTEMA: My name is Jeff Santema. I serve as legal counsel to the committee. []

SENATOR STUTHMAN: Senator Arnie Stuthman, District 22, which is Platte County, the Columbus area. []

SENATOR HOWARD: Senator Gwen Howard, District 9 in Omaha, but I apologize because I'm going to have to leave you to go to Revenue. (laugh) []

SENATOR WALLMAN: Senator Norm Wallman, District 30, which is south of here. []

ERIN MACK: I'm Erin Mack, the committee clerk. []

SENATOR GAY: Okay. And Senator Howard has left. She does point out that we will be...Senators will be coming and going as we're introducing bills in other committees so don't take any offense to that. Also Senator Kathy Campbell from Lincoln is on our committee who is actually right now introducing a bill in another committee. So also, courtesy, cell phones if you could turn those off, we'd appreciate that as well. If the committee members...sometimes we have our own phones on. We forget to do that. (laugh) But anyway, if you can help us out with that. With that, we'll get started. Senator Rogert is here to introduce LB141. Welcome, Senator Rogert. [LB141]

SENATOR ROGERT: (Exhibit 1) Thank you, Chairman Gay, and members of the committee. Good afternoon, my name is Senator Kent Rogert. I represent the 16th Legislative District and I'm here today to introduce LB141, a bill that creates the Brain Injury Council and the utilization of resource facilitators to enhance existing services for veterans in Nebraska who suffer from traumatic brain injury. Currently, according to the RAND Center for Military Health and Policy Research, we have approximately 320,000 service members returning from Afghanistan and Iraq who have reported experiencing a traumatic brain injury during deployment. Since brain injury screening began in April of 2007, 2,029 Nebraska veterans have been screened for brain injury. Of those screened, 500 Nebraska veterans have screened positive and only 316 have agreed to undergo a full brain injury assessment. This low number illustrates to us that many veterans are not getting screened for brain injury once they are in their community because they are choosing to seek medical attention from the civilian sector as opposed to returning to the Veterans Administration Hospital or clinics where such screenings take place. With only 40 percent of the veterans who return to the VA healthcare system, it's important for us to provide a systematic way to facilitate the connections between VA services and the civilian sector. The Nebraska Veterans Brain Injury Task Force states that returning veterans with brain injury need support not only from the VA and the Department of Defense but also from employers, educators, local healthcare systems, the state, and their community to be successful. The RAND report states that unless treated, symptoms such as brain injury can have far reaching and damaging consequences such as homelessness, domestic violence, possible unemployment, low productivity, reduce quality of life, and strain on families. Proper research facilitation will help identify and link returning veterans with brain injuries who are not a part of the VA screening or who were missed to available services in the VA system. In this case, the VA system would be a partner with the resource facilitator as they transition veterans back to the community by assessing available community resources. LB141 seeks to provide linkage between VA services and the civilian sector for the benefit of veterans with brain injury. It seeks to rectify the disconnect and also provide education and communication

between the VA, Department of Defense, employers, educators, local healthcare systems, the state, communities, to help veterans with brain injury. It's my hope that you consider this legislation and vote it out to General File for debate. I have an amendment that I passed around. What it does, it ensures that a physical therapist be part of the 15 member council. More specifically within the language, it provides for four members to be from the public or private health organizations. I'll be happy to answer any questions but there will be some folks behind me that may be able to answer some more of the technical stuff when it comes to the brain injury. [LB141]

SENATOR GAY: Thank you, Senator Rogert. Are there any questions from the committee for Senator Rogert? I don't see any. Are you going to stick around? [LB141]

SENATOR ROGERT: For a little bit, yeah. [LB141]

SENATOR GAY: Okay. Thank you. All right, proponents on LB141. [LB141]

PEGGY REISHER: (Exhibit 2) Good afternoon, Senator Gay and members of Health and Human Services Committee. My name is Peggy Reisher, and spelled P-e-g-g-y, last name R-e-i-s-h-e-r. I'm here today asking you to vote yes on LB141, the Brain Injury Act. And I've got some copies of things here and also another lady had given us a letter of support and I'll hand that to you too. I've worked at Madonna Rehab Hospital for the last 12 years as a social worker helping assist Nebraskans return back to their communities after having a brain injury. What I found is, it's not always hard...it's not always easy to find services exist in Nebraska for those with brain injury. In addition to my duties at Madonna, I'm the coordinator for the Brain Injury Advisory Council. The advisory council is funded by a HRSA grant. This is a competitive grant which encourages states to work on systems change for specific populations, one of which is veterans with brain injury. In efforts to be a state selected for the HRSA grant, which awards two federal dollars for every one state dollar, the advisory council has partnered with healthcare providers, veterans with brain injury, and representatives from the government and military sectors to form what's called the Veterans Brain Injury Task Force. This task force has been meeting since June of 2008. We have looked at the strengths and weaknesses of the delivery system of services for those with brain injury in Nebraska. We know the gaps in services for veterans is very similar to those...services for veterans is very similar to those gaps in services for civilians. As advisors to the task force, the VA healthcare system and the National Guard representatives have helped us understand the efforts that they have made in reaching out to Nebraska veterans with brain injury. However, the fact remains that statistically only 40 percent of those veterans are going back to the VA healthcare system. We know there is a large group of veterans in Nebraska not getting screened for brain injury, thus not getting the assistance they may benefit from after having a brain injury. As a task force, we feel Nebraska needs to establish a system of resource facilitation for individuals with brain injury. Resource facilitation can be that designated first stop for

learning about what brain injury services exist in the state at a state as well as national level. It can be that link to the VA, it can be the number which the VA and the DOD case managers call as they help transition veterans back to Nebraska. It can be that resource which helps build brain injury awareness and information to those communities which have a limited understanding of how to support those individuals with brain injury. Resource facilitation is a concept similar to what's trying to be accomplished with the children's behavorial health initiatives. However, this would be the first stop for those with traumatic brain injury. Resource facilitation is not a new concept. Forty states have had some form of resource facilitation. Unfortunately, Nebraska is not one of them. Task force advisors from the DVBIC or the Defense and Veterans Brain Injury Center, as well the VA, have worked with states such as Iowa, Kansas, Colorado, which have resource facilitation available. They report those states are a lot better equipped to help them identify resources, thus making veterans transition back to the community much smoother. If you're interested in the information about how resource facilitation has done in other states, just let us know. And I know, I have given you some examples of how other states are doing this. Although each state seems to deliver this service in a different way, the bottom line is they've all recognized there's a need in their state to find, and have found ways to support it. I think it would be hard for any of us to turn his or her back on veterans who have stood tall and protected our nation. But I also know these tough economic times one of the first questions which come to mind is, how can we afford resource facilitation. It comes down to the almighty dollar, the price tag, the benefit versus the cost. It's important for us to be good stewards of Nebraska resources. But I think it's also important to look at this fiscal note and ask the question, is that too much money to spend to helping the veterans returning to Nebraska with brain injury. Many of those returning with brain injury also have sacrificed their dreams, their jobs, their relationships because of the implications of brain injury. They need the support of our state to make that transition back to living productive lives and that starts with connecting them with resources that can make it happen. Again, I will be the first to say the VA and DOD are working hard to meet the needs of all those veterans with brain injury but the issue reaches way beyond the VA and the DOD. We as healthcare providers, family members, employers, community leaders, and state, yes, even the state of Nebraska needs to join together to support these warriors. It seems like a small price to pay when you think of the commitment, service, and courage our 7,000 Nebraskans, or Nebraskan veterans have shown us. And I ask for your support on this bill. Thank you. [LB141]

SENATOR GAY: Thank you. Any questions? Senator Gloor. [LB141]

SENATOR GLOOR: Thank you, Senator Gay. Ms. Reisher, I have a question, hopefully you can clarify. I'm trying to decide whether this bill is geared primarily towards veterans returning to civilian life after active duty and/or if it's also geared towards veterans like me who have been around for a while, and perhaps have had a car accident or suffered a stroke. [LB141]

PEGGY REISHER: I think for the most part, I know as our task force we've talked about that and I guess our dream would be that it would be for anybody, any of the veterans returning. But right now there's so much emphasis. The only ones getting the screening are those who are coming back from OEF/OIF. [LB141]

SENATOR GLOOR: And so that's the focus really primarily. [LB141]

PEGGY REISHER: At this point but if somebody called and said, okay, I've had a brain injury back in Vietnam, I think we would still do our best to try to link them with services. [LB141]

SENATOR GLOOR: Okay. Thank you. [LB141]

SENATOR GAY: Any other questions? Don't see any...oh, Senator Wallman, get that hand up. [LB141]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you for coming. I have a relative that was Korean war vet so when you diagnose this, sometimes the client still doesn't want help. How...do you have psychiatrists or psychologists that help people out on that at Madonna? [LB141]

PEGGY REISHER: Yep, and actually one of them will be here testifying for us today. [LB141]

SENATOR WALLMAN: Okay. It's a tough issue. [LB141]

PEGGY REISHER: It is a tough issue. [LB141]

SENATOR WALLMAN: Thank you. [LB141]

SENATOR GAY: Senator Pankonin. [LB141]

SENATOR PANKONIN: Thank you, Chairman Gay. Peggy, thanks for coming and had to work with you a little bit on this issue. Do you think having this for the veterans also help civilians because our state infrastructure in this area would increase and there would be more? Is there any relation there? [LB141]

PEGGY REISHER: That is my dream. (laugh) That we open this up. I mean, start the ball rolling for the veterans, but there's thousands of those with brain injury across the state and it needs...if we can start the infrastructure, start identifying those resources that eventually those who aren't necessarily veterans can turn to that same set of resources that's been developed because of this. [LB141]

SENATOR PANKONIN: This morning on the way down here early, and I can't even remember if it was NPR or listening on the radio to a TV station, but they were talking about a new study on athletes, young athletes that had concussions and as they aged, they might be healthy otherwise but that those had an effect as well. So it reminded me about this bill being up today and that this issue is, even though this is fairly tightly focused, is a broad issue of our society. [LB141]

PEGGY REISHER: Yeah, I know last year you guys helped us pass a bill for us to send out information, resource information to those veterans...or to those folks with traumatic brain injury and within a nine month period we have over 4,000 people that we sent letters to. So it's not a, it's not a just a veterans issue, it's a larger issue. [LB141]

SENATOR PANKONIN: Thank you. [LB141]

SENATOR GAY: Any other questions? I have one. Were you involved with the drafting of this bill somewhat? [LB141]

PEGGY REISHER: Part of it, yeah. [LB141]

SENATOR GAY: Okay. And it sounds like your professional in the field, but when you get to 15 members...and I apologize, maybe I should have asked Senator Rogert this. When you get to 15 members, why 15? And I see we have an amendment to add someone else. Is that...that seems to me like a lot of members maybe, but... [LB141]

PEGGY REISHER: It's kind of based on...I guess, we have specific questions. I'll maybe turn it over to Mark Schultz whose... [LB141]

SENATOR GAY: And if you don't feel comfortable, I can wait, but somebody can address that. [LB141]

PEGGY REISHER: I'm going to have Mark address that. [LB141]

SENATOR GAY: Okay. No problem. I just... [LB141]

PEGGY REISHER: That's a good question though. [LB141]

SENATOR GAY: If it's something specific that we need all 15 in each field or what, so we'll deal with that. All right. Any other questions? I don't see any. Thank you. [LB141]

PEGGY REISHER: All right. Thank you. [LB141]

SENATOR GAY: Thank you. [LB141]

LORI TERRYBERRY-SPOHR: (Exhibit 3) Good afternoon, Senator Gay, and other members of the Health and Human Services Committee. I'm Dr. Lori Terryberry-Spohr, that's spelled L-o-r-i, last name, T-e-r-r-y-b-e-r-r-y-S-p-o-h-r. I am the Brain Injury Program manager at Madonna Rehabilitation Hospital here in Lincoln. And professionally, I am a clinical neuropsychologist and I have worked in the field of brain injury throughout the last 18 years during my training and career. Additionally, I am currently a member of the Veterans Brain Injury Task Force and it is primarily in that capacity that I come here to urge your support for LB141, although my experience as a clinician have made me aware that this issue is in dire need of attention. Last year Madonna Rehabilitation Hospital secured a contract with the Veterans Administration to provide evaluations for returning Operation Enduring Freedom and Operation Iraqi Freedom veterans that had screened positive for symptoms of a possible brain injury. Although working in the field of brain injury has previously made me well aware of the difficulties with accessing resources for all of the brain injury population, becoming more involved with the veterans of this war has brought greatly increased awareness of the challenges that they face in particular. When a veteran returns from the war, they are generally very anxious to get home, not surprisingly, often they try to get through any exit questionnaires or procedures as quickly as they can in anticipation of returning to their family and community. What often happens though is after that honeymoon period has worn off and they try to return to their jobs and previous activities, they find they simply cannot function as well as they have previously and they do not know where to turn. Common...physical symptoms include headaches, dizziness, and balance issues. Common cognitive complaints include problems with memory and focusing their attention. Psychologically, they commonly report irritability and may have symptoms of post-traumatic stress disorder and depression. But as is commonly part of the military mindset, they often try to struggle through on their own, not knowing where to turn to for help. If they are forward enough to bring it up to their primary care provider, those providers generally have very little training in identifying resources for them or even how to diagnose a brain injury months or perhaps years after it has happened. Although the military system, including the DOD and the VA, have done a tremendous job of increasing the awareness and services for veterans with brain injury, they too have difficulties with identifying resources for individuals with brain injury and they cannot be responsible for educating all the other nonmilitary providers in the state. In addition, only about 40 percent of returning veterans utilize the VA system for their healthcare, suggesting that evaluation and diagnosis of brain injury as well as helping these individuals to identify appropriate resources for treatment, support, funding, etcetera, is at best hit or miss. Even when the veteran informs a military case manager of their need for services, that case manager may not be from their area and may even be in another state and Nebraska has no identified contact person to help them. Forty other states have developed the position of resource facilitator to address this issue. Most of those states have multiple resource facilitators because they have come to appreciate both the need for a contact person as well as a central resource for brain injury information.

Our vision for LB141 is that the resource facilitator will be both a point of contact and an educational resource. They will play the role of information center for those around the country who need to identify services for veterans with brain injury in our state. In addition, they can help educate primary care providers and the general public on the signs and symptoms of brain injury. They will serve as the information center for the resources available for those veterans who may question if they are having symptoms of a brain injury, or who have been diagnosed and are in need of vocational, educational, financial, medical or psychological assistance. It is our hope by having this position be a state position rather than affiliated with any particular organization or group that it will be readily utilized by all. Obviously, I am passionate about my work with this population, but I feel that LB141 is well past due as evidenced by the fact that 40 other states already have this position in place. We cannot continue to let care providers for our military service personnel or those veterans themselves feel lost without a place to turn to for assistance or ask questions. I encourage you to vote in favor of LB141 so we can address this issue within our state. I thank you for your time. [LB141]

SENATOR GAY: Thank you. Are there any questions from the committee? Senator Stuthman. [LB141]

SENATOR STUTHMAN: Thank you, Senator Gay. Doctor, is it fairly simple to diagnose brain injury or is it a real complex problem? [LB141]

LORI TERRYBERRY-SPOHR: It's fairly simple if the injury was severe because of that usually the trauma is easily recognized and the symptoms are easily dated to that severe brain injury. When the brain injury is milder, it can be just as disruptive to their life but oftentimes doesn't get diagnosed in theater or at the time of the events. It happens later when they try to return to the less regimented structure of a nonmilitary life when they realize how significant the problems are. And then it becomes difficult because it has to done retrospectively and you have to know what you're looking for and all the different criteria to meet the diagnosis. [LB141]

SENATOR STUTHMAN: Is there as much in the general public with brain injury or is it more from military, people coming back from the service? [LB141]

LORI TERRYBERRY-SPOHR: In the general public, the civilian population, so to speak, most brain injuries occur as a result of falls or motor vehicle accidents and so they're directional force injuries, is what we refer to them as. They're from a single direction and they're a certain type of brain injury. In the military population what's so different about this conflict than previous ones is that we have a lot of blast related injuries which are more compression and wave type injuries. And so they're a little bit different in terms of the mechanism of force and we're still learning about how that's different in terms of symptoms and exacerbation and how long it lasts, the course and duration following that. But in general, there are just different types of mild brain injuries and both occur

with a very high incidence. [LB141]

SENATOR STUTHMAN: Okay. Thank you, Doctor. [LB141]

SENATOR GAY: Senator Pankonin. [LB141]

SENATOR PANKONIN: Thank you, Chairman Gay. Dr. Terryberry-Spohr, welcome. She's from Cass County so I'm very proud to have her here. [LB141]

LORI TERRYBERRY-SPOHR: Thank you. I am and I still live there, so thank you. [LB141]

SENATOR PANKONIN: And I know her folks real well. But from a medical standpoint when people are diagnosed is...what's the chances for recovery and I know every case is different, but can people make significant progress with a place like Madonna and what's kind of been your experience in this area? [LB141]

