[LB316 LB534 LB557]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, March 3, 2011, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB316, LB534, and LB557. Senators present: Kathy Campbell, Chairperson; Mike Gloor, Vice Chairperson; Dave Bloomfield; Tanya Cook; Gwen Howard; Bob Krist; and Norm Wallman. Senators absent: None.

SENATOR CAMPBELL: I want to welcome you to the committee hearings for the Health and Human Services Committee. I'm Kathy Campbell, Senator from District 25, Lincoln, and I'll start on my far right for the senators to introduce themselves.

SENATOR BLOOMFIELD: Dave Bloomfield, District 17 in the northeast corner of the state.

SENATOR WALLMAN: Senator Norm Wallman, District 30, Beatrice just won their game (laughter)...Gage and part of Lancaster County.

SENATOR GLOOR: Senator Mike Gloor, District 35. That's Grand Island.

MICHELLE CHAFFEE: Michelle Chaffee. I'm the legal counsel for the committee.

SENATOR HOWARD: Senator Gwen Howard, District 9 in Omaha.

SENATOR KRIST: Bob Krist, District 10, northwest Omaha.

SENATOR CAMPBELL: To my very far left is Diane Johnson, who is the committee clerk, and our pages are Ayisha and Crystal, so we want to welcome all of you. We'll take care of a few tips on testifying in front of our committee. Please silence all your cell phones, and welcoming Senator Cook, who has joined us. And silence them, so they do not bother your neighbor as they are listening to the testimony. Although handouts are not required, if you did bring handouts, we would like 12 copies of them. And if you do not have 12 copies, posted outside is where you might obtain additional copies. If you plan to testify, we need you to fill out one of the bright orange sheets that are on each of the tables on the sides of the room, and please print, so that Diane can easily read them. If you are not testifying today, but you came to show support, we have white sheets on the side that you can sign and say, I'm supporting a bill, and you don't have to testify that way verbally in front of the committee. We do use a light system in this committee. You have five minutes except for the introducer of the bill. They can take as long as they wish. The green indicates that you're good to go, and you have four minutes, and it'll...you know, you'll be fine, and all of a sudden it will go to yellow, and then it rapidly one minute goes to red, and you're going to look up, and you're going to see me going time, time, time. We try to be as fair as we can, because for the hearings

that come later in the afternoon, that they have as much time and courtesy as the first hearings do. So with that, we will open the hearings for the afternoon, and our first hearing is LB316, Senator Heidemann, to change provisions relating to the practice of optometry. Senator, first visit this year.

SENATOR HEIDEMANN: This is probably the only second time in my seven years in the Legislature that I've been before the Health Committee.

SENATOR CAMPBELL: Well, we're awfully glad to have you, so please go ahead and open on your bill.

SENATOR HEIDEMANN: Thank you. Senator Campbell and members of the Health and Human Services Committee, I'm Senator Lavon Heidemann spelled H-e-i-d-e-m-a-n-n, representing District 1 in the southeast corner of the state. I am here today to introduce LB316. LB316 would allow licensed optometrists to update and improve the services they provide to their patients. In many communities across the state, optometrists are the sole providers of professional eye care. LB316 is a scaled-down version of LB417, which was introduced by Senator Mike Friend before the Health and Human Services Committee in 2009. It was held by your committee until adjournment in 2010. LB316 would add oral medications for treating glaucoma and the inflammation of the eye to an optometrist's present prescriptive authority. Optometrists are presently able to treat these conditions with topical medications as well as to prescribe a wide range of other oral medications for the treating diseases of the eye. This would remove two narrow exceptions to the existing authority. The legislation would create the following exceptions to the present optometry statutes' categorical ban on the surgery: minor surgical procedures on the eyelid for the removal of skin tags and certain cysts which can be performed in the optometrist's office under local anesthesia; three types of common in-office laser procedures, two of which are utilized in the treatment of certain types of glaucoma and one which improves the vision of certain post-cataract surgery patients; and (3) the use of injections into the eyelid or tissue surrounding the eye, but not the eye itself, to anesthetize patients for these procedures. LB316 would allow optometrists to gain clinical experience with new optometry procedures as part of a course conducted by the approved College of Optometry without violating the current approved scope of practice for optometrists. To be authorized to perform this improved scope of practice as authorized by LB316, optometrists would have to complete additional training and education approved by the State Board of Optometry, although most optometrists already have some training and experience in these additional procedures. Nothing in LB316 is unique in Nebraska in terms of optometry scope of practice. Optometrists in Oklahoma have been successfully performing laser procedures since 1988 while 19 states allow optometrists to administer injections; 21 states allow the prescription of an unlimited range of oral medications; and 36 states allow the use of oral glaucoma medications. It has been more than 12 years since the last update to the state's Optometric Practice Act. During that time, much has

changed in eye and healthcare and the necessities of flexibility in the scope of practice for optometrists. Students graduating from the optometry school today are unable to utilize their training due to current Nebraska law. We don't want the best students to locate elsewhere in order to use their full range of skills and knowledge. I would ask for your favorable consideration of LB316. If there are any questions, I'd be happy to try to answer them, but there are persons here today that are far more knowledgeable, and I want to emphasize far more knowledgeable than I am on this subject. They may be able to better answer any questions that you might have. With that, I would try to answer any questions. [LB316]

SENATOR CAMPBELL: Okay. Any questions from the senators before we go to the testifiers today? Seeing none, will you be here for closing, Senator? [LB316]

SENATOR HEIDEMANN: I am going to waive closing, heading back to Appropriations for a little while. [LB316]

SENATOR CAMPBELL: And we do want you there (laughter). [LB316]

SENATOR HEIDEMANN: Thank you. [LB316]

SENATOR CAMPBELL: Thank you, Senator. We will open with the testifiers, but before we do, how many in the room wish to testify in favor of the bill? Okay, three. How many wish to testify in opposition? Boy, I'm having trouble speaking. All right, in the neutral position? Hum, no neutral. Okay, with that, we'll open with the proponents. Good afternoon. [LB316]

COREY LANGFORD: (Exhibits 1, 2) Good afternoon. My name is Dr. Corey Langford, L-a-n-g-f-o-r-d, and I'm the president-elect of the Nebraska Optometric Association. Optometrists are the primary providers of eye care in Nebraska. We are a doctoral level profession that is responsible for diagnosing and treating diseases of the eye and treating with topical and oral medications. We also manage surgical cases, both pre- and postoperatively with our ophthalmologic colleagues. I'm here representing our 280-member optometrists across the state to speak in favor of LB316. Many of you have asked us in our individual meetings whether or not these new procedures have gone through the 407 process. They have, but part of a larger bill two years ago, as Senator Heidemann suggested. And while we acknowledge that that bill did not receive a favorable review, we would remind you that optometry has never received a favorable review on any 407 process, and yet we've been able to pass legislation that has improved access to quality care for our patients. What we learned from this 407 process was that we needed to be more specific on what we were asking for, and the result is the bill that you see before you. There are four fundamental components to this bill. The first and second proposed changes will allow us to have more options for medications to use in the treatment of eye disease. Change number one: Nebraska optometrists have

used anti-inflammatory and antiglaucoma medications for 17 and 12 years, respectively--with the exception of oral steroids and oral glaucoma agents. It is time that these exclusions, which were put into place through political compromise, are lifted. We are requesting that we be allowed to join the 31 states where optometrists can provide oral steroids as well as the 45 states where optometrists can prescribe oral glaucoma medications by removing these two restrictions. Change number two: The proposal would allow optometrists to use injectable medications, but only for the treatment of anaphylaxis or severe allergic shock, and for the treatment of eyelid "lumps and bumps." The authority to use an EpiPen during severe allergic shock is granted to optometrists in 34 states. Ten states allow for injections into the eyelid tissue, and it is important to note that we are not talking about injections into the eyeball. The bill specifically excludes that. The third and fourth proposed changes will modify the all-inclusive ban on surgery that is in our current law, and the change number three is that we are proposing a change that would allow for the performance of minor surgical procedures relating to the eyelid and tissue surrounding the eye. This change would allow for removal of superficial eyelid growths and surgical drainage of clogged glands and cysts. Currently, optometrists in 14 states are allowed minor surgical procedures beyond what Nebraska optometrists are allowed to do. Again, it's important to note that we are specifically excluding cutting into the eyeball itself. Change number four: We are proposing that we be allowed to perform three specific laser procedures, two relating to glaucoma and one relating to a common aftereffect of cataract surgery. We acknowledge that these procedures are currently only done in one other state, and that is Oklahoma, but we would like to point out that they have been doing them since 1998 without any adverse complaints to the Oklahoma Board of Optometry. We're also proud to report that two weeks ago, the state of Kentucky, 87 percent of their legislature voted to pass a similar bill to this, and the governor has signed that, and it will become law this summer. Under the current system, optometrists are forced to refer patients for these simple procedures to an office that they don't know, to a doctor they don't know, and for a redundant appointment that they will have to pay for or their insurance will have to pay for, adding an unnecessary burden of time and expense to our patients. Nebraska optometrists already diagnose and manage all of the conditions we're asking to treat with this bill. Nebraska optometrists already diagnose and manage all of the postoperative complications that may occur as a result of these procedures, although they are quite rare. All the aspects of this bill are taught in optometry schools across the country. We are not talking about major eye surgery, using operating rooms and general anesthesia. We are talking about procedures easily performed under local anesthesia in our exam rooms. We believe that the additional authority we are asking for represents a skill set that is well within the expertise of optometrists, and we believe that this bill is an important step in the evolution of healthcare for Nebraska, and that it will greatly improve access to care in a safe and effective manner. Thank you for your consideration, and I ask that you vote to advance this bill onto the floor, and I would be happy to try to answer any questions. [LB316]

SENATOR CAMPBELL: Thank you, Dr. Langford. [LB316]

SENATOR LANGFORD: You're welcome. [LB316]

SENATOR CAMPBELL: Questions from the senators. Senator Bloomfield. [LB316]

SENATOR BLOOMFIELD: Thank you. As an optometrist, are you currently allowed to do anything with laser? [LB316]

COREY LANGFORD: As an optometrist, we are not currently allowed to do anything with laser. We are not, no. [LB316]

SENATOR BLOOMFIELD: Okay. Thank you. [LB316]