LORI TERRYBERRY-SPOHR: Okay. Most of the research suggests that early identification and treatment is most successful. Because what happens over time is there's a lot of overlay of maladaptive coping patterns, additional onset of depression, things like that when people sense they're failing and they don't understand why. So we do...we are more successful with our treatment when we can get in there early, but we also have considerable resources, or research to suggest that it's never really too late either. That if at any point the person asks for assistance and help, that they can still benefit from learning additional coping skills, additional compensatory mechanisms like how to aid their memory, how to aid their attention, how to pace themselves. We might be able to do something to control the headaches. There may be treatments for the dizziness problems that have never been addressed. So it's really never too late but early is better. [LB141]

SENATOR PANKONIN: And a follow-up question as I asked before, any improvement in this area would also help the general population because of furthering...not only military veterans but just more progress we make in this area would be something you'd like to see as well, I'm sure. [LB141]

LORI TERRYBERRY-SPOHR: Well, in an ideal world, and when we first started talking about this, we would love for this to be a resource facility that is open to all individuals with brain injury. But we recognize there are limited resources in our state as well as around the country right now and we feel like we have a very deep sense of obligation to the veterans population in particular, so that's where we've chosen to start to introduce this. But as a resource facilitator has all those resources and things in place, there's nothing to say that at some point that couldn't be expanded to anyone who could benefit from that service. [LB141]

SENATOR PANKONIN: Thank you. [LB141]

SENATOR GAY: Any other questions? Senator Wallman. [LB141]

SENATOR WALLMAN: Thank you, Chairman Gay. Yes, Doctor, thanks for coming. Do you think as a military...I'm a former military person, when we muster out or, you know, discharge, do you think these people are told their conditions or warned or have places to go, then you want a facilitator like Madonna, be automatically hooked up to something, you know. If your get wounded you'll be discharged, so...severely wounded. So do you think that should be something in place to that, to hook that together better? [LB141]

LORI TERRYBERRY-SPOHR: If I understand correctly the question, I believe that our more severely wounded are actually better transitioned back to services than our mild to moderate. Because we have put in place at the federal level the Polytrauma System of Care, which was specifically designed for individuals with multiple types of injuries, including brain injury, to be transitioned back to stateside and given, hopefully, the best of care in rehab. And so those more severely impacted soldiers who are military personnel they get, I think, very good care. But they also, I've even heard from the Polytrauma Centers because we've talked considerably with the individuals at the Minneapolis Polytrauma Center about how, what a challenge it is for them when they have four Polytrauma Centers around the country, soon to be five, how do they get them back to their home state and who do they go through to set them up at home once they leave there. And so even the individuals from the Minneapolis Polytrauma Center have said, we really need contact people so when we send someone who is from Nebraska back there after they leave here, we know how to identify what's there for them. And so I think it would be beneficial even at that level. [LB141]

SENATOR WALLMAN: Okay. Thank you. [LB141]

SENATOR GAY: I have one question for you. In your testimony you had stated only 40 percent of returning veterans utilize the VA system for their healthcare. And then also you had mentioned a little bit that you felt the military system, Department of Defense and the Veterans Affairs has done a tremendous job of increasing awareness. Do you...can you expand on that a little bit of what they're doing to increase awareness because I've seen issues on this just reading about it. But also and then where you came up with that 40 percent and why you think only 40 percent would take advantage of that benefit as access or whatever. Anyway if can expand on that a little bit, that paragraph. [LB141]

LORI TERRYBERRY-SPOHR: I can try because we've had a number of conversations about that. I think, you know, the VA person are better equipped to answer it even than I

am, but they did put in place in 2007 what they call the first level screening for brain injury for returning OEF and OIF veterans. And essentially that's a four question screening tool that they try to ask every returning veteran but they have to go back retrospectively now and catch everybody that came home before 2007 and so there's a large backlog as they try to work through that group. Since that point in 2007 that that's been implemented, I think we're doing a better job of getting people to the resources they need. But there's still a lot of people who don't realize it right up-front. They may choose not to get their healthcare through the VA system for some particular bias in their past or somebody else's experiences there. They're hesitant. They just need to know, where do I go to ask some good questions. And this would, hopefully, fill that gap of all those individuals who don't connect for some of those reasons. Whether they're accurate or not, we know they exist, so. [LB141]

SENATOR GAY: Thank you. Any other questions? Don't see any at this time. Thank you for your testimony. [LB141]

LORI TERRYBERRY-SPOHR: Thank you very much. [LB141]

SENATOR GAY: And for the record, just note that Senator Campbell has joined the committee. Other proponents? [LB141]

MACK RICHARDS: (Exhibit 4) Good afternoon, Senator Gay, and members of the Health and Human Services Committee. My name is Mack Richards, M-a-c-k R-i-c-h-a-r-d-s. I was a Sergeant in the Nebraska Army National Guard. I joined November, 2001, at age 46. I was deployed to Bosnia and then to Iraq. During the deployment to Iraq, I came under a rock attack in May 4, '06, and was wounded and sustained a brain injury. That was the start of a long journey back to the United States where some things worked well and some things did not. Many of my fellow veterans and I came back to an overburdened system which was not able to deal with the large number of soldiers. In my experience, the bureaucratic system prevents soldiers from timely treatment in military hospitals. One program that did work well for me and others was the Community Based Health Care Organization and the state that I went through was in Arkansas. I felt lucky to be placed there. I feel the reason this program worked well is that they were able to send veterans to treatment closer to home. I would consider the two case managers, Lieutenant Colonel Urdahl and Lieutenant Colonel Sandbothe and two platoon Sergeants to be the unseen and unknown heroes in all of this, and true advocates for the soldiers they help. They were key in helping me get back to Nebraska. However, it's my understanding this was not an easy feat. This team of people found Nebraska to be a difficult state to find healthcare services for those with brain injury. These case managers help place veterans across the United States so they have experience in trying to identify resources across the nation. They reported they know many other states have a point of contact for healthcare information regarding brain injury, but they didn't find that to be the case in Nebraska. Because of that

experience, I'm here today in support of LB141. I am hopeful this will help fix the problems I ran into as I attempted to return to Nebraska. I feel that it is important to get resource information into the hands of those helping us to return to Nebraska. It would make sense and provide services in a timely manner so people heal quicker and can get back to living productive life and paying taxes. Taxes which will help pay for a position like resource facilitation. I feel this program would pay for itself in the long run. None of us know when we will get sick or injured so it may help you or a family member. I feel resource facilitation makes sense as veterans return with brain injuries. Again, I encourage you to vote in favor of LB141. Thank you. [LB141]

SENATOR GAY: Thank you. Any questions from the committee? Senator Gloor. [LB141]

SENATOR GLOOR: Thank you, Chairman Gay. Is it General Richards? [LB141]

MACK RICHARDS: Sergeant Richards, sir. [LB141]

SENATOR GLOOR: All right. (Laughter) Sergeant Richards, first of all, thank you. Second of all, outside of this bill, if you could change anything else about the way this state treats its veterans, what would you try to change or improve on? [LB141]

MACK RICHARDS: In my experience and correct me if I'm getting of course, I was medivacked out of Iraq to Germany and then to a Army hospital here in the United States. There seems to be a disconnect or a gum up in the Army hospital system. I got into this program because I was National Guard. And it's my understanding that reservists are in the program too. Whereas, full-time Army can't get into a program like this and it's...I just don't know. It's bizarre, the way they do things some times. [LB141]

SENATOR GLOOR: Okay. I appreciate... [LB141]

MACK RICHARDS: I wish I could give you a better answer, sir. [LB141]

SENATOR GLOOR: Thank you. You can provide a unique insight so I appreciate your candor. [LB141]

SENATOR GAY: I've got a question for you. You talked about some people that helped you along the way. Were those Nebraska National Guard advocates, or... [LB141]

MACK RICHARDS: They were my case managers and the two platoon Sergeants in Arkansas, sir. [LB141]

SENATOR GAY: Oh, down there? And they helped you? [LB141]

MACK RICHARDS: Yes, sir, but they were National Guard. [LB141]

SENATOR GAY: Yeah, and they were advocates for the soldiers to... [LB141]

MACK RICHARDS: Well, they were case managers and, but I still am in phone contact with them off and on, still. Both of them have retired since then. I've gone through two of them. I've been in long enough, so. [LB141]

SENATOR GAY: But, they've been a good resource. [LB141]

MACK RICHARDS: Excellent. [LB141]

SENATOR GAY: All right. Any other questions? I don't see any. Thank you for coming today and testifying. [LB141]

MACK RICHARDS: Thank you, sir. [LB141]

SENATOR GAY: You bet. Other proponents who would like to speak. [LB141]

MARY BRASFIELD: Thank you Senator Gay, and Senators of the Health and Human Services Committee. My names is Mary Brasfield, M-a-r-y B-r-a-s-f-i-e-l-d. I'm here to support bill LB141 because it has, it could have affected my family in a positive note. My daughter and son-in-law were almost killed in a motor vehicle accident in Lincoln, April 19, 2007. A gentleman run the stop sign and hit them. My son-in-law's active duty, Army. My daughter, while she's a military wife by all standards for TRICARE, she's considered a civilian. And now I also have a nephew who is stationed in Georgia who just came back from Iraq who suffered six direct AED hits but has not been tested for traumatic brain injury. As Peggy so correctly told me, my family is raining in brain injuries at this moment. The things that happened to me along the way were positive for my children but because I became my children's advocate I never stopped making phone calls to make things happen for my daughter or my son-in-law that needed to happen. Many people would not have went that far, would not have known they could challenge the system as much as I did. When Kristi and Josh were getting ready to transfer from Madonna to Quality Living to further their rehab, Josh was able to go because his commanding officers could sign a note saying he could go to Quality Living. Kristi had the only option of going to a nursing home because that's just the way TRICARE works. Two weeks worth of phone calls. I called our Governor, I called many of you, Senators. I put on my web page and had people who read my web page daily call their senators, and Kristi went to Quality Living. Not everybody would have known they could have challenged the system. I believe if Nebraska passes this bill, we're going to be proactive to our veterans and to those who have traumatic brain injury instead of reacting, which is what I was doing at that point in my life. I reacted to everything that came along because I did not have an advocate in my corner who had

all the answers I needed. So sometimes it would take me three phone calls to find the person I needed to give me the answer and the direction to go. And sometimes it took me 25 phone calls. But I wanted the best there was to offer for my children so I never stopped. Those phone calls continue even today. Today I know about Hyperbaric Oxygen Therapy for traumatic brain injury. The sooner you have it, the more positive results there are, but I just now found out about it because there was nobody who had all this information at hand. We're still going to try. In fact, I got notice today that we have permission from the doctor to take Josh to Louisiana for Hyperbaric Oxygen Therapy. Hopefully, it will soothe some of the spacidity he has. Maybe it will improve his speech. Maybe it will improve his cognitive awareness. We're not sure, but whatever positive outcome comes from it, we're willing to take. I called a friend and asked her to help me with this and she told me I didn't need any help knowing what to say to you guys because I was going to speak to you from my heart and soul. And just you guys knowing how my children suffered and all the phone calls I had to make to make things happen for them, would lead credence to the fact that LB141 is a necessity in our state. It's not going to change anything for me but it's going to change for those who come after me, for the mother who doesn't know to make 25 phone calls to get one thing done for her children. It would have brought faster treatment for Josh and Kristi. It would have allowed me to be at their bedside more often. It would have allowed me to spend more time with the four grandchildren I'm now raising because I would not have had to make quite so many phone calls. I thank you for your time. And passing this bill will provide the much needed professional assistance necessary when a family is faced with a loved one who has been injured either in wartime or peacetime that results in a traumatic brain injury. Thank you for your time. [LB141]

SENATOR GAY: Thank you. You did an excellent job. Any questions? Senator Wallman. [LB141]

SENATOR WALLMAN: Chairman Gay. Thank you for coming. Now are you satisfied with Quality Living? [LB141]

MARY BRASFIELD: Do what? [LB141]

SENATOR WALLMAN: Are you satisfied with Quality Living? [LB141]

MARY BRASFIELD: We were. We were very satisfied. [LB141]

SENATOR WALLMAN: We are too. So... [LB141]

MARY BRASFIELD: We were very impressed. In fact, Josh has been home. He came...Josh came home July 11 and Trish Clark visited us just last week to make sure things were going okay and to bring down some paperwork for us about Josh being a volunteer at the VA. [LB141]

SENATOR GAY: All right. Let's see if there are any other questions. Any other questions from the committee? No. Thank you for joining us today. [LB141]

MARY BRASFIELD: Thank you. [LB141]

SENATOR GAY: Thank you. Any other proponents on LB141 that would like to speak? Come on forward and... [LB141]

KIRK PECK: Good afternoon, Senator Gay, and members of the committee. My name is Kirk Peck, K-i-r-k, last name P-e-c-k, and I'm a physical therapist in Omaha, Nebraska, and I'm here representing...I'm chair of our legislative committee, so I'm actually here representing our Nebraska Physical Therapy Chapter in Nebraska. And I just brought forth a statement of proponent for LB141 in support. If you don't mind my reading this, it's fairly brief but as to why we support this bill. This is from Teresa Cochran, who is our chapter president. If you want her spelling, T-e-r-e-s-a, last name is C-o-c-h-r-a-n, as chapter president of Nebraska Physical Therapy Association. I am here to submit this letter as president of the Nebraska Chapter Physical Therapy Association in the capacity which represents over 80 percent of all licensed physical therapists and certified physical therapist assistants in the state of Nebraska, wish to express our support for LB141 which would impanel the brain injury council to oversee programs created under the federal Traumatic Brain Injury Act. The role of the council would involve coordination of support for veterans with brain injury by maximizing and enhancing existing resources to allow veterans to live and function in the community. For this endeavor to prove successful, it will be important to ensure that the council membership would include stakeholders who offer expertise and provision of care for persons with traumatic brain injury, as well as a consistent advocacy for persons with disabilities. The Nebraska Physical Therapy Association would be pleased to offer such expertise to help the council utilize and increase capacity of existing services available to veterans with brain injury. In summary, we're very supportive of the intent of LB141. We're offering to identify a physical therapist with both clinical and advocacy skills needed to serve as an effective member of the proposed Brain Injury Council. NPTA's goal is protect Nebraskans with disabilities while serving as good stewards of limited health resources. I am pleased to have the opportunity to provide this information on behalf of the Nebraska Physical Therapy Association. I'd like to express our gratitude for the opportunity to serve those Nebraskans who have served our country so selfishly. Thank you. [LB141]

SENATOR GAY: Thank you, Mr. Peck. We did receive also, Senator Rogert gave that amendment to add a physical therapist on to the committee so we have an amendment here that was submitted to that affect, just so you know. [LB141]

KIRK PECK: Okay. Sure. [LB141]

SENATOR GAY: I don't know if you caught that earlier. Any questions from the committee? I don't see any. Thank you for joining us. [LB141]

KIRK PECK: Thank you. [LB141]

SENATOR GAY: Other proponents who like to speak on LB141. How many more do we have, proponents? Looks like maybe you're the last one. Any opponents that are going to be speaking on this? No opponents. And anybody neutral that might like to speak? Okay, looks like none. Okay, go ahead. [LB141]

MARK SCHULTZ: I'll be brief. Good afternoon, Senator Gay, and members of the committee. My name is Mark Schultz, M-a-r-k S-c-h-u-l-t-z. I'm the associate director of Vocational Rehabilitation Services in the Department of Education. And I'm just here to answer your question in regards to the makeup of the, for an injury council that's outlined in the bill. There's an existing Brain Injury Council that's a part of the federal TBI grant that the state receives and so it's based on that. And that makeup was based on technical assistance that was provided by the National Association of State Head Injury Administrators. When we were establishing that we asked for their assistance in determining the makeup of the council and they provided us with information about how their state's had established their councils and that's what we used, so. [LB141]

SENATOR GAY: Okay. Any questions from the committee? I have one then. So if we'd adopt this amendment, that would be 16 then... [LB141]

MARK SCHULTZ: That's no problem. [LB141]

SENATOR GAY: ...on the physical therapist if...so, you're not removing anybody. We're getting one more. Okay. I don't see any questions. Thank you. [LB141]

MARK SCHULTZ: Thank you. [LB141]

SENATOR GAY: (Exhibits 5, 6, 7, and 8) All right one more to call for any more opponents. Are none. Any neutral? None. And Senator Rogert, I don't see here. But we do have some letters of support also just for the record, from the Nebraska Hospital Association, the State Board of Education, and Marsha Stuckey (phonetic) is a personal letter and a service provider. Was there another letter to add to it? And also we have a letter that was submitted from a Chris Wolf from Scottsbluff, Nebraska, as well, it looks like. So Senator Rogert is not here so looks like he waives his closing, and his staff left, too, didn't they? All right, so we'll close the public hearing on LB141 and open the hearing on LB250. Senator Gloor. [LB141]