COREY LANGFORD: Right now, the...as I said, the only state that can is Oklahoma, although Kentucky just passed their bill, so they will be number two. [LB316]

SENATOR CAMPBELL: Other questions? Senator Gloor. [LB316]

SENATOR GLOOR: Thank you, Senator Campbell. Dr. Langford, thanks for...I'm guessing since you're first up, people decided you'd be the one that we should all ask our (laughter) questions of. [LB316]

COREY LANGFORD: I think you can wait till the other two. That's fine (laughter). [LB316]

SENATOR GLOOR: Do we know, will insurers pay for optometrists? I mean, has there been that discussion with some of the larger insurance companies--Medicaid, Medicare--is there going to be any problem getting payment through the payers? [LB316]

COREY LANGFORD: Well, in all other cases, of all the things that we do, do that overlap with ophthalmology right now, there are very few problems, and I don't believe that there are any problems in Oklahoma with that. So I can't anticipate that there would be in Nebraska. [LB316]

SENATOR GLOOR: Okay. Senator Heidemann made a comment, and I've got to be careful I don't quote him, except I thought he was talking about something that was a broad use of prescribing medications. Does this statute speak only specifically to those issues of anti-inflammatories, I mean, and glaucoma meds? Is it very specific about the meds that this would allow optometrists to prescribe? [LB316]

COREY LANGFORD: I think what you're asking is, is a little clarification on what

medications we're asking for, is that correct? [LB316]

SENATOR GLOOR: Yep, yep, yep. [LB316]

COREY LANGFORD: And number one is just the oral steroid medications and then oral glaucoma medications, and then also, just routes of administration with injections, so the injections typically...like I mentioned, the EpiPen for anaphylaxis, but also, there could be steroid injections and also anesthesia. [LB316]

SENATOR GLOOR: But oral steroids is a pretty broad formulary. I mean, is...and in some cases, maybe even steroids that a family practitioner wouldn't be comfortable prescribing without having an internist who gets involved. [LB316]

COREY LANGFORD: Sure. [LB316]

SENATOR GLOOR: I mean,...so does this talk about oral steroids in a very general way or is it specific to the type of oral steroids that would have (inaudible)... [LB316]

COREY LANGFORD: It would be oral steroids in the treatment of eye disease, but you mentioned that, you know, even a family practitioner would work with...or any other specialist would work with a family practitioner. We would do the exact same thing. I mean, absolutely, we would be double-checking medications and diagnoses and all kinds of active disease in that patient before you prescribed them. [LB316]

SENATOR GLOOR: But you wouldn't have to necessarily. I mean, I want to make sure I understand if we pass this, and it's stated that way, and this isn't requiring you to do that. It would (inaudible)... [LB316]

COREY LANGFORD: Oh, absolutely not. No. Matter of fact, there are things right now that some optometrists don't do. If you're not comfortable with it, you refer. I mean, yeah. [LB316]

SENATOR GLOOR: Sure. Okay. Thank you. [LB316]

COREY LANGFORD: Sure. [LB316]

SENATOR CAMPBELL: Other questions. Doctor, at present, how much do you do...what are the typical types of things that you do with children...young infants? [LB316]

COREY LANGFORD: Typical types of things that we do with children. [LB316]

SENATOR CAMPBELL: Well, because...and the bill would allow you to treat an infant,

would it not? [LB316]

COREY LANGFORD: For a specific condition or are you...? [LB316]

SENATOR CAMPBELL: Yes, for glaucoma testing, other testing? [LB316]

COREY LANGFORD: Right now our law specifically excludes congenital glaucoma, and I believe that it still does. [LB316]

SENATOR CAMPBELL: Okay. [LB316]

COREY LANGFORD: Written this way. Is that what you're asking about? [LB316]

SENATOR CAMPBELL: So at this point, yeah... [LB316]

COREY LANGFORD: Yeah. [LB316]

SENATOR CAMPBELL: I'm asking whether this bill would allow you to begin working on infants in a way that you do not now? [LB316]

COREY LANGFORD: I would say no. [LB316]

SENATOR CAMPBELL: (Laugh) Legal counsel is pointing out the part that I have. On page 4, line 5, minor surgery for the eyelids or ocular. Okay. Strikes the word infantile in the bill, which would mean that you could do that. And I'm just trying to... [LB316]

COREY LANGFORD: Yeah, I don't think that it's our intention to do that, so that would be something we needed to clean up, but... [LB316]

SENATOR CAMPBELL: Okay. [LB316]

COREY LANGFORD: ...yeah. I don't...there's really no change that we are anticipating with that, no. [LB316]

SENATOR CAMPBELL: That you're anticipating. And I have to tell you, sir, I probably wouldn't have paid as much attention to this a couple of years ago, but I have a new grandchild, so now anything infant draws my attention. [LB316]

COREY LANGFORD: Sure, sure. You know, we definitely see babies in my practice from six months and up usually, but not in congenital glaucoma cases. Most of those cases require surgery into the eye, so not things that we're asking for here. [LB316]

SENATOR CAMPBELL: Okay. Any other questions that the senators have? Thank you

very much. [LB316]

COREY LANGFORD: You're welcome. [LB316]

SENATOR CAMPBELL: Thank you. Next proponent. Good afternoon. [LB316]