SENATOR GLOOR: Thank you, Chairman Gay, and esteemed fellow committee

members. I am Senator Mike Gloor, M-i-k-e G-l-o-o-r, from District 35, which is the district from Grand Island. I am here today to introduce LB250, a bill about physicians assistants, and I would deviate from my prepared text to relate to you that as a young medic in the Air Force many years ago, I was surprised and very proud when I kept running into physicians assistants who were trained at the University of Nebraska Med Center as PAs. And of course, being far from home at the time, and glad to have this connection with whom I asked, how did you end up at the University of Nebraska for your PA training? And the answer was, it's considered one of the few and leading places to get PA training in the United States. Because of that, from an historical perspective, I find it very serendipitous and quite an honor to be able to have an opportunity to present legislation that I believe modernizes statutes pertaining to the practice of PAs in the state of Nebraska. Nebraska originally authorized physicians to employ physicians assistants in the early 1970s. In 1985, that authority with limitations, prior approval, and time requirements expanded to using PAs in secondary offices and hospitals. LB250 has the goal of updating statute to reflect the reality about physicians and their physicians assistants practice medicine today. It changes the required proficiency exam for PAs to the nationally required exam, it assures standardization of practice and adherence to the nationally accepted level of education and scope of practice for PAs. It eliminates the additional level of credentialing for the supervising physician and eliminates the current requirement of supervision stated in hours or percentage of practice time. Importantly, it increases from two to four the number of PAs one physician can supervise and also allows a waiver for more. Eliminates obsolete language regarding specialty classifications since all education for PAs is really primary care, eliminates the statutory language regarding the backup physician to supervise PAs, eliminates the current requirement prior board approval for physician-PA agreements. This new agreement will identify the scope of practice delegating medical tasks appropriate to the level of competence of each PA, establishes the scope of diagnostic, therapeutic, and other medical services the PA provides. A physician assistant with less than two years of experience will have a higher level of supervision to be set by rule and regulation by the board, delineates methods of supervision, delineates methods of evaluation. The original agreement between the physician and the PA is to be housed at the physician's main office, copies at each satellite office or hospital that the PA may work in, have privileges for, and, importantly, with death certificates, will allow PAs to make death pronouncements and sign death certificates. This is an important move as it relates to the challenges in many of our rural communities having someone available to do this. It gives extra level of discipline regarding death certificates, requires the name of the PA to be on the prescription label in order to comply with federal changes in electronic prescribing. It does not change the current disciplinary procedures for a PA or physician under the Medicine and Surgery Practice Act. It does not allow the PA to practice without the supervision of the physician. It keeps requirements for the PA and supervising physicians to still meet, this specific hospital policies related to privileging. It's goals, in short, are to update statutes to make better use of physician's time and the PAs time, to increase the use of PAs,

and as a result in this state, with a workforce shortage when it comes to trained professionals, should help increase access to primary care services for a whole host of Nebraskans. Thank you, Mr. Chair, and I'll be glad to answer questions although there will be and is to follow a subject expert on this specific issue. Thank you. [LB250]

SENATOR GAY: Thank you, Senator Gloor. Any questions from the committee for Senator Gloor? I don't see any right now. Thank you. [LB250]

SENATOR GAY: All right, proponents on LB250? [LB250]

BONNIE SHEARER: (Exhibit 1) Mr. Chairman, members of the committee, thank you for the opportunity to appear before your committee today. My name is Bonnie Shearer, B-o-n-n-i-e S-h-e-a-r-e-r. I am a licensed physician assistant and also serve as the legislative chairman of the Nebraska Academy of Physician Assistants. NAPA is the state professional society for physician assistants representing the approximately 775 PAs in Nebraska. PAs have become well established as a member of the medical team since the original statute was passed in the early 1970s. I'm asking today for your support of LB250, which will modernize the PA Practice Act so that PAs and their supervising physicians may increase patient access to healthcare in Nebraska. It does not change the physician assistant scope of practice in Nebraska. The key provisions of this bill will (1) establish more meaningful standards of supervision for PAs. Supervising physicians will have more flexibility in determining how PAs can best be used to serve community needs. Supervising physicians will retain the ability to establish requirements that ensure patient safety and remain captains of the team. (2) Require that PAs with less than two years of experience abide by additional regulatory restriction. (3) Eliminate credentialing of supervising physicians and biennial fees. Streamlines procedures for physicians and hospitals to employ PAs. (4) Increase the number of PAs that one physician may supervise from two to four. This change allows physicians to adjust the number of PAs supervised to meet increased patient need for primary care. While PAs see patients for routine care, physicians can focus on more complex cases. (5) Allow PAs to sign death certificates and (6) clarify whose name must be written on prescriptions to comply with federal standards. The genesis of these changes began nearly a decade ago when physicians employing PAs found the 1985 statute outdated as medical models of care progressed. It had been increasingly difficult for these physicians to use PAs as the law became confusing and illogical as the healthcare environment changed. Medical health systems have changed to include Critical Access Hospitals, group practices, telemedicine, electronic medical records, Pads, etcetera. Physicians, PAs, and health facility administrators approached the state academy regarding their concerns. A poll of supervising physicians in 2006 found that the majority confirmed the law was outdated, and they agreed to these changes. A consensus was established with the NMA. The Department of Health and Human Services' licensing staff and their legal counsel raised no objections, and the staff felt that their workload would be reduced. The Board of Medicine took no action on LB250 at their January

meeting, the Board of Health has taken no action as well. The UNMC legislation review committee has issued a fiscal note that there would be no impact on UNMC and strongly supports passage of this bill as it updates the PA Practice Act which is over 20 years old and does not reflect current practice. These changes are in accordance to practice guidelines established by the American Medical Association and American Academy of Physician Assistants. LB250 will have no effect on the current disciplinary processes of PAs or physicians. Hospitals will still maintain their current ability to limit privileges of PAs. Physician Assistant scope of practice is unchanged. The academy does request an amendment on page 2, line 5. Commission...that's stated on the bill should be changed to Accreditation Review Commission on Education for the Physician Assistant. This is the correct name of the accrediting body for PA educational programs. The Nebraska Academy of Physician Assistants asks the committee to advance this bill to the full legislature. Thank you very much for your time today and for your continued work on behalf of all Nebraskans. [LB250]

SENATOR GAY: Thank you. Any questions from the committee? Senator Wallman. [LB250]

SENATOR WALLMAN: Chairman Gay, yes. I realize this grants quite a bit more authority to physicians assistants. As far as the death certificates, is that okay with insurance companies? [LB250]

BONNIE SHEARER: I don't see why that would be a problem for insurance companies. What is meant...not all PAs need that, to do that but for those PAs that are especially covering nursing homes, and when the physician is out of town, this expedites matters. [LB250]

SENATOR WALLMAN: Thank you. [LB250]

SENATOR GAY: I've got a question for you, thank you for this fax sheet. It says...and my question is the PAs with less than two years, you say there would be additional regulatory restrictions. What would those be? [LB250]

BONNIE SHEARER: Well, those would still be determined at the Health Department level and the Board of Medicine and Surgery's level, but it was...the thought was that this would give the more inexperienced PA an opportunity to define their skills a little bit better. And currently it could be current regulations that we have currently, that we have now which include charts signing, time together requirements, so that's very likely they will be those requirements that are currently in place for all PAs. [LB250]

SENATOR GAY: Okay, so at this point there is nothing specific, then, you just think there might be? [LB250]

BONNIE SHEARER: Well, there will be. There will be rules and regs that will be established and we'll flesh those out. And, again, they can be as liberal as what they are currently or they can be more restrictive. [LB250]

SENATOR GAY: Okay, and then that would just be with the department deciding that but I guess I'll follow-up on that later but, what that would be would be interesting to me. We...I can get that information then down the road but as we draft the regulations you just feel it should be less than two years, two years or less should have more restrictions than... [LB250]

BONNIE SHEARER: Right. Correct. [LB250]

SENATOR GAY: Okay. I'll follow-up on that on my own, then. Okay, all right, thank you. [LB250]

BONNIE SHEARER: They would have more stringent standards of supervision. [LB250]

SENATOR GAY: Which, yeah, and I can see that. Okay, all right, thank you. Any other questions from the committee? I don't see any. Thank you. Other proponents who would like to speak on LB250? Proponents, come on up. Oh, yeah. Do we have any other proponents? Hello. [LB250]

RICHARD BLATNY: Good afternoon, Senator Gay and other members of the committee. My name is Richard, R-i-c-h-a-r-d, Blatney, B-l-a-t-n-y, I am a practicing physician boarded by the American Academy of Family Medicine. I practice in Fairbury, Nebraska, I have for 36 years. We have had PAs in Fairbury for 30 years, and it has worked out very well. I speak in support of LB250. Senator Gloor kind of blew our thunder as far as mentioning all the things that this bill is going to change so I'm not going to go through all that again. The Nebraska...I am speaking for the Nebraska Medical Association. The Nebraska Medical Association and the PA group have been working together to update the PA law, and the NMA does support these changes. The PAs, I know, have also consulted the Board of Examiners in Medicine and Surgery, and obviously LB250 will make the physician-PA relationship more workable. Under LB250, it will still be up to the supervising physicians and the Board of Medical Examiners to define the matter and extent of supervision which is required, but the key is obvious that there is supervision. In our practice of four physicians and three PAs, I think we have the ideal situation. We're there for consultation, we're there, we supervise our PAs, every PA chart is cosigned by a physician. In our instance, passage of LB250 will not change anything. We feel supervision is important, our PAs totally agree with it and they really don't desire anything else other than the current situation. But I have to realize that in some areas of the state, these rules and regulations, the bill has not been changed since 1985 as Bonnie said. I served on the PA committee at the same time she was there, from 1985-89, and it's probably amazing that for its...it has held for 20

years right now. But probably in areas of the state, things do need to change. I personally have some concerns that four PAs are supervised by one physician. It's not something I would particularly want to do, but there may be a situation where it is necessary to provide quality care. The key is, again, supervision. The supervising physician is responsible, morally, liablely (sic), for that care. These changes, let's see, I agree with the stated design in that the PA, some of these supervisory conditions will have to be set up by probably the PA committee, which will work that out. I really don't have anything else to say, like I say, because we have already discussed what a PA does. So I thank you and would welcome any questions. [LB250]

SENATOR GAY: Thank you. Any questions? Senator Stuthman. [LB250]

SENATOR STUTHMAN: Thank you, Senator Gay. Would you say that if there is a physician and then you have the assistants, would they all have to be in one location or could you have a satellite station working where a physician assistant could work out of? And I am concerned about the rural areas, you know, because there's where the need is for some medical assistance. Would that work? [LB250]

RICHARD BLATNY: I think it would work, sir. We had a satellite office for a period of time. We had a situation where the physician would be there Monday, and a PA was there on Thursday. We did that. As time went on we eventually closed that because there became more other providers in the area and it just didn't seem to be that efficient. But we did that for 25 years. We, again, made certain that they were supervised, that we were available, I think telecommunication has been mentioned here, and I think it is valuable. The key is, is if you're there to consult with your PA and the degree of comfort that you have in knowing that they are performing the way you want them to. Yes, I think that is the answer in some of the more rural areas. [LB250]

SENATOR STUTHMAN: Well, with the technology that we have now, you know, in the telemedicine and the tele...conversation, you know, there can be satellite operations. [LB250]

RICHARD BLATNY: That's right. [LB250]

SENATOR STUTHMAN: And I think that's a need in the future because, you know, the people that are in these very small communities deserve, you know, health assistance also. [LB250]

RICHARD BLATNY: That's right. And records, you know, they're going to be electronic health medical records. [LB250]

SENATOR STUTHMAN: Yeah, um-hum. [LB250]

RICHARD BLATNY: And although I have to admit we are...I'm in a group, like I said, of four, seven providers. What we are relying on now is stenographers that are there just typing away, and what I did this morning will be on my desk this afternoon. They're excellent at it. But with electronic medical records, that will allow a physician to supervise even a little easier because of, just the time involvement, yeah. [LB250]

SENATOR STUTHMAN: Okay, thank you. [LB250]

SENATOR GAY: Are there any other questions? Don't see any, thank you for your testimony. [LB250]

JODENE SCHMIDT: (Exhibit 2) Good afternoon to the chair and the committee. My name is Jodene Schmidt, J-o-d-e-n-e S-c-h-m-i-d-t. I have been a physician assistant with Alegent Health in Schuyler, Nebraska, for nine years. I work in family practice with my main clinic locations being in Howells and Clarkson, which is about 20 miles away from our main clinic and hospital. I am here today to speak in support of LB250 because I feel current laws pertaining to PA practice and supervision often make our jobs as PAs, particularly in the rural areas, much more difficult than need be. More importantly, it oftentimes causes disruption in the care that we are trying to deliver to the people in rural Nebraska. I'd like to give...we have already talked about a lot of the reasons we are in support of it, but I want to give a few specific examples of problems, specific problems that I have incurred over the last few years. My first example is with the current regs that require a PA and an M.D. to have overlap time of 20 percent of the time that the PA is working. Meeting that requirement is not typically a problem in larger locations where there is more than one M.D. to do the supervising. However, in rural areas, this requirement causes unnecessary scheduling problems, particularly if there is only one physician physically present at the clinic to serve as their supervisor, or if we are trying to staff more than one clinic location. Scheduling the M.D. and the PA becomes a challenge sometimes, and it potentially also decreases the availability of medical services in the rural communities. For example, if you have more than one clinic, you might have to close clinic B for an afternoon or a day so that both providers can be present at clinic A at the same time to meet that 20 percent overlap rule. My next example also deals with the 20 percent overlap rule that we currently have. This becomes a huge problem anytime a PA, particularly in a rural location, loses their, what we call now primary supervising physician. Under current regs, if I lose my primary supervising physician, whether it is due to death, retirement, resignation, extended medical leave, basically, you know, I can't see patients until we rework my schedule to make sure that I am meeting that 20 percent overlap with the physicians at one of our other locations. And so in that case, one of two things would have to happen. Either one of the doctors from Schuyler has to come up to Clarkson or Howells or I have to go down to Schuyler for a day a week or a half day a week, whatever is needed to meet that 20 percent overlap. And this arrangement causes a lot of disruption and can decrease, again, the availability of one of the providers in one of those other areas. My

third example, currently the regs require that anytime I have a new supervising M.D., I must work side by side with them for 12 weeks before I can practice at a satellite clinic on my own. This requirement needs to be met anytime I have supervising physician turnover. Our Howells Clinic is a satellite clinic of the Clarkson Clinic, and so in the past this requirement actually had forced us to close the Howells Clinic for 12 weeks until I spend 12 weeks with my new supervising physician at the Clarkson Clinic location. And, you know, it doesn't matter how long I have worked with them or at those clinics or how much experience I have, that's the regs, and the clinic had to be closed. And this was...you know, the patients had to drive further for their care to the other clinic, it was very inconvenient for our patients, particularly for the elderly patients, and it resulted in a significant disruption in care. My fourth example has to deal with the PAs currently not being able to sign off on death certificates. Right now, if my supervising physician is gone on vacation for a few days, and one of our patients, like at the nursing home in Howells or Clarkson, dies, I can't sign it off, so I have to route the death certificate to Schuylar, and then those physicians don't know the patient, they may not even have a chart on the patient, so I have to route down and fax down chart information. And for them to sign off on something that I could have taken care of, and in particular it's sometimes frustrating to family members because they get the death certificate signed by some physician that that family has never seen or dealt with in the past. Current regs don't take into consideration key information, such as how much experience the PA has, how long they have worked at that clinic or how long the PA has worked with the other M.D.s in that practice. And so to me good supervision does not necessarily have to do with spending a certain amount of time together. You can spend as much time together as you want, that doesn't necessarily mean you're getting good supervision. Good supervision has to do with good communication between the M.D. and the PA, and good supervision does not necessarily need to be carried out face-to-face or during clinic hours. There are other ways these days we can meet those needs. Thank you. [LB250]

SENATOR GAY: All right, thank you. Any questions? Senator Stuthman. [LB250]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you for testifying, Jodene. I... [LB250]

JODENE SCHMIDT: I...sorry. [LB250]

SENATOR GAY: It won't be that bad, I bet. (Laughter) [LB250]

SENATOR STUTHMAN: Don't be nervous. But, you know, a testifier like yourself is really what we like to hear because, you know, you're in the situation, you're in the trenches working, and you know what you need and how things will work. Do you feel with the passage of this bill we will have addressed enough of the situations that you'll be comfortable with? [LB250]

JODENE SCHMIDT: I think so. I tried to think of all the situations where I ran into problems and have been frustrated over the past nine years, and it looks to me like it is loosening the regulations enough that hopefully I shouldn't run into those problems anymore, and yet I still think there will be appropriate supervision. I think it is appropriate that a new grad, somebody who has only been out a couple years, needs to have more supervision initially. But it looks to me like it would address the problems that I have run into. [LB250]

SENATOR STUTHMAN: And with the passage of this, this would be a good step forward? [LB250]

JODENE SCHMIDT: This would be a fabulous step forward. [LB250]

SENATOR STUTHMAN: Okay. Thank you very much. [LB250]

JODENE SCHMIDT: Um-hum. [LB250]

SENATOR GAY: Hold on one minute. Any other questions from anyone. I might just ask you one just for... [LB250]

JODENE SCHMIDT: Can you tell I'm new at this? [LB250]

SENATOR GAY: No, it's okay. All right. I know we'd have one soon. Senator Wallman. [LB250]

SENATOR WALLMAN: Thank you, Chairman Gay. Yeah, thank you for coming. You know, I have to say I've seen a physicians assistant before, and I am quite satisfied even though they might put you in the hospital. Thank you for coming. [LB250]

SENATOR GAY: All right, that's it. Thank you for your testimony. Other proponents? [LB250]

BRUCE RIEKER: (Exhibit 3) Chairman Gay, members of the Health and Human Services Committee, my name is Bruce Rieker, R-i-e-k-e-r, vice president of advocacy for the Nebraska Hospital Association. Before I even start, Senator Stuthman when you mention that she was a witness you liked to hear from, I took that somewhat personally. I think that maybe I'm one you don't want to hear from. (Laughter) [LB250]

SENATOR STUTHMAN: She has a wonderful smile. [LB250]

BRUCE RIEKER: She does, she does, and I don't blame you for keeping her in the chair. On behalf of the 85 member hospitals that we represent, we, the Nebraska

Hospital Association, supports LB250. And at this point in the testimony, it could almost be summarized as us too. There has been great testimony before that. We commend Senator Gloor and his collaborative partners for his efforts to modernize the delivery of healthcare. LB250, as already recognized, helps address the increasing shortage of healthcare professionals throughout the state in a creative manner, particularly for Nebraska's medically underserved populations. The Nebraska Hospital Association commends the intent of the legislation and maintains that the quality of healthcare can be delivered in an innovative and resourceful way as described in this particular...laid out in this particular legislation. Although we support the macroapplication of this bill, our member hospitals have asked us to share a couple considerations or recommendations for you to consider. One of them has already been addressed, and that is it's been mentioned that the Commission on Accreditation of Allied Health Education Programs should be replaced with Accreditation Review Commission on Education for the Physician Assistant. Furthermore, the Hospital Association contends that the Board of Medicine and Surgery should retain authority to recognize other accreditation programs that may be developed or offered in the future. As pointed out, LB250 changes current statute to allow a physician assistant who has more than two years of experience to practice in a setting that is geographically remote from his or her supervising physician as well as the oversight previously held by the Board of Medicine and Surgery to establish geographical limitations has been removed. Although this change would allow for the increasing number of...for increasing the number of physician assistants to practice in underserved areas of the state, we once again contend that the board should retain some level of governance, regarding the relationship between the supervising physician and the physician assistant. And maybe this will be something that is dealt with in the regulatory discussion that was held earlier during this particular hearing. Nebraska's residents deserve a healthcare delivery system that emphasizes quality, care, and accessibility, and on behalf of the Nebraska hospitals, we urge you to consider our recommendations and advance LB250. Thank you. [LB250]

SENATOR GAY: Thank you. Any questions? Senator Stuthman. [LB250]

SENATOR STUTHMAN: Senator Gay. Bruce, I just have one comment. It's just so nice to hear that you are in support of a couple things once in awhile. And I appreciate that. (Laughter) [LB250]

BRUCE RIEKER: I have to tell you, Kurt, your staff person, asked me about that. He said, have we introduced anything this year that the hospitals won't like? And in so far, we are much in agreement, Senator, you bet. [LB250]

SENATOR STUTHMAN: Okay, thank you. [LB250]

SENATOR GAY: I don't see any other questions right now. Thank you. Any proponents

who would still like to speak on LB250? All right, we're going to close for proponents. Any opponents who would like to discuss this? No opponents. Anybody neutral? All right, Senator Gloor, would you like to close on LB250? [LB250]

SENATOR GLOOR: Thank you, Chairman Gay, and my apologies to my fellow committee members, but this is my first bill, and so I'd like to make it last as long as it can, so, I do want to close. I'm also trying to recover my composure. In my previous life as a hospital exec anytime I stole a physician's thunder, it was a career limiting maneuver on my part, so my apologies to Dr. Blatny. I want to emphasize just a couple of points in closure. Remember that this really doesn't significantly change the scope of practice for the nurse practitioners, it does change the supervisory relationships. As relates to the death certificate, I would also point out that a number of counties have struggled with the issue of trying to find someone who could, in fact, sign death certificates if there were no physicians that were nearby in their community. And as relates to any county, large or small, I certainly, if it were me, would prefer to have my death certificate signed by somebody trained as a healthcare professional as opposed to a young attorney just out of law school who serves as the county coroner, which is allowed for in this state. Let me speak to the supervisory requirements, or specifically to Dr. Blatny's comment about supervising two versus supervising four. Specific experience that I had with my institution is we tried to staff satellite outreach clinics was that you could find three physicians assistants who might, because of other commitments that they have, be willing to share two positions. But because it was three PAs sharing two positions, you had to find two physicians who were willing to sign off that supervisory order. There is a degree of simplification, getting rid of some redundancy and simplifying the supervisory requirements that I think is a big plus. I also think on the fiscal note, that's overstated. This also assumes that all the physicians in this state who realize that they need to update their license by way of supervising PAs know that, and a number of physicians that I know of come into this state from other states where that's not the requirement, don't realize, and therefore that fee isn't paid. The flip side of that is, is we're able to hire and expand PAs. There will be fees, license fees that come in that aren't represented in this. And finally, this is an effort to improve workforce staffing for healthcare in this state, and I think it will make a difference. Thank you very much. [LB250]

SENATOR GAY: (Exhibits 4, 5 and 6. See also Exhibit 7) All right. Hold on, Senator Gloor. Senator Gloor, there are two letters of support, too, I'll just put, for the record, that I need to read in. One is from Jack Andersen, he's the Sheridan County Commissioner. And then also we received a letter, Internal Medical Associates of Grand Island, and Darcey Kramer, and we have one neutral letter from the Department...we're going to call it neutral. They said they would take no position, but Department of Health and Human Services with some recommendations that I know you have discussed with them. [LB250]

SENATOR GLOOR: Absolutely. [LB250]

SENATOR GAY: So then we'll continue...we have a question. Senator Pankonin. [LB250]

SENATOR PANKONIN: Along that line...thank you, Senator Gay. We received a letter today, did you...were you aware, Senator Gloor, of the letter from the Department of Health and Human Services and those issues? [LB250]

SENATOR GLOOR: Yeah, it just came in and I think some of this is easily addressed. [LB250]

SENATOR PANKONIN: Well, I'm not as interested in specifics, but you are open to working with them? [LB250]

SENATOR GLOOR: Absolutely, yes. [LB250]

SENATOR PANKONIN: And Dr. Schaefer, and you think they'll be...it'll be probably...would be able to do that and satisfy some of their concerns? [LB250]

SENATOR GLOOR: I believe this is low hanging fruit that should be easily grabbed a hold of. [LB250]

SENATOR PANKONIN: Good. Thank you. [LB250]

SENATOR GAY: All right. It doesn't look like (inaudible). All right. Thank you, Senator. That will close the hearing on LB250. Senator Stuthman is here to introduce LB230. Go ahead, Senator Stuthman. [LB250]

SENATOR STUTHMAN: Good afternoon, Chairman Gay and members of the Health and Human Services Committee. For the record, my name is Arnie, A-r-n-i-e, Stuthman, S-t-u-t-h-m-a-n, and I represent the 27th Legislative District. LB230 eliminates the requirement that certified nurse practitioners must enter into Integrated Practice Agreements with collaborating physicians. Under LB230, a nurse practitioner would be allowed to complete a minimum of 2,000 hours of practice under the supervision of a nurse practitioner participating in the same specialty area or a physician should a nurse practitioner not be available before they can start a practice. They would have to furnish the department with proof of professional liability insurance. Currently, nurse practitioners must enter into an Integrated Practice Agreement with a collaborating physician before they can practice in Nebraska. Physicians are charging nurse practitioners when entering into these agreements. There is no limit for what they can charge and it was not intended for this practice to take place. Nurse practitioners are also limited to the scope of service that they can provide before they have to refer a

patient to a physician. There are nurse practitioners here today that will testify on the aspects of Integrated Practice Agreements and their scope of practice. Nurse practitioners play a vital role to the healthcare in rural Nebraska where physicians are not always available or willing to practice. LB230 would make affordable healthcare more accessible to all Nebraskans. Last year, former Senator John Synowiecki introduced LB753 which dealt with the same Integrated Practice Agreements. It is my hope that this committee would advance LB230 to the floor for the entire body to debate. Those are my opening comments. [LB230]

SENATOR GAY: Thank you, Senator Stuthman. Are there any questions? Not at this time. All right, thank you, Senator Stuthman. Can I see a show of hands how many proponents are going to be speaking on this? All right, so we got about one, two, about seven or eight. We did get a list, and we don't need to follow it exactly, because you still need to state your name and come on forward. But make your way forward and speak and we'll go from there. Welcome. [LB230]

ANNETTE HARMON: Thank you. Good afternoon, Senator Gay and members of the Health and Human Services Committee. My name is Annette Harmon, A-n-n-e-t-t-e H-a-r-m-o-n, I'm executive director for the Nebraska Nurses Association, which represents the 20,000 plus registered nurses in this state. The reason I'm here is not because I'm a nurse or a nurse practitioner because in my executive director role I work with nurses across the state. My purpose is to give you the 30,000 foot view of this regulation, of this law...proposed law change. In the regulatory arena, this change would not be a change in the scope of practice for a nurse practitioner. We are not asking for them to do anything that they are not currently already allowed by their scope to do. Instead, it eliminates a barrier to their practice. It would allow them, without undue burden, to practice in various areas. From a 30,000 foot view, we feel that this will greatly increase access to care, not only in our rural areas, but in our urban areas where there is a great need for various specialties. In particular, psych and mental health. And we have a number of nurse practitioners who are well-versed in those areas and can fill a need, not only in the rural, but in the urban areas as well. The purpose of the IPA, I think, over the years has somewhat been changed. According to the statute and according to law, the purpose is to enter in with...between the nurse practitioner and a physician for consultation, collaboration, and referral. Indeed, the statute for the scope and function of the nurse practitioner requires a nurse practitioner to have a collaborative network, meaning, they have a slew of healthcare providers with whom they collaborate, with whom they consult, and to whom they refer. An Integrated Practice Agreement is just with one physician. Therefore, they already have within their statute the requirement that they have the ability, outside of their scope of practice when they are faced with a patient to refer them appropriately or to consult or to collaborate with other healthcare providers. And that's not limited. In reality, many nurse practitioners, especially those that are currently working in physicians offices or in clinics or even in hospitals, have what is known as an employment agreement that goes

above and beyond the Integrated Practice Agreement. Indeed, it is the employment agreement that regulates or controls what they can and cannot do in the practice where they are at. So we would suggest that in...with the elimination of the Integrated Practice Agreement, there are still controls that could be put into place and are currently with an employment agreement. On the national level for nurse practitioners, just in 2008 there was released a consensus model for APRN regulation, moving the practice of nurse practitioners to independent practice. It is the model legislation. It does not require supervision or collaboration, or excuse me, or an Integrated Practice Agreement. There are 23 states currently that do not require physician supervision or an Integrated Practice Agreement, and those include our neighboring states of Iowa, Colorado, and Wyoming. As you look at what those states have that we do not, as far as controls that are in place for the practice of a nurse practitioner, their scope of practice is what regulates their practice. They currently have education requirements, they have certification requirements, licensure requirements, and there are disciplinary procedures that take into account those nurse practitioners who either do something they should not do or do not do something that they are required to do. I mentioned that it is a barrier to practice to have the Integrated Practice Agreement and those that come behind me will tell you about the specific difficulties that we have had with the Integrated Practice Agreement. In particular we are concerned, as the Nebraska Nurses Association, with access to care. There are a number of patients that are not going to be able to be served because of the difficulties with the Integrated Practice Agreement. Therefore we would urge you to look at this bill with some seriousness in terms of healthcare reform agenda, in particular. We know there is a need for more primary care providers and nurse practitioners are excellent at filing that role. That's all I have, I'd be happy to answer any questions. [LB230]

SENATOR GAY: All right, thank you. Any questions? Don't see any right now, thank you. [LB230]

JOYCE SASSE: (Exhibit 1) Senator Gay, respected members of the Health and Human Services Committee. My name is Joyce Sasse, I am a certified registered nurse practitioner and a certified clinical nurse specialist in psychiatric nursing practice. I am here today to talk to you about the failure of the nurse practice agreement and the frightening facts regarding what is happening to Nebraska as far as healthcare provision. The nurse practice...Integrated Practice Agreement that we have with physicians has failed. The original intent was a great one. Physicians in Nebraska and the Nebraska Medical Association wanted to make sure that everyone who received care was going to be protected and receive safe care. That was the intent that was put into the original nurse practice agreement that later became the Advanced Practice Nursing Act. At this point, nurse practitioners have a mandatory master's degree. By 2015 it will be a mandatory doctoral degree, that is education. We are also certified by a national board certification. We must recertify every five years with a combination of continuing education and service or 150 hours of continuing education. We are highly

trained, we are well educated and we have a lot of practice hours that go into our ability to give care. We also have an APRN Board. We are the only state in the country that has a board specifically for Advanced Practice Nursing that monitors our practice the same way physicians have a medical board. With those things in place, we no longer need an Integrated Practice Agreement. As Annette said, we have to have our collaborative practice networks in place because we have to have someone we can refer to, people that we can ask questions of, and people that we can network with so that when we have a question or we need to refer someone that we have someone safe for our patients because our patients' care is our utmost concern, as it is for any careful practitioner. Our whole purpose in our training, like any careful caregiver, is to give careful care. Nurse practitioners serve primarily people that have functionally uninsured, uninsured, and people who fall between the cracks for a lot of things that they don't have care provision for. We have a lot of those people in the inner cities and in the rural population. We are stymied in our areas that we would like to provide care in by the fact that it's sometimes very hard for an individual practitioner, such as myself, who does not work in a clinic, a hospital or in a care provider group to get someone to sign our care practice agreement. To go on, at the present time, we have very few primary care practitioners who are out there in Nebraska, especially in the rural areas. I brought one copy of a critical match that was written by Keith Mueller's group with UNMC, which I will make available. It outlines the fact that the few practitioners that we have, and when I'm talking about this I'm talking about physicians in primary care, are aging and are not in very great number. Nurse practitioners would be there to fill the bill if they could get the ability to have an independent practice. We are low cost, 85 percent or less of physicians, and we would be there to serve that call. But we can't be there if we can't get an Independent Practice Agreement. I am asking you to advance this bill into the legislature so that we can be free to be there to serve Nebraskans. Thank you very much for your time. [LB230]

SENATOR GAY: Thank you. Are there any questions? I don't see any. Thank you for your testimony. [LB230]

JOYCE SASSE: You're more than welcome. [LB230]

RICHARD FORSMAN: (Exhibit 2) I'm Richard Forsman, R-i-c-h-a-r-d F-o-r-s-m-a-n. I'm an M.D. in Omaha, and I didn't really realize when I came here I would be testifying for two different bills. In fact, to date myself back, I was on the original admissions committee for the PA program at UNMC. Anyway, my purpose here today is to try to point out to this committee where we are in healthcare numbers, nationally and in the state of Nebraska. Other people have alluded to it, I have been able to bring some numbers together that may give you an idea of where we're at because what I'm asking this committee to do, or going to try to help them, is see where we are and how dire medical care is going to be on the horizon soon. On the handouts here, there are several articles I have for you. I think one of the most compelling is the first one, which

is primary care physicians lack job satisfaction. It's an interesting article and that there were 12,000 physicians interviewed. Half of them said that they would plan to reduce the number of patients or stop practicing entirely over the next three years. The reasons are here which is, demanding...declining reimbursement, demands of physician's time, nearly two-thirds said, Medicaid reimbursement is less than the cost of providing care. You can read this on your own, but I think it very concisely says. The next print out I have here, if you read the third paragraph, this is about students who enter primary care. A survey of nearly 1,200 fourth-year students found that just 2 percent plan to work in primary care internal medicine. Now more earthshaking is before I came down for the hearing today, I had a drug representative in the office who has a sister who is a sophomore medical student at UNMC. There are 106 in the class, and they have done an informal poll among the classmates. Only 2 percent are going into primary care, all the rest of them are going to specialize, which I think spells real trouble for the state of Nebraska, rural areas especially but also the urban areas. Overall, nationally they are predicting somewhere between 85,000 and 200,000 physician shortage by 2020. Now you say, 2020, if you think about it, this last year's high school graduate in '08, four years of premed, four years of medical school, four years of residency, will be entering the workforce. Our time to do something is really closing if we are going to meet that manpower need. Now, forty...out of that there are only 49,000 primary care physicians. I don't know where we are going to get them. Equally as bad on manpower is going to be this next article out of the World Herald. And the Nebraska Center for Nursing had an organization charged with addressing the state's nursing shortage, projects a shortfall of almost 4,000 RNs and 1,700 LPNs by 2020. Four thousand in the state of Nebraska. I have talked to the head pharmacist at UNMC who is just down the hall from me and my office. He was saying the same time, we are going to be short 330,000 pharmacists in this country. So my purpose to come here today is to say whatever decisions you make on either the PA bill or on this one here, I think you need to look at the big picture of how you can provide care for people in the state of Nebraska with a very dwindling resource, and you have to remember, the state of Nebraska is in competition with every other state. Some states are much more aggressive on this than we are. We do not have water, we don't have mountains, which attract a lot of these kids, so we're going to have to come up with something to be able to provide healthcare here. Our daughter graduated from UNMC about eight years ago. The day she graduated, 70 percent of her class left, and only one that I know of has come back to practice in the state. So my overview here...I...this is just to give you an overview of what's happening. The next sheet here is a little further on the nurses. This says we will be short 1,000,000 nurses by 2020, and they show the supply and demand on the graph, and you will see that demand is going up and supply may even be going down. Now, the crux of this, is this article from the New England Journal of Medicine, which is a graph. And if you look at that, what they talk about is the median salary of medical specialties in '06. If you look, the bottom is family practice, next is general pediatrics, next is general and internal medicine, which is what I do, and general psychiatry. Then from there on the reimbursement goes up dramatically. We are in our lower four here, what we call

cognitive services. We do not do procedures. We also do 70 percent of the primary care and preventive medicine in this country. The specialists are not into primary care, it is not in their interest if I may say so, to do so. But 70 percent of the preventative medicine is done by us, with a dwindling number of people. So that's why, once again, speaking to the previous bill of the PAs, speaking to this bill here, we need to be able to get our...expand, utilize effectively every which way we can our limited health services in this state. [LB230]