JEFF PAPE: (Exhibits 3, 4) Good afternoon. My name is Jeff Pape, P-a-p-e. I'm a licensed optometrist, practicing in Norfolk with satellite clinics in Pierce and Randolph. I am here as a rural optometrist in support of LB316, and I want to explain how this bill would benefit the people in my area and other rural areas like mine. Despite being from a community of 24,000, Norfolk is like a lot of rural communities in that we have no full-time coverage from ophthalmologists. We have a number of ophthalmologists from outside the community, even outside the state, who travel to Norfolk to see patients, but they consider Norfolk a satellite clinic, and the hours that they can be seen are often sporadic and subject to cancellation, especially in winter. Even in a town the size of Norfolk, it is not uncommon for our patients to wait one to two months for an appointment or an evaluation for one of the procedures that LB316 would allow me to perform. I have colleagues in towns all over Nebraska, many of them smaller than Norfolk whose patients have to wait even longer for appointments and travel even further. That's an inconvenience to the patients, and if they need transportation, it can be an inconvenience to family or friends who have to take off from work. In addition, an extra office visit may be needed to diagnose the same thing I saw in my office which increases the cost to the patients or insurance providers such as Medicare and Medicaid. I am providing a handout that shows the distribution of optometrists and ophthalmologists from across the state. According to the AMA, there are 106 ophthalmologists in the state of Nebraska. All but 21 of those are within 30 miles of the Omaha and Lincoln metropolitan areas. Of the remaining 21, all but four are along the I-80 corridor. What does this mean for the people of rural Nebraska? I know ophthalmologists have tried to show in earlier discussions that satellite locations assure convenient access to most of the state's population. They have also tried to argue that there is no demonstrated need for this legislation, because there is no vocal outcry from patients or consumer groups. In my opinion, the demand is there--it's just a little bit more subtle. Why do you think hospitals are opening off-site care facilities, and health clinics are opening up in strip malls? Why do you think Omaha hospitals are building satellite hospitals in other parts of Omaha? To my knowledge, there have been no consumer groups petitioning the Legislature for these type of public access. Providing better access for the care of our patients is the fundamental reason for this bill. Ophthalmologists may be accessible on a map, but if patients in towns all across the state have to wait a month or two before they can be seen by an ophthalmologist for care that optometry can provide, that's not the best that Nebraska can do for its citizens. I'd like to point out one other reason why this legislation is needed. Nebraska, especially rural Nebraska, needs doctors--all kinds of doctors, including doctors of optometry. If we want to attract the best and brightest doctors to our state, it is important that students

that are being trained in optometry schools today are allowed to use the skills and knowledge when they graduate. We need a law that lets them do that. I am confident this committee will hear that optometrists are not trained or educated enough to be granted this additional authority. Dr. Baxter, who will be following me, will be addressing in more detail the educational background of doctors of optometry and the qualifications that would be expected related to this bill. But as you listen to questions and concerns about the qualifications of doctors of optometry today, I hope the committee can remember one key point. This is the same argument that medicine has used every time that optometry has approached the Legislature to enhance its scope of practice. M.D.s have said that patients are at risk if optometrists are allowed to do more, because we do not attend medical school, and consequently, can't be trusted with expanded scope. And with the passage of each of these bills, these arguments, assertions, and dire predictions have been proven wrong. Optometry last expanded its scope of practice in 1998, 12 years ago--over 12 years ago. That change allowed us to treat glaucoma and was strongly opposed by ophthalmology, using the same arguments that you will hear today. In those 12 years, many thousands of patients have been treated, and the Board of Optometry has not even had one action related to the treatment of glaucoma. My colleagues and I are ready to advance the care we provide to our patients, and I ask for your support of LB316. [LB316]

SENATOR CAMPBELL: Questions for Dr. Pape. Oh, Senator Bloomfield. [LB316]

SENATOR BLOOMFIELD: Thank you. I looked at your map here, and I'm curious. Is there an...ophthalmologists, I assume, are in Sioux City? [LB316]

JEFF PAPE: Is there one in Sioux City? [LB316]

SENATOR BLOOMFIELD: Yeah, I assume there is. [LB316]

JEFF PAPE: Yeah, I believe so. [LB316]

SENATOR BLOOMFIELD: What about Yankton? [LB316]

JEFF PAPE: Yankton's got three ophthalmologists, and they actually use Norfolk as a satellite clinic then, too. [LB316]

SENATOR BLOOMFIELD: Okay. Okay. Are there any more around the outside of the state that we're not seeing on this map that you're aware of? [LB316]

JEFF PAPE: I would imagine Council Bluffs would have some, too. I'm trying to think of any other big cities. No. [LB316]

SENATOR BLOOMFIELD: Okay. Thank you. [LB316]

JEFF PAPE: Yeah. And that map doesn't show the satellite clinics for ophthalmologists or for optometrists then, too. [LB316]

SENATOR BLOOMFIELD: Okay. Thanks. [LB316]

SENATOR CAMPBELL: Other questions from the senators? Thank you, sir. Next proponent. Welcome to the committee. [LB316]