SENATOR GAY: Thank you, Doc, thank you. [LB230]

RICHARD FORSMAN: Now... [LB230]

SENATOR GAY: I mean we do have plenty of other people. [LB230]

RICHARD FORSMAN: All right. Okay. [LB230]

SENATOR GAY: Thank you very much. Any questions? Senator Gloor. [LB230]

SENATOR GLOOR: Doctor, thank you for testifying and I apologize if you mentioned this. In the paper blizzard we have in front of us in supporting material I got a little distracted. I used to, or my institution used to employ nurse practitioners, and I would say that we could not provide service to the level that our patients expected did we not have nurse practitioners providing service everywhere from primary care to emergency services to oncology. Do you employ nurse practitioners? [LB230]

RICHARD FORSMAN: No, I have not. [LB230]

SENATOR GLOOR: Okay. Physicians assistants? [LB230]

RICHARD FORSMAN: No, I have not. [LB230]

SENATOR GLOOR: Okay, there is a letter here that points out something in the revisions that I would like to get your opinion on it. It talks about one of the changes recommended is allowing nurse practitioners to complete the required 2,000 hours of supervised practice under the supervision of a nurse practitioner in the same specialty or a physician. Are you comfortable with that level of supervision being another nurse practitioner as well as a physician? [LB230]

RICHARD FORSMAN: I'll have to answer it two ways, and this hit me last week. I got a call from the nurse practitioner office at the UNMC. They could not find a place for one of their nurse practitioner students in general internal medicine in Omaha to do her in-office work. The primary care docs are stretched too far, they could not find a general internist. So with everything evolving and times changing, no, I'm not entirely happy with

it, but on the other hand, we are probably going to have to, if we have good qualified nurse practitioners, you know...I'm just stating my experience last week. [LB230]

SENATOR GLOOR: This was in Omaha? [LB230]

RICHARD FORSMAN: Yeah. I'm in Omaha. [LB230]

SENATOR GLOOR: Boy, howdy. [LB230]

RICHARD FORSMAN: But the head of the...Dr. Joyce Black, who is a professor of nursing, called me up and begged me to take a nurse practitioner and to shadow me. I had to turn them down because they take 50...they slow you down by 50 percent, and I literally do not have that time. I cannot slow down for a day to take that person. I have done a lot of teaching. I have been on faculty there for 30-some years but I had to turn them down. [LB230]

SENATOR GAY: Thank you. Senator Gloor, do you have a follow-up question? [LB230]

SENATOR GLOOR: No, I did not. Thank you. [LB230]

SENATOR GAY: Senator Pankonin. [LB230]

SENATOR PANKONIN: Thank you, Chairman Gay. Doctor, I'm sorry I missed the start of your testimony, but is the Medical Association in favor of this bill? [LB230]

RICHARD FORSMAN: I am not sure. I do not belong to the NMA or AMA. [LB230]

SENATOR PANKONIN: Okay. [LB230]

RICHARD FORSMAN: Now, there might be others who could speak to it, but I do not know. [LB230]

SENATOR PANKONIN: All right, we'll find out. [LB230]

SENATOR GAY: Senator Wallman. [LB230]

SENATOR WALLMAN: Thank you, Chairman Gay. Thanks, Doctor, for coming. This physicians assistant and general practitioner, specialist, all these issues, do you feel the specialists are plentiful? [LB230]

RICHARD FORSMAN: They are more plentiful but they are going to be short also. [LB230]

SENATOR WALLMAN: And the second, following that up, do you think they take some of your patients? That's been some...complaints of some of my GPs in my area. [LB230]

RICHARD FORSMAN: There are so few of us now, that if they take our patients it's fine. [LB230]

SENATOR WALLMAN: That might be Omaha, but that might not be everywhere. [LB230]

RICHARD FORSMAN: No, that's right. That's right. It might be. But you also have to look at this in just manpowerwise. [LB230]

SENATOR WALLMAN: Sure. Thank you. [LB230]

SENATOR GAY: Any other questions? I don't see any, thank you. [LB230]

RICHARD FORSMAN: Okay. [LB230]

SENATOR GAY: Other proponents? [LB230]

SANDRA BORDEN: (Exhibit 3) Good afternoon, my name is Sandra Borden, S-a-n-d-r-a B-o-r-d-e-n. Senators, it is a pleasure to be here today, and I appreciate this opportunity to speak in favor of LB230 before your committee. Thirteen years ago the Unicameral first authorized nurse practitioners to practice in Nebraska, and it was over the objection of the physician community who had a primary objective of expanding the access to primary medical care, especially for residents of rural communities unable to attract physicians to practice locally. It was a bold move and well-intentioned but that has not come to pass. Nurse practitioners have become important players in the Nebraska medical community and are providing high-quality care to Nebraska residents in hospitals and clinic settings in predominantly urban areas. But the Unicameral's original version of NPs moving to rural towns and villages, opening primary care practices to expand access to primary healthcare has not come to a reality. The primary reason for this is due to a barrier to entry known as Integrated Practice Requirement. When the original bill was passed, Nebraska physicians argued successfully that a requirement for Integrated Practice Agreements that established a collaborative agreement with physicians would do nothing to inhibit NP practice, but would assure quality of care and high level, professional oversight. Instead, collaborative arrangements are used by the medical establishments to severely restrict nurse practitioners to services. Agreements are signed and exist almost exclusively in circumstances where nurse practitioners work in the same urban setting as the physicians who sign for and employ them. If an employed nurse practitioner leaves the practice, the collaborative agreement is null and void and another must be obtained before the nurse practitioner can continue to see patients. When an agreement can

even be obtained, it is often in the form of shamelessly crass financial relationships, charging exorbitant fees to practicing nurse practitioners to sign and file a document, often with no actual physician supervision or oversight taking place. Such relationships do nothing to enhance the quality of care. They merely raise the financial barrier for a successful rural practice and profit the physicians who peddle them. Thirteen years ago it could reasonably be argued that nurse practitioner practice was unknown, and there was little experience in other states of unsupervised nurse practitioner practice, and that Nebraska should proceed cautiously. That argument can no longer be made. In those years, many other primarily rural states have allowed nurse practitioners to practice without physician collaboration or oversight. Other states are added to the list yearly. It should be made clear that the passage of LB230 would not change in any substantive way what nurse practitioners have been doing successfully for the last 13 years. All it would do is remove the requirement of physician collaboration agreement after a reasonable time of supervision by a healthcare professional. I have two stories to show the unintended consequences of collaborative arrangements. First story, I currently work at Prompt Care, an ambulatory care clinic in Grand Island staffed by one very part-time physician and a number of nurse practitioners. We are open from 9:00 a.m. to 9:00 p.m. during the week and eight hours on the weekends. We see an average of 280 patients a week, well over 14,000 patients a year. Approximately 25 percent of our patients are Hispanic, a substantial number have no insurance. Most children we see are on Medicaid, and many of our patients have no other medical provider. The physician who signs our collaborative arrangement is, from what I can tell, a kind and competent practitioner. But in those two years that he has worked there, I've only met him twice for less than two minutes. He signed my collaborate arrangement two years ago as part of his contract, but in no way provides any clinical oversight. When I am confronted by a patient who exceeds my skills, I call for advice or refer patients to any one of a large number of specialists with whom I maintain professional relationships. I have never called nor had access to my collaborating physician. For this service, my collaborating physician is paid a yearly sum of $15,000. Before the clinic hired our current collaborator, another local physician in Grand Island offered to sign the agreement, but only if we kept it secret from the rest of her medical colleagues if there would be no actual consultation or involvement with clinic operations and if we pay her $36,000 a year. If you think this is an exception, please know that Saint Francis Hospital currently pays a local family practice group to provide their collaborative arrangements for their rural clinics run by nurse practitioners. In a time of cost containment, it makes it hard to justify an outlay of funds when such prices must be paid for what can only be described as a mandated legal formality. My second story, is I would like to open a clinic in Gibbon but have been stopped from doing that because I cannot find a collaborating physician. It is difficult for rural patients to drive a distance, it is inconvenient for them. It is...makes no sense when my next door neighbor has to drive to Grand Island to see me to provide care for her daughter who is sick, or an elder who has fallen and needs pain relief when I am right across the street. Other states are recruiting our nurse..our Nebraska nurse trained practitioners to serve their own rural populations. An attraction

of independent practice is a powerful magnet for NP providers. Passage of LB230 would free nurse practitioners to serve in local communities to move without restriction of a collaborative arrangement. I recommend you support this bill. Thank you. [LB230]

SENATOR GAY: Thank you. Any questions from the committee? Senator Pankonin. [LB230]

SENATOR PANKONIN: Thank you, Chairman Gay. Appreciate your testimony, thanks for the work you do. Question on the collaborating physician. Is there any liability for malpractice or for the practice overall? Do you have the malpractice insurance? [LB230]

SANDRA BORDEN: Yes. By statute I am required to maintain a independent, private malpractice policy that is a $2,000,000, $6,000,000 policy. [LB230]

SENATOR PANKONIN: Does the collaborative physician have any liability for your work? [LB230]

SANDRA BORDEN: No. [LB230]

SENATOR PANKONIN: Okay. Thank you. [LB230]

SENATOR GAY: Senator Gloor. [LB230]

SENATOR GLOOR: Thank you, Senator Gay. It's nice to finally meet you. You have sent me several letters, and you have been nothing if not politely insistent that I should shadow you for a couple of days. [LB230]

SANDRA BORDEN: I think that would be wonderful. [LB230]

SENATOR GLOOR: I would have to tell you that given my busy schedule that's been pretty difficult for me to do, and I don't want you to think I don't believe or know that you have a very busy professional practice and that you conduct yourself accordingly. I, at least, have somewhat of a background to have an appreciation for that, so I appreciate the invitations. Let me ask you the same question I'm going to ask the good doctor who was just up here, and that is, are you comfortable with the 2,000 hours supervision being done by either another nurse practitioner as well as a physician and why? [LB230]

SANDRA BORDEN: Yes, I am. And the reason is because nurse practitioners have the same professional standards and the same professional ethics that other medical providers do. A nurse practitioner would not agree to supervise a new graduate if they were not willing to spend the time and the effort to make sure that adequate preparation and oversight was taking place. Just as physicians do not have oversight to make sure they correctly supervise their staff because of their ethical and moral standings, nurse

practitioners would be the same. [LB230]

SENATOR GLOOR: Are you not concerned that the same human nature that had, in some cases...this become a business enterprise, supervision is also going to be an issue with nurse practitioners as opposed...since it currently seems to happen with physicians in some cases? [LB230]

SANDRA BORDEN: As long as the requirement for supervision is removed, first...there are two things that come to mind. As long as the requirement for supervision is removed, even after the two years, then whatever fees would be paid would be short term by definition to two years. Do I think that it is morally acceptable to charge something? No, not if you are willing...either you enjoy teaching and that is your environment, and you are willing to spend the extra time in which case you do take on additional people newly graduated or you don't want to spend the extra time. In which case, you are better off not taking someone. [LB230]

SENATOR GLOOR: Okay, thank you. [LB230]

SENATOR GAY: Any other questions? I don't see any. Thank you for wrapping that up, you did see the...thank you for summarizing towards the end, there. Can...and I think we are done with the questions. Thank you very much Ms. Borden. Can I see a show of hands how many more proponents want to speak? One, two, three, we've got three. How many opponents? One, two opponents. And anybody neutral on this? Okay I would say last two testifiers, red lights...we are allowing you to go a little longer, but this can stretch out fairly quick if we keep doing that. So if you can summarize, that's always great too. We do just...we do read these testimonies and no action is done today, so we will take time to read them as well I think. But if you can summarize them out of respect for everyone else, and we'll get moving. Thank you. [LB230]

KATHY MURPHY: (Exhibit 4) Good afternoon, Senator Gay, my name is Kathy Murphy, K-a-t-h-y M-u-r-p-h-y. Members of the Health and Human Services Committee, thank you for allowing me to testify. As you have heard from the previous testimony, and there is still a couple more to testify that will give you specific examples of how the Integrated Practice Agreement has influenced their practice and established some barriers to their practice, I'll forego most of my testimony. But I am the past president of the Nebraska Nurse Practitioners Association, and I am speaking on behalf of the Nebraska Nurse Practitioners. The Nurse Practitioner Association promotes high standards of nurse practitioner practice, influence legislation affecting healthcare and maintain and promote and nurture the role of the nurse practitioner. Over two-thirds of our licensed nurse practitioners in the state are members of our organization. I have been a nurse practitioner since 1994, and that was the first graduating class from the University of Nebraska Medical Center, and that was the first program that educated nurse practitioners here in Nebraska. We had nurse practitioners here in Nebraska prior to

that time, but they had been educated in other states, so my class was the first. Since that time, I've been employed in Franklin, in Red Cloud, and we have a rural health clinic, three rural health clinics and a hospital which we serve. There are three nurse practitioners and two physicians and a PA that work within that facility. We as nurse practitioners provide care at our satellite clinics, there are no physicians there on site with us because those requirements are not the same as they are for the PAs. So when I am in a clinic in Red Cloud, I am there by myself so I handle everything that comes in the door. And I have to know when it's beyond my scope of practice, whether I need to refer patients on, and most of the time that referral process is not to my Integrated Practice Agreement physician, but to physicians that I have a relationship with. Broken legs, broken arms, things go to the orthopedics in Hastings or Grand Island or Kearney. And so those are the kind of things that are not going to be taken away by taking away the Integrated Practice Agreements. I just wanted to make that clear, that the Integrated Practice Agreement is not going to take away all those referral networks that we've already established and that we are already a part of. So I would encourage you to support LB230 and vote it out of committee, and I'll leave my testimony for you to read later. [LB230]

SENATOR GAY: Okay, thank you. Hold on for a minute. Any questions? Senator Pankonin. [LB230]

SENATOR PANKONIN: Thanks, Senator Gay. Thank you for coming today and for your work on your association. How long ago was it that you were head of the Nurse Practitioners? [LB230]

KATHY MURPHY: I am the current past president. So the previous two years. [LB230]

SENATOR PANKONIN: Okay and you've been interested in this type of legislation and been involved in its presentation? [LB230]

KATHY MURPHY: I was around for the original legislation and so they...I think they think of me as the grandmother. [LB230]

SENATOR PANKONIN: Okay. Well, let me give you the perspective of...for being a third year on this committee and my background and what I look at in these scope of practice deals. I'm a farm equipment dealer. If you need to price out a 24-row planter that costs $150,000 with all the attachments, I could do it. I don't know much about the medical area, I'm learning. But what I like to see is when these groups get together and work together and finally get something figured out. We're going to have a bill that comes up next that was very contentious between two different doctor fields, pathologists and dermatologists, some of the ugliest hearings we have ever had, they say, regarding this group. And they are probably both not happy, but apparently they have come to an agreement unless it falls apart in the next 20 minutes or whatever. So my question is,

you had some discussions with the doctors about this, and you just have not been able to work out some kind of compromise or better solution that everybody will be satisfied with? [LB230]

KATHY MURPHY: Dr. Johnson, Senator Johnson, was...last year sent us a letter asking us to sit down with the Nebraska Medical Association. The Nebraska Nurse Practitioners, Nebraska Nurses Association, Nebraska Medical Association came together at several meetings to talk about this. And we felt like, you know, there was good dialogue. We tried to share with them our stories, and many of them were a little bit horrified by the thought that all this money was being charged for these agreements. But they were not willing to compromise on getting rid of that, and so after several meetings we felt like we were just saying the same thing over and over and there was no compromise could be reached. And I think that, I mean, I think that we were open to listening to their points of view but many of the physicians that we were talking with were...many of them had very specialized practices, and they said that their nurse practitioners weren't interested in getting rid of this Integrated Practice Agreement. Well, as an organization, I have to represent all nurse practitioners in the state and so there's going to be differences. Just as you are out in the farm community, I also am in the farm community, live on a farm, and so I'm trying to be open to all of this too. But when I can see that affecting these nurse practitioners that have yet to testify and those that have, it's just been such a barrier, and it's hard for us to figure out a solution when there is no compromise in sight. And I guarantee you that we did try. I think they'll say the same thing, that they felt like they were trying too. Because I don't think they were, you know, doing it to be malicious and saying well, you nurse practitioners don't know what you're doing, but I think that they just felt like they were not willing to compromise on that issue, so then we have to bring that back to you. [LB230]

SENATOR PANKONIN: Thank you for your response. And you can see what our difficulty is when we're trying to make policy decisions and... [LB230]

KATHY MURPHY: Yes. [LB230]

SENATOR PANKONIN: ...trying to be fair to everyone but also have to look at the general public and the benefits and the potential risk. [LB230]

KATHY MURPHY: And that is our primary goal, is the safety of the public. [LB230]

SENATOR PANKONIN: And that's what my line of questioning, just to explain to everybody here, is after three years on this committee is try to figure out these scope of practices. When you're a lay person it's hard. [LB230]

KATHY MURPHY: Exactly. I understand that, thank you. [LB230]

SENATOR PANKONIN: Thank you. [LB230]

SENATOR GAY: Any other questions? Nope, thank you. Other proponents? [LB230]

KATHY HOEBELHEINRICH: (Exhibit 5) Mr. Chairman, members of the committee, I'm Kathy Hoebelheinrich, and that will be the longest name you type in today, H-o-e-b-e-l-h-e-i-n-r-i-c-h. And I believe you have copies of my testimony, I also have a letter of support. There's three points that I want to leave you with. The first is, that as a nurse practitioner, I am certified in diabetes management. Diabetes is widely prevalent and a very costly disease in this state, in fact across the country. And the Practice Act as written, as you have heard, is a barrier for me to a very innovative and a truly new practice opportunity here in the city. I'm an adult nurse practitioner, I am board certified in advanced diabetes management. I am a certified diabetes educator and insulin pump trainer. And I am likely one of two or three in the state with those credentials. Prevalence of diabetes is presently at 8 percent of the population. After the age of 60, those numbers climb to about 23.1 percent. In all age groups type 2 diabetes parallels the epidemic of obesity and overweight in this country. It's a lifestyle disease. Healthcare costs for diabetics are estimated to be 2.3 times that of those without diabetes. And the diabetic can expect to pay about $1,600 out-of-pocket this year, and I believe that is a conservative estimate. A single bottle of insulin costs $100 retail. Most need two or three per month, and some clinic visits can have a copay of $50. Estimates are that 40 percent of those with diabetes have a household income under $35,000. This is a costly disease. 60 percent of diabetics have at least one complication, heart disease, stroke, lower extremity amputation, blindness, or kidney failure. An additional 30 percent have two or more of those complications. Landmark clinical trials have established that the risk of complications increases in direct relationship to the control of diabetes and the marker of that is blood glucose targets. And in this state, over half of those that have diabetes have failed to reach their targets. By 2020 there will be a 25-35 percent shortage of endocrinologists. These are physicians that specialize in the management of diabetes. That shortage is felt most keenly here in the Midwest where we do not have the lure of the cities. That means that the burden for good diabetes care will increasingly fall on primary care physicians. And I think you have heard good testimony that they are likewise in short supply. I am presently employed as a registered nurse certified diabetes educator at a diabetes center in a hospital-owned wellness facility here in the city. I accept patients by physician referral for education and lifestyle intervention, as a diabetes educator, and that is essentially nutrition, exercise, weight management. I see outcomes there that I never witnessed from the endocrinologist's office. And it's not that we didn't want those things to happen, we simply lacked the personnel and the expertise to do that. My employers offered me a position as a nurse practitioner that would enable me to see patients for insulin management. Insulin is something that I do well. It's tedious and time-consuming for the primary care physician and the endocrinologist too. It's frequently an underutilized therapy, delayed, and poorly understood. And it requires more than a typical 10-15 minute clinic visit. I have been

able to secure the requisite Integrated Practice Agreement. The questions that have been posed by physicians are legitimate. What is their liability, how can they oversee the practice, me, a mid-level in a remote location with a skill set that they don't have and what compensation is reasonable? These are legitimate questions and for me, real barriers. In summary, I am highly specialized as a nurse practitioner diabetes management. Diabetes is widely prevalent and a very costly chronic disease under the current healthcare model. The present Nurse Practice Act as it is written today with the requirement for the practice agreement posses a barrier to me for an opportunity for innovative, and what I believe would be a very effective health practice. Thank you for your time and I urge you to vote in favor of LB230. Are there any questions? [LB230]

SENATOR GAY: Thank you. Senator Gloor. [LB230]

SENATOR GLOOR: Thank you, Chairman Gay. Thank you for being here, and the work you do is extremely important in the state and unfortunately I don't think a lot of folks realize how almost epidemic diabetes is within our populations. Coming from a community, Ms. Borden can attest to a large Hispanic population with incidents in Hispanic populations. And this is a problem, and so you do good work. And I appreciate that you are out there. But I don't understand your description. I thought I heard you say you were employed by a hospital. I don't understand why you are having a problem finding physician supervision. I'm trying to figure out how the change will make a difference in the way that you practice. [LB230]

KATHY HOEBELHEINRICH: Sure, I cannot secure a physician practice agreement. What we do, and I'm employed by LifePoint which is a hospital-owned facility here in town, is other than mid-level practitioners, so it's a hospital-owned facility. I am not working there as a nurse practitioner. I am there as a registered nurse. [LB230]

SENATOR GLOOR: But they're not going to line up the physician for you? [LB230]

KATHY HOEBELHEINRICH: We have been unable to do that. [LB230]

SENATOR GLOOR: And so they have been trying, as well as you. [LB230]

KATHY HOEBELHEINRICH: Yes, yes, for the past year, yes. [LB230]

SENATOR GLOOR: I understand now, okay. Thank you, [LB230]

KATHY HOEBELHEINRICH: Yes. [LB230]

SENATOR GAY: Any other questions? I don't see any. Thank you for your testimony. [LB230]

KATHY HOEBELHEINRICH: Thank you very much. [LB230]

SENATOR GAY: You bet. [LB230]

RUBY HOUCK: (Exhibit 6) Good afternoon, Senator Gay and members of the committee. I testified here last year for a similar bill and some of you I recognize but most of you are new. And I had them handout copies of... [LB230]

SENATOR GAY: Can you state your name and spell it? [LB230]

RUBY HOUCK: Oh, I'm sorry. [LB230]

SENATOR GAY: That's all right, that's all right. [LB230]

RUBY HOUCK: My name is Ruby Houck, R-u-b-y H-o-u-c-k. Now, let me go on (inaudible). I handed out tests...copies of patient support letters to all of you. Because, you know, my patients wrote some of them are last year, some of them are this year, but they were so moving and I wanted you all to have those because that was big effort for some of these patients to write. And then the other thing I handed out to you was a written, long testimony, you know, for me. But I'm just going to touch on the high points here. I am an independent nurse practitioner, one of the few in the state. And I started my own clinic in Bertrand, Nebraska, little tiny town, no healthcare there. Okay, they hadn't had healthcare there for...since 1965, I think, the last healthcare provider...doctor that lived there. There are physicians in Holdredge and Lexington, and those towns are 23 and 17 miles from us, which doesn't sound like far, unless you have to walk. And, you know, there are people in my town that they simply cannot drive anywhere. So I had this dream of opening a clinic and I worked hard to find a collaborating physician. Well, there are eight physicians in my local county and they refuse to collaborate with me. Part of the reason, and that was eight years ago, part of the reason is they didn't know what a nurse practitioner at that time really was, they weren't familiar. So then I went outside of my county, and I checked with nine different clinics with multiple physicians and then five other individual physicians and all declined due to lack of interest, being too busy, or employer restrictions, you know, if they were employed by a hospital or they would say those weren't...that they weren't allowed to do that. And so, then I went to the Advanced Practice Board, which had a provision that said, if you can't find a collaborating physician, it is possible to have this waived. And I had been a nurse practitioner since '98 and so, this is 2000, and I went to them and...well, first I got a collaborating practice agreement with a physician that was 70 miles away from Bertrand. And I had my clinic for four years, and he had never been to my clinic, he had never seen any of my patients, and well, and then when he resigned as my collaborating physician then I had to try to find another collaborating physician which was just a nightmare. And so then the nurse practitioner board, I wrote to them to have the Collaborating Physician Agreement waived. And they said no, it wasn't possible

because they have these restrictions that even nurse practitioners that have their doctorate cannot meet these restrictions, and I have my masters. And so then a pathologist in a laboratory service that I use for the clinic, he said, well, I'll be your collaborating physician. Well, I said, I don't know if that's legal, and the board said, yeah, he could do that for awhile as long as I continued to search for somebody. So he signed that, and so my clinic ended up being closed for, I think it was, three days in 2004 and my patients, I couldn't refill their scripts, and they'd say, well, why not, you have all this time? And so then they would...I would talk to physicians that maybe they had seen previously and they would refill the scripts. So, anyway, it ended up that now I have a wonderful collaborating physician, but he's 60 miles away and he has seen...I have referred three patients to him in four years. I typically, like the other nurse practitioners, said, when I refer, I refer to specialists, cardiologists, orthopedists, pulmonologists, internal medicine sometimes, and my patients feel like I am their healthcare provider. The will tell everybody that, that I am their healthcare provider and I never list myself as a doctor, I never say to them, I'm your doctor. I'm their healthcare provider, I take care of their healthcare needs, I encourage them to see other professionals as needed. But, I think the thing I want you all to think about is, if you were in a town and you couldn't drive, how difficult would it be for you to get to a physician, I mean, or any healthcare provider. And that's just what as nurse practitioners what we want to do, is provide the best healthcare to people in the areas that need it. You know, as far as taking patients away, most of my patients were not seeing anybody, so it's not that I took patients away. And I see the red light's on and so I'll stop. [LB230]

SENATOR GAY: Thank you. Any questions? Senator Howard. [LB230]

SENATOR HOWARD: Thank you, Mr. Chairman. Well, I have listened to all this and just some questions cross my mind. The supervising physician that you had for four years, was it? Lived 70 miles away, never came to the clinic. Did you go see him? How did that work? [LB230]

RUBY HOUCK: I...what I did was I had worked in his clinic after I had gotten out of school, why I did clinicals with Kathy Murphy in that clinic. And then I had worked in that clinic, some to fill in for a nurse practitioner that was off for medical reasons. And so he knew me, and then I would cover...to pay him what I did was I would cover ER when it was his weekend, I would cover ER for him. And that worked fairly well, and really when he...when I got the letter that he was resigning as my collaborating physician, there was no reason attached to it, and so I had a month to find a new collaborating physician. And you know, that was very difficult because I had spent two years looking for one and so. [LB230]

SENATOR HOWARD: Well, so you didn't ever have to pay him cash, you traded off? You had kind of an in-trade... [LB230]

RUBY HOUCK: I did not pay him cash. No, I was blessed, and then this collaborating physician that I have, he is such a kind man. What I do for him is I pay his extra liability insurance, which is like, I think like $500 a year. [LB230]

SENATOR HOWARD: Okay, so that sounds fair to take on that. [LB230]

RUBY HOUCK: No, it's wonderful for me. The barrier was just finding somebody. [LB230]

SENATOR HOWARD: Okay. But it sounds like the burden really is on the nurse practitioner. I mean, the doctor really just can say he is acting in this position and charge whatever. Is that correct? Is that... [LB230]

RUBY HOUCK: It seems to us to be a collaborating agreement on paper. I mean, I call my... [LB230]

SENATOR HOWARD: Yeah, I don't see that you're really getting too much out of this. I'm sorry, maybe that... [LB230]

RUBY HOUCK: What do you mean? [LB230]

SENATOR HOWARD: Well, he's available to you, the individual doctor would be available to you, but if he never comes to see the clinic, if he never sees what you're doing, how does he really know? [LB230]

RUBY HOUCK: Well, and...what he and I do is we meet once a year, and I take ten charts on people that I have called him about, generally. And he looks over them and signs the sheet that.... [LB230]

SENATOR HOWARD: Does that cost you, to have him supervise you that way? [LB230]

RUBY HOUCK: Customary? [LB230]

SENATOR HOWARD: Does it cost you? [LB230]

RUBY HOUCK: Oh, cost me. Just his extra liability insurance. [LB230]

SENATOR HOWARD: Oh, the extra liability insurance. Okay, gotcha. All right, thank you. [LB230]

SENATOR GAY: Senator Pankonin. [LB230]

SENATOR PANKONIN: Thank you, Senator Gay. I did remember you from last year, and those letters, I'm going to go through them again because I remember some of them, and thanks for your great service in your community that you're providing, and hopefully there's some kind of solution that can be worked out to make it better. But you live...if I remember right you live in the community as well. [LB230]

RUBY HOUCK: I live, yeah, outside, I mean, in the country close to the community. [LB230]

SENATOR PANKONIN: Right, and I remember that as well. But I'm sure those folks, especially with your enthusiasm for what you do, are very appreciate to have you. [LB230]

RUBY HOUCK: And the other thing is, like the kids from school...Bertrand doesn't have, you know...so if they have to see somebody, a lot of the kids, their parents will call me up and say, can you see, you know, my kid? So the kid will walk down, and so that saves the parent taking time off from work because a lot of parents don't work in Bertrand. They work outside of town and so that saves a lot, and the kids are really comfortable coming to see me. [LB230]

SENATOR GAY: Senator Campbell. [LB230]

SENATOR CAMPBELL: Thank you, Chairman Gay. In the course of that year, you said, I took ten charts. Would those be the...those are the ten cases where the scope of practice was beyond what you could do? [LB230]

RUBY HOUCK: No, not necessarily. Sometimes I would just have a question on what would be the best course of action, you know, for treatment or what he would recommend. [LB230]

SENATOR CAMPBELL: So if something comes in that is just...you go, 'ope', I can...this is beyond what I should be...then, what do you do? [LB230]

RUBY HOUCK: Well, I have never...I refer, but I've never had a physician refuse my referrals. I mean, they are always glad to take them. And what I typically do when I refer is I fax the physician I am referring to just a brief history of the patient, so when the person gets there, you know, they don't have to start out cold. [LB230]

SENATOR CAMPBELL: Thank you. [LB230]

RUBY HOUCK: Um-hum. [LB230]

SENATOR GAY: Any other questions? Don't see any. Thank you for your testimony.