KIM BAXTER: (Exhibit 5) Good afternoon. Thank you for the time to speak. My name is Dr. Kim Baxter, B-a-x-t-e-r. I'm pleased to address you today on behalf of the Nebraska Board of Optometry. This is my fourth year on the board, and I currently serve as vice chairman. I am in a multidoctor practice in North Platte where I have been in practice for 30 years. The purpose of the Board of Optometry is to provide for the health, safety, and welfare of the citizens of Nebraska by ensuring that licensees are meeting minimum standards of proficiency and competency. Board members' duties include, but are not limited to, recommending the issuance or denial of licenses; developing regulations; screening complaints; and making recommendations on disciplinary actions. I speak for the Board of Optometry in favor of LB316. During the 407 process for this legislation, questions were raised about the exact education requirements for Nebraska doctors of optometry related to the passage of this bill. The members of the Board of Optometry have put a great deal of thought and discussion into this matter. We know for certain that these educational requirements will mirror those implemented in Oklahoma, Kentucky, and other states who have authorized similar legislative authority for optometry. Optometry's impeccable track record from these states, as well as Nebraska, speaks for itself. Nebraska optometry has a proud history of providing the highest quality of care delivered safely to our patients. I can assure you that once the final form of this bill is passed, the Board of Optometry will move quickly and thoughtfully to lay out specific education requirements. I can tell you that the coursework required will include classroom and didactic lab education, as well as supervised clinical hands-on training at selected clinics, both instate and out of state. All of this education will be fully accredited by one or more colleges of optometry. We are committed to ensuring that doctors of optometry in Nebraska are fully prepared to deliver these added services with the utmost level of care, discretion, and responsibility. I believe the Board of Optometry knows the qualifications of the licensees we regulate better than anyone in the state, and I am confident that the new training and education requirements that would be implemented will be appropriate. These new requirements will build on the education and experience that doctors of optometry have already obtained. The reality is that a substantial portion of what doctors and all healthcare professionals learn is from ongoing clinical experience and continuing education, not just school. All doctors of optometry in Nebraska have been required to obtain at least 16 hours per year of approved continuing education credits, and the board has increased that requirement for license renewal to 22 hours per year beginning in 2012. We are engaged in lifelong

learning just like our other healthcare colleagues. In that regard, I'd like to comment on an important feature of LB316 that relates specifically to our education. Nebraska doctors of optometry are disadvantaged when it comes to getting clinical training related to new techniques and procedures. The Legislature wants assurances that current licensees have training. However, current statutes set limitations on what we can do in that regard. For this reason, one very important element of LB316 is the student exemption provision which would allow Nebraska doctors of optometry to be trained for new techniques and procedures not yet enacted into law. It is worth noting that optometry is the only doctoral level profession in Nebraska that does not have this student exemption. The Board of Optometry strongly feels the addition of this exemption is very important for doctors of optometry. Each time optometry has sought to enhance its scope of practice, concerns have been expressed by opponents about insufficient training and increased risk to patients. These concerns have never proven to be true. The Board of Optometry has seen no complaints related to these prior scope enhancements. The trust the Legislature has had in this profession, and in this board to protect the well-being and safety of the public, has always been well placed. The Nebraska Board of Optometry feels strongly that LB316 is an important move in the right direction for our state and its citizens. The board stands ready to implement educational standards that ensure that Nebraskans will continue to receive the safe and effective eye care they have come to expect throughout the history of the optometric profession here in Nebraska. Thank you. [LB316]

SENATOR CAMPBELL: Questions from the committee? Senator Wallman. [LB316]

SENATOR WALLMAN: Thank you, Chairman. Yeah, thanks for coming, Doctor. Since the board has changed their scope in '98, has your education requirements increased? [LB316]

KIM BAXTER: As far as continuing education? [LB316]

SENATOR WALLMAN: To get...yeah. [LB316]

KIM BAXTER: They have remained 16 hours per year since that time, but, as I said, we will be increasing that to 22 hours per year, beginning in 2012. [LB316]

SENATOR WALLMAN: Thank you. [LB316]

SENATOR CAMPBELL: Other questions? Doctor, in a letter that we have received on the committee level, Dr. Schaefer has indicated that...well, has asked us to review the 407 process which I always assumed would be a part of our review, too. But in a paragraph, she...and I quote, "In addition, the credentialing 407 review that was completed in 2010 did not address the creation of a new certification which is proposed by this legislation. The department believes that this new issue would benefit from a

credentialing review...a 407 review." Would you like to explain a little bit to us what she might be...what is meant in the bill by this new certification, for the record? [LB316]

KIM BAXTER: Well, if this...given the passage of this bill, every doctor in the state will have to take the education that the Board of Optometry will be requiring. And we have long been...particularly, in recent years, the Board of Optometry has been very concerned about what we consider level licensure. We don't want different levels of licensure within the optometric profession in the state. We want every consumer to know when they go into an optometrist's office, that that optometrist is fully qualified at the utmost level. So, for that reason, we only have two optometrists currently in the state who are not therapeutically certified. They were given notice a few years back that their license would expire if they did not take the additional education and become therapeutically certified as required for previous scope enhancement legislation. One of those doctors is now in the process of getting the education, because time is running out on that. We've told him the other doctor is on the verge of retirement. So we want to continue that. That's very critical, and we are not going to have a separate level of certification relating to what we're talking about in this bill. Every doctor of optometry who wants to practice in Nebraska will be required to take this education unless they are coming directly from a college of optometry, who teaches these things, and that they have been tested on already. And that will be reviewed by the Board of Optometry in each individual case. And so, we are not going to have a level of separate level certification. I think that's what is being asked... [LB316]

SENATOR CAMPBELL: And, well, and I was just somewhat struck... [LB316]

KIM BAXTER: ...and if I understand the question correctly. [LB316]

SENATOR CAMPBELL: Okay. And I was somewhat struck by the sentence in Dr. Schaefer's letter to us that would say that this new issue...that's the new certification, would benefit from a 407 review. And so...you helped explain, I think, that you didn't want new levels, but what comment would you want to make on her suggestion that another 407 come into play? [LB316]

KIM BAXTER: To just review what's going to be asked for...of the certification requirements? [LB316]

SENATOR CAMPBELL: The certification...um-hum. [LB316]

KIM BAXTER: Well, that, we feel, is the responsibility of the Board of Optometry, and we have taken that responsibility seriously throughout the course of this profession, and would continue to do so. And we are not going to be doing anything...the education that we will require will closely mirror that from the other states with similar legislation that's been enacted. So, I don't know why another 407 process would be needed or required

in that regard. We can't be super specific at this point as to the number of hours going to be required, but we have already studied this closely from other states like Oklahoma and Kentucky and many other states that already, where optometrists can do a lot of what we're asking for here. And we intend to make sure that our educational requirements are at least in line with what they have required and proven to be successful in protecting the public. [LB316]

SENATOR CAMPBELL: Thank you for your comments on that letter, Doctor. [LB316]

KIM BAXTER: Thank you. [LB316]

SENATOR CAMPBELL: Senator Gloor. [LB316]

SENATOR GLOOR: Thank you, Senator Campbell. Dr. Baxter, thanks for your testimony. [LB316]

KIM BAXTER: Thank you. [LB316]

SENATOR GLOOR: We don't have a school of optometry in Nebraska, do we? [LB316]

KIM BAXTER: No, we don't, sir. [LB316]

SENATOR GLOOR: So, explain to me how the...I've been looking at this, and I've been thinking, I'm not (inaudible) on something. That's what I just figured out is, we don't have a school of optometry, so explain to me how the student exemption would actually work since we don't...I'm guessing there are students who come out here to train, but I'm looking for an explanation on that. [LB316]

KIM BAXTER: Right. We have certain clinic settings. They may be medical schools. They may be optometric clinics that are set up well for...to be stations for education of this sort to be able to provide clinical experience to all of our doctors. This would be overseen and supervised, however, by a College of Optometry that would be...they would accredit the program for us, and it would be closely supervised. It would almost be like a smaller optometry...a portion of an optometry college operating within this state as far as the fact that it's accredited by an established College of Optometry. Those clinic sites have not been determined and we would be looking closely at that to determine who is best qualified to be able to offer that aspect of our education to our doctors. And there are some doctors possibly that, as long as it's approved by the Board of Optometry, they may travel out of state to receive some of that clinical experience. But we want to make this accessible enough to our own doctors to where they don't have to travel out of state to do it. That's why this student exemption is so important that we can have our doctors working with actual human patients and these procedures in clinical settings. [LB316]

SENATOR GLOOR: Well, I'm still not connecting, though. You're really not talking about students who are coming into the state to get what would be called, you know, some sort of a residency or internship. For other healthcare professionals, you're talking about established optometrists, who would be able to do these procedures while they're being trained in the state of Nebraska? [LB316]

KIM BAXTER: Yeah, established currently licensed optometrists...that's one group who would cycle through these clinic sites and have to take a certain number of clinical hours of education that would be...they would be proctored and tested on. We'll have some...the students you're talking about coming directly from optometry colleges. Some of the students from Northeastern in Oklahoma will already be fully accredited with their education when they come here, so they would not be required to take additional education. Some of the other colleges...we'll look at each of those students coming in individually, see with the curriculum...review the curriculum of their college. And since most of this is being...all of this is being taught in all the colleges of optometry, as far as the clinical experience aspect, that's not being...there isn't as much opportunity for some of the colleges, because of their state law prohibiting it, you know. So, some of these students are going to Oklahoma to get this clinical training, and we want to be able to...for those students who we feel are the least bit deficient in any of this area of education, they'll be required to take the course before they can be licensed here. And the same thing applies with any doctors from other states who are wanting to come here to obtain a license to practice in Nebraska. If they're coming from a state where they're not already licensed to perform these functions for their patients, then they will have to take the course as well and be tested. [LB316]

SENATOR GLOOR: Okay. Maybe that answers my... [LB316]

KIM BAXTER: Did that adequately answer...? [LB316]

SENATOR GLOOR: ...maybe that answers my question. If I...as I pore through it and think through it, if I still have a question, I'll look for somebody else to answer it. [LB316]

KIM BAXTER: Yeah, please let us know, and we'll provide all the information we can for you. [LB316]

SENATOR GLOOR: Thank you. [LB316]

SENATOR CAMPBELL: Any other questions for Dr. Baxter? Thank you for your testimony. [LB316]

KIM BAXTER: Thank you very much. Appreciate it. [LB316]

SENATOR CAMPBELL: Next proponent. Next proponent. If not, we will move to the...those who are in opposition to the bill. First testifier. Good afternoon. [LB316]