[LB230]

RUBY HOUCK: Thank you. [LB230]

SENATOR GAY: Other proponents? [LB230]

TOM MONTEITH: (Exhibit 7) My name is Tom Monteith, thank you very much for the opportunity to be here, today. We heard earlier about Prompt Care, I am the owner of that facility. It started out as a vision by four doctors in Grand Island that all left the community to go to bigger and better spots, I guess, for more populated areas. So the clinic stayed on, and I inherited the remaining ownership interest. The...if...the clinic is not a primary care facility, it's a walk-in, I'd call it more convenient medicine. If you're daughter is at 8:00 at night crying because she has an ear ache, and you want to get her treated, you can run there and run back home. And the instruction of the clinic is any of my nurse...any of the medical providers, the number one instruction is, if you don't feel comfortable handling that patient, depending on the nature of it, we will stabilize and get them sent on to the emergency room or we refer them back to their primary physician if they have one. If they don't, we refer them to the specialist or back to another doctor. The clinic has been operating for 13 years, and in that 13 years it has used a lot of nurse practitioners and there's never been a medical claim against any of the nurse practitioners. I think a job very well done by them. There's been twice that I have had to struggle with finding a supervising physician. Sandra told you one of the softer offers was $36,000, didn't want to be seen, didn't want anybody to know. I would say the medical community in Grand Island is different than most cities. We have been welcomed by open arms by some in the medical community and by others we have had less open arm receptions. Some employers have said if you work part time at Prompt Care you are fired on the spot, so we have had mixed receptions by the people in Grand Island, even though we were started by four doctors there. The...basically, in general our experience with trying to find doctor supervision, the first time we probably called...contacted 50 doctors and never got anyone to say yes. And because of the doctor that was supervising, was a personal friend, I begged him to stay on, and we did some things for malpractice insurance to get it covered so he could be taken care of. But my general thought at that time was, the doctors I think would tell the truth, told me they didn't want their name associated with the nurse practitioners and the clinic and didn't want to be shunned by the medical community in Grand Island. I have had numerous nurse practitioners from rural Nebraska call me wanting to put their clinic under my ownership, or some type of deal because they couldn't find any other way to meet...they were having terrible times trying to find their supervising physician, and they was hoping that there was someway I would be able to help them in that process. Unfortunately I wasn't. The last time I got back in a situation...even though someone here said there is no liability for the physician that is supervising, I think 99 percent of the physicians don't believe that and we all know anybody can get sued for anything. I've gone through the biggest insurance brokerage agency in Omaha, there is no

insurance product out there to sell to cover the doctor from being a supervising physician. The only thing you can do is buy his regular malpractice insurance. If he's working for some hospital group, and you have a policy, then you get in all this legal subrogation that is going to effect what the employers premium is going to be, even if you're trying to isolate them, the original employer is going to say, no, you still can't do it. So right now there is no...as far as I know, there is no way that I can go out and buy malpractice insurance even though there is potentially no liability exists, the perception is there. There is no way I can isolate that doctor coverage...let's say he works for a hospital and they say you can't do this because we don't want your malpractice...our policy affected. I can't do anything to do that. So if you figure out in this state, I don't know what percentage your physicians are employed by hospitals, clinic groups, that don't want...that prohibit their doctor from doing outside activity because of malpractice reasons, but it's going to be a significant portion. They cannot be supervising physicians for my nurses. So there is a...I'm guessing you're taking out half the doctors can't do it because their employer prohibits them from doing it even if they wanted to. Numerous states have already said, we don't...that they don't have to have supervision. Anyway at this point, the other thing I'd briefly like to say is anybody that's wanting to start a business, such as a nurse practitioner, and they are going to try to go to a bank to get a loan, how are you ever going to start a business when you got to tell your banker in 30 days you can be out of business. And that's, I guess, all I want to say at this point. [LB230]

SENATOR GAY: Thank you. Any questions? Senator Pankonin. [LB230]

SENATOR PANKONIN: Thank you, Senator Gay. Sir, just two questions briefly. Do you have a medical background, then, are you a nurse practitioner? [LB230]

TOM MONTEITH: No. I am by trade a CPA attorney. [LB230]

SENATOR PANKONIN: Okay, and you mentioned that most the people that come to the clinic then are referred on, is the general kind of anecdotal idea here. How many people do you treat, probably the final time there, that come in, they've had some kind of issue, how many are you able to treat versus the ones that are referred on? [LB230]

TOM MONTEITH: You'd have to ask...I don't know that number. [LB230]

SENATOR PANKONIN: Okay, so basically you are interested in the business part of the operation? [LB230]

TOM MONTEITH: I'm interested in that the clients get good care, but I am interested, as the owner, in the business aspect of it. [LB230]

SENATOR PANKONIN: Thank you. [LB230]

TOM MONTEITH: The other thing I'd like to say is recruiting nurse practitioners is very difficult, and it definitely puts us at a disadvantage having the supervision, with other states. [LB230]

SENATOR GAY: All right, thank you. Any other questions? Don't see any. Thank you. Other proponents? How many more proponents? All right, this will be the last proponent and then we'll get into opponents. And we did receive several letters as referenced before. I'm not going to read every single one into the record, because there's about 10 or 12 of them. Those are into the record and will be noted by the clerk, so we did receive many of those. So go ahead. [LB230]

DR. SUSAN BEIDLER: (Exhibit 8) Okay, Senator Gay and other members of the Health and Human Services Committee, my name is Dr. Susan Beidler, I'm the director of the Morehead Center for Nursing Practice and a faculty member at the College of Nursing at the University of Nebraska Medical Center. I am a family nurse practitioner for 27 years, I am an educator and a nurse researcher, and I am very pleased this afternoon to have this opportunity to discuss with you some of the issues related to the removal of the Integrated Practice Agreement. I have prepared testimony which I am distributing, and I'm going to divert from that for the interest of time and just address a few key points that I think have come up in the other presentations that I think would benefit from some clarification. The first thing is, you know, why do we have an Integrated Practice Agreement in the first place. There is no evidence to support why there are IPAs in Nurse Practitioner Practice Act, in other words, there was no research that was ever done that says, if we have an IPA we are somehow going to create some sort of a better practice environment and protect the health, safety, and welfare of the citizens of any state. Another role I have is as on the board of directors of the National Nursing Centers Consortium, that is a national group that provides the advocacy and legislative support for nurse-managed healthcare. Nurse-managed healthcare is that care that is provided by nurse practitioners in a number of...various settings around the country. So we have nursing centers throughout the United States. I've also had the opportunity to practice in Pennsylvania, in Florida, and now in Nebraska for the last year, all in settings where there are nurse-managed health centers. So I can give the perspective of what happens in the other states and what doesn't happen to patients when there isn't an Integrated Practice Agreement. I can reiterate what everyone has said about the existence, they are in existence in statute. They basically serve no practical purpose. As professionals, nurse practitioners collaborate, that is the nature of healthcare. We don't need a statute or a law to say that this is required. As far as supervision, the process of the training, the educational process for nurse practitioners is thorough. There are national certification exams that will verify that the nurse practitioner is prepared for practice when he or she graduates. So the idea of supervision beyond graduation is not substantiated through any sort of evidence or any sort of research. So I think the other issue that was brought up was the issue about liability and whether in fact the IPA

creates a liability situation for the physician or not. We have had legal opinion in the state of Pennsylvania that the existence of an IPA or collaborative agreement is where the liability exists. And when the nurse practitioner is practicing under his or her own license in an independent fashion, under his or her own malpractice policy, they are, you know, individualized, professional at that point and there is no liability, direct liability, to, you know, anybody that they are referring to or collaborating with. So I think those are the key points I would like to make. [LB230]

SENATOR GAY: Thank you. Any questions from the committee? I don't see any. All right, thank you very much. I'm going to close for proponents. It looks like that was it. I'd like to thank you all, it was very good testimony, very diverse, and I thought we shed a lot of light on this issue. We're going to go now to opponents, and we'll hear from any opponents if you want to make your way forward. [LB230]

RICHARD BLATNY: Well, hello again. This is...I'm Richard Blatny, R-i-c-h-a-r-d B-l-a-t-n-y. I am a physician practicing in Fairbury, and I am, this time, speaking to oppose LB230, eliminating the practice agreement for nurse practitioners. The NMA supports the increased use of nurse practitioners as part of the continuum of providers who provide primary care. The vast majority of nurse practitioners currently practice in clinical or hospital settings where they are supervised by or have formal collaborative relationships with physicians. Nebraska's current law protects patients by requiring every nurse practitioner to have an Independent Practice Agreement with at least one collaborative physician. And we've heard a lot about these. We've heard a lot about what sounds like they're ineffective collaborative agreements but I assure you, there are many collaborative agreements that are effective. Many nurse practitioners are working with other specialists and they seem to have a very good arrangement. The nurse practitioner and the physician have a joint responsibility for patient care, and the physician is responsible for supervision to ensure the quality of care provided to patients. And we have heard about them not being liable, I do not believe that. The lawyers who I have asked have said we would be liable. We are liable for our PAs, if we are in a collaborative agreement with the nurse practitioner, you better believe we are going to be listed if there is a problem. LB230 would allow nurse practitioners to practice independently without physician involvement. In effect, it allows nurse practitioners to become primary care physicians without having attended medical school or going through a residency training. Now, when a nurse...at the very start, the nurse practitioners agreed to having a collaborative agreement. I served on the 407 process. I'm old, I have been here a lot. I was involved with that. In the end, they agreed to have a collaborative agreement. That would be in some assurance, that their care provided was quality care. Later on, they decided that they did not want to be under the licensure board of surgery and medicine. They wanted to have their own board, the only problem with that is we looked at it is, there were more RNs on that, more nurse practitioners, and I do not remember exactly, but it's one or two physicians. Well, when it comes to voting, obviously, and we're talking scope of practice, things are granted, who's going to

get outvoted? Those two physicians. But we were said, well, but you know, they can't advance, they can't do...go beyond their scope of practice because they have a collaborative agreement and the collaborative agreement will assure that the board...that everything will work. Of course now we are looking at let's get rid of the collaborative agreement. We are then turning these people loose on the residents of Nebraska. I also serve on the volunteer faculty at the University of Nebraska Medical Center, I have been doing that for over 30 years. We have medical students that we preceptee, we have PAs, and I've had nurse practitioners. And I'm here to tell you there is a difference. The PA students sit in class with some of...some of their classes are with the medical students, and they have to compete with them. The nurse practitioners do not have that, they have their own training, they're trained basically by the nurses. We're talking a physician has four years of prerequisite and a nurse practitioner has four years they become nurses. Then we have seven years, four years of medical school and three years of residency at a minimum. The nurse practitioners have two years. That training is not equivalent at all. What we in medicine see is that there is a lacking of clinical skills and diagnostic skills, wonderful bedside manner but when it really comes the problem that I have and other physicians in the state have, is when a patient comes into see you, often it's not that main reason they come in that really is the big problem. You discover something else. They have a heart condition, they have a cough that maybe is a cancer starting. They have the cough, maybe it isn't bronchitis, maybe it's a pneumonia, maybe it's a pulmonary embolism, they can die in minutes with that. Our concern is that those things are missed and then precious time is lost before that patient, if they are out in a rural setting, is again brought in, and the cancer has grown, whatever has happened, things have gotten a lot worse. Quality of care is what we are really after. Now I can't dispute it if there are some of these individuals who are signing into collaborative agreements where they are not truly supervising the nurse practitioner, but then something should be done about that, not necessarily say because of that you just open it up and not have supervision. We already know there is a provision to have a waiver, and we have heard of someone who has a waiver. To date, though, there have been very few applications submitted under this waiver provision. The people in those areas are receiving care. They may have to go 17 miles. Often those communities, like our community, has a bus that takes people elsewhere and so I can't believe that they are not getting care. The nurse practitioner currently have the 2,000 hours, and we've heard about that today, of supervision by a physician when they first graduate. Now what we are proposing here is that they be supervised by another nurse practitioner. Two thousand hours is not that great, that's a 40 hour week for 50 weeks. That's one year. And you do not get exposed to everything there is in medicine in one year. And now we're being...we are saying that a nurse practitioner is going to be the one that is going to be educating them. I do not think that's good. It's not equivalent training, they are mid-level practitioners. [LB230]

SENATOR GAY: Doctor, can you...there are going to be others behind you. [LB230]

RICHARD BLATNY: Okay, I'll summarize up. I think that, in summary, if getting a physician in a rural area is the problem and the incentive for this bill, then we need to look at the incentive packages to address the issue, not compromising the medical care of those living in the rural areas. Thank you, I'll take questions. [LB230]

SENATOR GAY: Thank you, any questions? Senator Pankonin. [LB230]

SENATOR PANKONIN: Oh, Senator...were you going to ask... [LB230]

SENATOR GAY: Let's go for the record, Senator Pankonin. [LB230]

SENATOR PANKONIN: Okay, thank you, Chairman Gay. Doctor I appreciate your comments and obviously part of my concern as well. But on the other hand I think it is probably realistic to say that we have got a problem in a town like Bertrand where, even though it's 17 or 23 miles or whatever it was from two larger communities, that some of those people, if it wasn't for that person who was there would have nil or none for healthcare. So that's our dilemma as people sitting here as policy makers, is that there are situations or at the Diabetes Clinic, that maybe just the support people needed. So that's the...I'll ask Mr. Buntain more about that. I mean, how can we come up with a solution to those issues? Because I think it is real that in some areas they just don't have the access to transportation or, you know, it could be a lot of reasons. But, I think...and you're in Fairbury, so, I mean, you know a little bit what I'm talking about and southeast Nebraska is similar. [LB230]

RICHARD BLATNY: Sure, sure. Yes. [LB230]

SENATOR PANKONIN: So I think, for our folks...and I am sincere, quality care is an important criteria, and I would probably agree with some of your comments about, you know, we want people adequately trained but also if it's no medical care versus even folks with more limited experience, I think then we have to...is some better than none? I mean that's literally what we're...in some of these issues... [LB230]

RICHARD BLATNY: Um-hum. See that's the issue, and I maintain that those people do receive care, I think they are going a little further for their care but I think the majority of those in Bertrand did receive care prior to that. They surely weren't out there isolated. [LB230]

SENATOR PANKONIN: Well, and I don't know, but I would probably disagree with you. I think there are people who just don't get care. [LB230]

RICHARD BLATNY: Don't get care. Okay. [LB230]

SENATOR PANKONIN: Yeah, so that's, that is the...I think we are in agreement on the

issue, but I think there is, because of convenience and just some of the things that have happened, it just doesn't work. But that's... [LB230]

RICHARD BLATNY: Is there not the provision for the waiver, though? And that's under current statute. I mean, one can apply and get a waiver. [LB230]

SENATOR PANKONIN: Right, but we heard from previous testimony that that's really tough to get, so I think it probably discourages people to do it. So...but we'll keep working on it. [LB230]

RICHARD BLATNY: Okay, yeah. [LB230]

SENATOR GAY: We will get information on the waiver, as well, to pass out to the rest of the committee. Did you have anything else, Dave? [LB230]

SENATOR PANKONIN: No, that's all. [LB230]

SENATOR GAY: Senator Howard. [LB230]

SENATOR HOWARD: Thank you, Mr. Chairman. Just a couple of questions really seem pressing to me, and I'm going to ask you this and you can give me your opinion so you have a lot of leeway here. You know, do you feel that...or can you justify someone doing supervision of a PA, here we have concerns about the quality of their work and the safety and the liability, etcetera, etcetera, etcetera, but never going to the clinic for four years. Never seeing the clinic they are operating out of, never seeing the hands-on work that they do. I mean, as a social worker, as a master's level social worker, I couldn't neglect seeing a, say a foster child for four years and just assume things were going right because the foster mother gives me an update from time to time? [LB230]

SENATOR PANKONIN: Senator Howard, you said PA. [LB230]

SENATOR HOWARD: PA? [LB230]

SENATOR PANKONIN: Did you...that's what you said. Did you mean that? [LB230]

SENATOR HOWARD: Nurse practitioner, I'm sorry. [LB230]

SENATOR PANKONIN: Okay, all right. [LB230]

SENATOR HOWARD: You got me rolling here, now. I think we know who I'm talking about. But can you tell me, in your professional opinion, is that good practice, is that good supervision? [LB230]

RICHARD BLATNY: No, no and, again, you know what our situation is because you've heard testimony earlier today. I...the only thing I picked up out of that is that the nurse practitioner presenting that said that she had worked with that physician for a period of time so she probably...wasn't that true, that she had worked in his office for a period of time? [LB230]

SENATOR HOWARD: She did, but if you translate this to the situation I presented to you, I could also say I have worked with that foster mom for four years and... [LB230]

RICHARD BLATNY: Sure, sure and no, I have to say that I don't agree with that and I think that if that, if things are that loose I think something should be done about it. I really do. But that doesn't necessarily state that everybody out there as a nurse practitioner graduating is qualified to be out there in Bertrand working by herself. We have a neighboring group close to our area that have a nurse practitioner, they have a PA, and there's a group of physicians, and the nurse practitioner herself just recently asked to be taken off of hospital service and emergency room service because she didn't feel qualified to actually perform it. Now I think that was a commendable thing on her part, rather than waiting until she got into something she said that when I went through school, nursing school, I was a, you know...and had my physiology and my anatomy, etcetera, was sometime before. And she said, I don't feel like I understand the medical process right now that I should be...that I can really make diagnoses and interpret and handle. Now, so now what she is doing is she's doing wellness exams and probably doing a wonderful job of it. But she's not out there by herself handling, and she's not even really in the emergency room by herself handling it. Now that...I mean, for every one of the bad stories that you hear of, I mean of the proponents, you probably are going to hear others that are on the opposite side, you understand. And I...and you don't have time, and it's not of interest to anyone to go out there. I think all of us as physicians know of situations and we're not going to come up here and hammer away to say this person did that wrongly, this was bad care here, this was there. I'm just saying I think there is a need for supervision, and when you take this last, last morsel of supervision that we have that requires it, whether it's being truly done by everyone or not as it should be, then you have opened it up and these people now, basically with two years of practice can do the same thing I do with seven years. And when we talk about getting physicians into family practice, if that happens, how many do you think are really going to go into family practice at all? And family medicine? They are like, holy cow, if they're going to crank out umpteen nurse practitioners and they are doing everything and the care is what it is, then why would anybody even do it? [LB230]

SENATOR HOWARD: I have one follow-up question to that, if I may. [LB230]

RICHARD BLATNY: Yes. [LB230]

SENATOR HOWARD: You seem pretty familiar with the waivers and that waivers have been requested. [LB230]

RICHARD BLATNY: No, I'm not real familiar with them. [LB230]

SENATOR HOWARD: Oh, well you did mention that. I wonder if you know how many waivers have been granted? [LB230]

RICHARD BLATNY: Yes. I only know that...I think perhaps Mr. Buntain might have that. I know there have been very few. I just run down a sheet of statistics which I don't have up here, and I also know that I think there are only states, 12 states, that allow prescribing without some physician involvement. So, we make it sound like there is...it's opened up in many states but I don't think you find absolutely everything opened up in those states, with no supervision. [LB230]

SENATOR HOWARD: Thank you, thank you. [LB230]

SENATOR GAY: Doctor, we...Senator Howard, we do have some information here from Jeff Santema. This is from department and says that since 1996, and this was dated February of last year, so it's probably changed a little, but, since '96 one has been granted, one did not meet the requirements for a waiver and one denied. So only three and then I have asked Jeff to supply us with what are the requirements to get that as well. So you will have that before you have to make any decisions on this, so. [LB230]

SENATOR HOWARD: Thank you. [LB230]

SENATOR GAY: You bet. Senator Wallman. [LB230]

SENATOR WALLMAN: Thank you for being here, doctor. I can understand your apprehension, licensure issues and accountability issues. And all your time though, with this nurse practitioner issue, has there ever been a malpractice lawsuit against the doctor who agreed to affiliate with a nurse practitioner? [LB230]

RICHARD BLATNY: Well, I don't have any statistics on that either. I'm sorry. [LB230]

SENATOR WALLMAN: Okay. That's okay. [LB230]

RICHARD BLATNY: All I know is that I was...I attended a meeting and during that meeting there was some legal counsel there, and the question was brought up, you know, what about the liability? And, again, just as I am liable for the PAs at work, and if we hire a nurse practitioner in our group, then I will be liable for her. I...they told us we were. I would think there would be with the collaborative agreement also. You're guaranteeing supervision. As Senator Howard says, it doesn't sound like it's working all

over. [LB230]

SENATOR WALLMAN: Okay, thanks. [LB230]

RICHARD BLATNY: Yes. [LB230]

SENATOR GAY: Any other questions. I don't see any. Thank you. [LB230]

RICHARD BLATNY: Thank you. [LB230]

DAVID BUNTAIN: (Exhibit 9) Senator Gay, members of the committee, I am David Buntain, B-u-n-t-a-i-n. I am the registered lobbyist for the Nebraska Medical Association. I know you have one more bill so I just want to make a couple of points. This issue is an issue that I worked on in 1984, the first year that I lobbied. We have had a nurse practitioner bill since 1981 so we have really been dealing with nurse practitioners for almost three decades now. And we have gone through an evolution. There was a significant amount of work that was done in 1996 when LB414 was passed, and that is much of what is in the law now, in the area of collaboration and supervision, was worked out through several years of negotiation between the affected parties. And the issue of whether there should be a continued reference to supervision by physicians, which is in the statute, was actually brought to the floor of the Legislature, and the Legislature as a body, rejected removing the requirement of supervision at that time. And the medical association believes that was the right decision at that time and it continues to be the right decision. Just because there are problems doesn't mean that we have...that you should get rid of the requirement of these Integrated Practice Agreements, which require collaboration and supervision. We think that you should be encouraging that interaction between professionals, and if there are problems with the way the system works, let's look at the current system. And part of the reason that the discussion over trying to resolve this has broken down is that the nursing profession's national stated goal is to get rid of Integrated Practice or collaborative agreements with medicine. And if you start the negotiation at that point, it's a short negotiation, and that's the problem we have had. This is actually not the same bill that you considered last year. It's a step back from LB753. LB753 provided that nurse practitioners would not need an Integrated Practice Agreement if they practiced under an Integrated Practice Agreement for five years and didn't have any disciplinary action taken against them. So even the bill a year ago required five years of practice under an Integrated Practice Agreement. It also provided that the 2,000 hours of supervised training that is a requirement for licensure would be under...would be with a physician. That is now changed so it would be under a nurse practitioner. Both of those we think are extensions, go beyond what LB753 sought and really a step backward from the bill last year. The information about what goes on in other states that has been presented is also somewhat misleading. I want to handout a chart or a couple of charts that appear in a document that is called the Pearson Report. This is actually a publication that is

available on the Web site of the nurse practitioners organization from the American Journal for Nurse Practitioners. The first map shows a listing of the states where there is no requirement of physician involvement in diagnosis and treatment. And I think it was stated and I think this chart reflects that 23 states have no requirement for physician involvement, 28 have a requirement, 4 of them it's not a requirement of documentation. The interesting chart is the second chart which shows of these states there are only 12 that do not require physician involvement in prescribing, and three of the states that have been identified as not requiring a physician oversight were Colorado, Missouri, and Iowa. Iowa, Colorado, and Missouri. And it is correct that they appear on the first list but if you look at the second list, only Iowa of our surrounding states, has removed the requirement of physician involvement with prescribing, and attached to this part is a chart that actually describes in some detail what the various requirements are. So what we really have nationally is a patchwork of state laws and this issue is being resolved in different ways in different states, but we think you should look very carefully at making these changes based on a few isolated incidents that have been reported. The last thing I just want to say, and it's been touched on, the section that deals with waiver provision is 38-2322. And basically what it says that if a nurse practitioner after diligent effort is unable to obtain an independent or Integrated Practice Agreement and satisfies the other requirements and will practice in a geographic area where there is a shortage of healthcare services, then the Advanced Practice Nursing Board can grant a waiver. And the statistics I am aware of were the same ones that were reported earlier. I think there have been fewer than five requests for a waiver, and this is a board that the nursing profession has a majority vote on. I mean it's the nursing profession, basically, and the Department of Health and Human Services that has...is the gateway to this waiver. So if there is an issue of not being able to find supervising physicians in rural areas, there is a mechanism that we negotiated and put in place back in 1996 to address that. [LB230]

SENATOR GAY: Thank you. Senator Howard. [LB230]

SENATOR HOWARD: I'm going to make this quick and I apologize for my not remembering this, but we hear a lot of bills. Last year the bill you referenced that required the five years of supervision, did you stand in support of that? [LB230]

DAVID BUNTAIN: No. No, but... [LB230]

SENATOR GAY: All right. Senator Pankonin. [LB230]

SENATOR PANKONIN: Thank you, Senator Gay. David, you probably know what my question is because it's the same line of when we have these situations where there is no care or nil care and, you know, I understand the waiver part of it, but on the other hand, some of these stories have put the medical profession not in the best light of people almost to the point of abuse in these type of arrangements. And I think that's what is enforcing it here is that, to me, there isn't maybe a pathway between the waiver

and the fact that people in the medical association if they knew because of some policy issues with underserved folks in our state, that if they would make a better effort or there is some mechanism we can come up with that we don't have to have this. If you've been at it since '81, I've been at it three years, getting tired of it also. But we need to come up with some kind of solution that maybe isn't opening the door totally but also helps make these situations better. So I, you know, I'm sure we'll be looking into...in our discussions on this committee into some of these, but it would sure help if...we encourage you again to try to redouble your efforts to figure out how we can make this work or if not, the waiver system work, or something. [LB230]

SENATOR GAY: (Exhibits 10, 11, 12 and 13) Thank you, Senator Pankonin. Any other questions? I don't see any. Thank you. Other opponents who would like to speak on this issue? I don't see any. And then on neutral testimony today, would anyone like to speak? If not, we did receive a letter from the Department of Health and Human Services regarding this. Senator Stuthman, would you like to close on this? [LB230]

SENATOR STUTHMAN: Thank you, Senator Gay, members of the committee. First of all I want to thank all of those that did testify here today, that was very educational. One of the things that I did notice, you know, that these nurse practitioners, they want to serve the people in the communities, and we have a very different situation from eastern Nebraska to western Nebraska, especially Ruby from Bertrand trying to help the people in that area. And it wasn't that she didn't want to get a collaborative agreement with a physician, it was that she could not attain it. And I think a lot of these cannot attain a collaborative agreement with a physician. That tells me that the physicians are not willing to work with the nurse practitioners and give them an agreement, an Integrated Practice Agreement. It seems like they have tried to get them and tried to get them and been turned down and been turned down. I think that's where, if we want to continue that, I think that is the side that we have to really take a serious look at as to, you know, why aren't they coming forward, too, to try to help with the profession? It was also mentioned in some of the opposition that these nurse practitioners would probably try to be the family physician. The nurse practitioners, in my opinion, have a scope of practice. And in listening to some of those that have this scope of practice, they all have a scope of practice, and when they felt that it was beyond their scope of practice, they asked for expertise. They sent these patients on. And I think they'll do that because I feel they have enough common sense that they are not going to do anything that would harm or not help their patients. I think that's very serious. And I think, you know, they do have four years of schooling, they do have four years of practice before they get the nurse practitioners license. So I, you know, I want to really thank those that came a distance to testify, and to me that is very important because these are the ones that are in the field, they are in there working, and we're hearing what is happening in their profession. So I want to thank them for that. If there are any questions, I would attempt to answer. [LB230]

SENATOR GAY: Thank you, Senator Stuthman. Are there any questions? I don't see any. Thank you for bringing this important issue to us today. [LB230]

SENATOR STUTHMAN: Also I...okay. Thank you. [LB230]

SENATOR GAY: Thank you. All right, thank you all for coming and testifying. We're going to go right ahead with LB394. Senator Fulton, you've been waiting, waiting patiently back there. Thank you very much. We were hoping your deal didn't fall apart while you were waiting out there. [LB394]

SENATOR FULTON: I'll go fast. [LB394]

SENATOR GAY: Thanks for being patient. [LB394]

SENATOR FULTON: (Exhibit 1) Good afternoon. Thank you, Mr. Chairman, members of the committee. For the record, my name is Tony Fulton, T-o-n-y F-u-l-t-o-n, and I represent Legislative District 29. I am pleased to present to you LB394. This is a bill that represents the culmination of several years of collaboration with the Nebraska Medical Association. LB394 is necessary both for the protection of healthcare consumers and for controlling the cost of healthcare. The bill amends the Medicine and Surgery Practice Act to require the referring physician, when he or she does not supervise or perform a component of a pathology service, to disclose in the patient's bill for services, (1) the identity of the physician or laboratory that actually provided the pathology service and (2) the actual amount to be paid to the pathologist or lab for such service. The bill further clarifies that the failure to disclose such information constitutes a departure from the ethics of the profession, that is, the American Medical Association code of ethics, and is thus an act of unprofessional conduct as defined by Neb. Rev. Stat. 38-179. Passage of LB394 would alleviate the confusion within the Nebraska medical community regarding the practice of marking up for pathology services, witnessed by this committee in recent years when I brought LB513 in 2007 and again in 2008 with LB1104. To ensure that no lingering confusing on charging a markup for pathology service remains, my introduction of this bill was predicated on the dissemination of a letter from the NMA to its members informing them of the prohibition against charging a markup for pathology services and of the requirements of LB394, and I'll disseminate that letter for your review. In conclusion, I'd like to thank the committee for its consideration of this bill, forged through considerate and thoughtful compromise with President Les Spry and the NMA, and I greatly appreciate the cooperative posture and dedication displayed by the NMA in working toward this mutually agreeable resolution. If there are any questions, I'd be glad to try to answer them. [LB394]

SENATOR GAY: Thank you, Senator Fulton. Are there any questions? I don't see any right now, thank you. Are there proponents who would like to speak on LB394? [LB394]

DAVID BUNTAIN: Senator Gay, members of the committee, David Buntain, B-u-n-t-a-i-n, registered lobbyist for the Nebraska Medical Association. Very briefly, those of you who are on this committee the last two years remember that this was a very contentious issue between several of the specialties within the medical community. We've had basically a long series of meetings over that three-year period which results in the bill that is before you today. I think this is a good result, the medical association is supportive of it, we encourage you to advance it, and I would be happy to respond to any questions that you have about it. We also have Dr. Lacey, a pathologist, if you have any of the technical questions which he can respond to. [LB394]

SENATOR GAY: Any questions from the committee? We've got one question. I've got one question for you. This letter, this draft letter, would that be after...if this proceeds out of committee, would that be on General File? When are you going to send this letter? At conclusion or are you going to let people know... [LB394]

DAVID BUNTAIN: No, I think the idea would be to send a letter to the membership explaining that the bill has been passed and what is involved in it. And I think the pathologists were concerned that we needed to have some further explanation and let our members know. I would indicate also that this is not the only thing we planned to do. I think there will be a need for some further educational activities, but, you know, we view the letter as, you know, it was part of the commitment we made in addition to saying that we would support the bill. [LB394]

SENATOR GAY: Okay. Senator Gloor. [LB394]

SENATOR GLOOR: Thank you, Chairman Gay. I have been waiting years to ask this question. What are the ramifications of being deemed to have exhibited unprofessional behavior, Mr. Buntain? [LB394]

DAVID BUNTAIN: Basically what this does is it puts under the licensure law for physicians. There is a whole list of activities that are identified as unprofessional conduct, and a physician can be held...his license can be disciplined, reprimand, everything up to having it...I'm struggling for the term at this late hour. But basically suspended or revoked if, you know, he or she engages in unprofessional activity. So it would be a...this makes it a licensure matter for the board of examiners. [LB394]

SENATOR GLOOR: Does that happen at the time that they reapply for a license or does...can it or does it or is it a combination of both, it can be an immediate action if... [LB394]

DAVID BUNTAIN: Normally it's a complaint procedure. Anyone can file a complaint against any licensed health professional on an anonymous basis, and the department is required to investigate it so it would most likely come about through a complaint that has

been filed. It would...there is no review done at the time licenses are renewed. [LB394]

SENATOR GLOOR: I'm just...I think the reason for my questioning is to find out if there is a strong enough accountability piece that there will be a positive response, or compliant response to this. That's the reason for my question. [LB394]

DAVID BUNTAIN: And that's a reasonable question. I...we think that if physicians are aware that their license may be at risk, that should be a sufficient incentive to address it. [LB394]

SENATOR GLOOR: Thank you. [LB394]

SENATOR GAY: Any other questions? Don't see any, thank you. [LB394]

DAVID BUNTAIN: Thank you. [LB394]

STEFFAN LACEY: (Exhibit 2) Mr. Chairman, committee members, thank you for the opportunity to speak. My name is Steffan Lacey, I'm a practicing pathologist and physician in Norfolk, Nebraska, proud hometown of the speaker of the house, as I have said before, and I thank you for the opportunity to have us testify on behalf of LB394. Senator Pankonin had an introduction for that in the last hour or so that probably many of us remember from last year. Mr. Chairman and members of the committee, the Nebraska Association of Pathologists has, since 2005, worked with the Nebraska Medical Association on the issue of referring physician markup on anatomic pathology services, i.e., biopsies and pap tests. After four years of vigorous debate, we are here today united with the NMA, the Nebraska Medical Association, in support of a compromise. The compromise entails both the legislation before you today, LB394, and the advisory communication to all Nebraska physicians, which was mentioned by Senator Fulton. LB394 serves Nebraska patients by requiring that they be made aware of the laboratory or physician that provided the anatomic pathology service and the actual cost of that service. This specific disclosure requirement is consistent with ethics policies of the American Medical Association. Moreover, LB394 will insure transparency and promote greater regulatory oversight over the billing for these services. Fourteen states already have disclosure laws for pathology billings and are similar if not substantively identical to the legislation in this language. However, as should be evident to the committee, disclosure alone does not make that legal. Referring physician disclosure of a markup, as we have pointed out, needs to follow the ethics policies of the AMA and are explicitly...the AMA ethics policies are explicitly opposed to markup billing practices. Therefore, as part of the compromise, the NMA has committed to issue the advisory letter to its members following enactment of this disclosure. We have provided a copy of that draft to Senator Fulton, which has then been entered into the record. The letter will advise Nebraska physicians that: a Nebraska physician who orders but does not supervise or perform a component of the anatomic pathology

service is prohibited from adding a markup to the actual cost of the service when billing a patient, insurer, or other entity. This policy does not prohibit physicians from adding an acquisition charge which is consistent with AMA coding guidance and policies. Physicians who order anatomic pathology services should be aware that the failure to comply with the disclosure and the applicable guidelines could result in disciplinary action against their license. It is the expectation of the Nebraska Association of Pathologists that physicians in Nebraska will refrain from engaging in markup practices in deference to this unequivocal policy statement by the NMA that will follow enactment of this bill. With the transmittal of this letter to Nebraska physicians, the legal guidance of the NMA will be aligned with the ethics policies of the AMA, and as such, should help put an end to the markup practice. This has been the objective of the Nebraska Association of Pathologists. In closing, I want to commend the leadership of the Nebraska Medical Association in taking a clear stand against the markup billing practice. It is their leadership, really, that made this compromise possible. I would also like to thank Senator Fulton for taking the lead on this issue, and I would like to thank this committee for their persuasion and guidance in the past because without the persuasion of this committee, I doubt that this would have been resolved. This is an important step in addressing healthcare costs and finding ways to reduce costs for Nebraska citizens. I would take any questions. [LB394]

SENATOR GAY: Thank you. Any questions? Don't see any, thank you. [LB394]

STEFFAN LACEY: Okay. Thank you. [LB394]

SENATOR GAY: Any other proponents? Any opponents? Anybody neutral? (inaudible) closing? Senator Fulton waives closing. Thank you all for your patience, as well, being the fourth bill today. Thank you. [LB394]

Disposition of Bills:

LB141 - Held in committee.
LB230 - Held in committee.
LB250 - Placed on General File with amendments.
LB394 - Placed on General File.

Chairperson

Committee Clerk