DAVID INGVOLDSTAD: (Exhibits 6, 7) Good afternoon. Thank you. Chairman Campbell and members of the Health and Human Services Committee, my name is David Ingvoldstad spelled I-n-g-v-o-l-d-s-t-a-d. I'm an ophthalmologist and a retina specialist in private practice in Omaha, Nebraska. I currently serve as the president of the Nebraska Academy of Eye Physicians and Surgeons. As eye surgeons and medical doctors, our mission is to protect the patient's safety in Nebraska through promoting the highest quality medical and surgical eye care for the citizens of Nebraska. We have submitted a formal opposition letter with the support of 17 state and local medical societies for your review. I have also submitted a letter of opposition from the American Medical Association. Let me begin by saying that I have great respect for my optometry friends and colleagues, and I appreciate the services that they provide to Nebraskans. In my practice, I work with 11 ophthalmologists and 6 optometrists, so I'm very familiar with how our two specialties can work together to provide safe and efficient patient care. The bill before you today, LB316, goes against this model of safe and efficient patient care. I would like to briefly outline the reasons for our opposition. This bill is extremely similar to LB417, a bill that was introduced in 2009. The original bill was rigorously evaluated by the 407 technical review, the Board of Health, and the Chief Medical Officer. In all three cases, these entities decided that the bill was not in the best interest of Nebraskans. The bill before us today would use the legislative process to grant surgical privileges to approximately 327 optometrists who have not had the prerequisite mentored surgical training that is required to safely perform these procedures. This includes laser eye surgery to cut and destroy tissue inside the eye itself; scalpel surgery to remove skin lesions and skin cancers from the eyelids and tissues around the eye. All of these procedures have a real potential for complications, or in the case of a misdiagnosed skin cancer, even death or blindness. In essence, LB316 is saying that training and education are not important in order to perform these delicate procedures. We believe that extensive one-on-one training is the only ethical route to obtain surgical privileges. This cannot be replicated in a weekend course. LB316 would also allow optometrists to prescribe certain oral medications that are currently specifically prohibited. This would include prednisone. In addition, it would include other immunosuppressants. This is a vague term, and it would include things like Imuran, methotrexate. These are rheumatologic, very powerful immunosuppressants and cancer drugs. These medications have severe side effects and are rarely used to treat eye conditions. When they are used, they are prescribed by a rheumatologist or an oncologist. Ophthalmologists know from firsthand experience gained in four years of medical school and four years of residency that these medications should only be prescribed by an experienced physician specialist who routinely uses these medications and is familiar with treating the side effects. Another extremely concerning provision is the portion which would allow optometrists to treat glaucoma in infants, as Senator Campbell pointed out. Infantile or congenital glaucoma is extremely rare. It occurs in

about one out of every 10,000 births. Only ophthalmologists who have completed a glaucoma fellowship or a pediatric ophthalmology fellowship in addition to their training are qualified to treat this disease. The stakes are high, and the condition is so rare, it is best managed by a specialist who receives the majority of the referrals in a given region. This is a very difficult surgery, and it can only be performed in a hospital under general anesthesia. The decision for when to use general anesthesia and when to perform surgery or cut on an infant's eye in Nebraska should only be made by a physician, who has undergone the extensive eight to ten years of training required to make this judgment. Passage of this bill would be very dangerous for children. Lastly, LB316 would create a Board of Optometry that would have unprecedented power over future scope expansion. They would decide what training requirements are needed for future expansion. This would allow optometry students visiting the state to train without regard to scope of practice laws. In contrast, the 26 specialties in medicine have a highly-regulated system that are governed and policed by an independent organization called the Accreditation Council for Graduate Medical Education or the ACGME. This system is specifically in place to prevent conflict of interest when making decisions about training. We agree, as physicians, that the standard of care for eye surgery must be upheld in Nebraska. The standard of care for surgery in prescribing the medications in this bill can only be upheld by a physician who has gone through the appropriate training. This bill does not live up to the standard. I would like to thank Senator Campbell and the Health and Human Services Committee for allowing me this time to speak on behalf of the Nebraska Academy of Eye Physicians and Surgeons, and I'm happy to take any questions that you may have. Thank you. [LB316]

SENATOR CAMPBELL: Are there questions for the doctor today? I appreciate that we have a lot of additional information included in your testimony, and that you hit the high points of it. That's great. [LB316]

DAVID INGVOLDSTAD: Okay. [LB316]

SENATOR CAMPBELL: Any other questions or comments that we wish to make? Oh, I'm sorry, Senator Krist, did you have one? All right. Thank you, Doctor. [LB316]

DAVID INGVOLDSTAD: Okay. Thank you very much. [LB316]

SENATOR CAMPBELL: Next opponent. Good afternoon. Welcome. [LB316]

CYNTHIA BRADFORD: (Exhibits 8, 9, 10) Thank you, Senator, for listening to me today. I'm Cynthia Bradford, and I'd like to thank you for taking the time to deliberate on this issue. It's a very important issue. I'm on the American Academy of Ophthalmology Board of Trustees... [LB316]

SENATOR CAMPBELL: Excuse me. Just want to...did you spell your name? [LB316]

CYNTHIA BRADFORD: Brad...I'm sorry. Bradford, B-r-a-d-f-o-r-d. [LB316]

SENATOR CAMPBELL: Thank you. I get in contempt of the clerk if I stray too far here. [LB316]

CYNTHIA BRADFORD: I'm on the Board of Trustees of the American Academy of Ophthalmology. I'm a professor of ophthalmology at the University of Oklahoma, practicing ophthalmologist now, so teach medical students and residents. Since my state expanded optometry scopes, there have been 25 states that have rejected similar legislation. There were ten states in the 2009-2010 legislative cycle. This includes a recommendation in 2010 from the Nebraska 407 process. Washington state also had a state review which had a similar administrative review that said, optometry surgical scope expansion was not justified by the evidence that was presented. We've been told about the Kentucky Optometric Scope Bill that passed the state legislature recently and was signed into law by the governor. It's similar to the Oklahoma optometric law, because it was written by an Oklahoma optometrist, but let's be frank. This bill was passed not as a careful review policy by the state senators and representatives, but its passage was based on political manipulation of our democratic process. For example, the bill passed the chamber in ten days. Medicine knew nothing about the bill until 12 hours before the Senate committee hearing. Testimony was limited as evidenced by the 15 minutes that the House Committee got to hear about our concerns on patient care safety with the bill. If you'd like, I have other stories that highlight some of the political games that happened in Kentucky. We've also been told about great things with the Oklahoma experience with optometric surgery. Whatever you've heard, the truth is, it hasn't been good. Surgery has been trivialized as a procedure. It's so much more. It's history and medical examination. You have to get the right diagnosis; you have to know alternative treatments; you have to know the risk of those treatments. Then you have to perform the surgery, and you have to manage postoperatively. And I can share a few examples of how optometry in Oklahoma does not have the education and training to perform surgery. For example, a patient that was examined by an optometrist, who noticed cysts on the eye. Rarely do we have to do anything about cysts. He stuck a needle in the cysts to flatten them, both eyes, same day. But you know, he didn't do a history, because he would have known that the patient had had glaucoma surgery, and that surgery was to create those cysts. And he put her at risk for having infection inside the eye. Another example, a patient needed a laser to prevent a glaucoma attack, and yet, after five or six visits, hundreds of dollars of medications, the needed laser wasn't performed, and this was a certified laser optometrist. The emergency room doctor is the one who ultimately made the diagnosis and sent her to an ophthalmologist. Another patient had that laser, but she didn't need it, because the diagnosis was wrong. So it's a little more than just doing a procedure. Patient with a lesion on her eyelid...you hear it called lumps and bumps, but it's an eyelid lesion. And this lady was treated with multiple steroid injections, over months, and the problem was it was the wrong diagnosis, the

wrong treatment. The correct diagnosis was a malignant skin cancer, and it spread to other parts of the body, and she suffered complications. Correct diagnosis and treatment is not limited to surgery. Glaucoma is a blinding ocular disease, and in a Palo Alto VA in California, veterans were blinded because of optometric mismanagement of the disease. And now in the VA, these optometrists are referring through ophthalmology regarding management. The difference in the professions is the difference in the education. Look at the class size...25 to 100 students per year for optometrists; two in Nebraska per class. Some programs are larger throughout this country, but that's how many ophthalmologists are trained per year. And look at the training program; 2,000 hours of clinical training for optometry; teaching done in group. In your handout there, you'll see students around a single patient. Ophthalmologists--17,000 hours of training one-on-one. Accreditation of the educational programs is not the same. Optometry--their only accreditation is subsidized by their national trade association. It's not independent. Medical schools and ophthalmology of training programs are by an independent trainer. And, finally, the regulatory boards in optometry have very few actions against their licensees compared to medical boards, and there's actual numbers that show that. There's no simple shortcut for bypassing the well-proven education pathway and training that assures the proficiency and the knowledge of an individual who is entrusted by the public to protect and promote their good health and vision. Thank you for your time. And for these reasons, I urge you to table this bill. [LB316]

SENATOR CAMPBELL: Questions. Senator Wallman. [LB316]

SENATOR WALLMAN: Thank you, Chairman. Yeah, thanks for coming here. In the University of Oklahoma, how many optometrists do they train versus ophthalmologists? [LB316]

CYNTHIA BRADFORD: University of Oklahoma doesn't train optometrists. [LB316]

SENATOR WALLMAN: You don't either? [LB316]

CYNTHIA BRADFORD: It's an independent optometry school. [LB316]

SENATOR WALLMAN: Okay. [LB316]

CYNTHIA BRADFORD: And last...I think it's like 30 to 35 students a year. [LB316]

SENATOR WALLMAN: Thank you. [LB316]

SENATOR CAMPBELL: Other questions? I just wanted to be clear that I don't know that you had...did you distribute this photo also? [LB316]

CYNTHIA BRADFORD: Yes. [LB316]

SENATOR CAMPBELL: Yes, and you were illustrating... [LB316]

CYNTHIA BRADFORD: That's the ophthalmologists. That's the way we train ophthalmology residents one-on-one. [LB316]

SENATOR CAMPBELL: Okay. [LB316]

CYNTHIA BRADFORD: The other one is from a brochure from the Oklahoma Optometry School, and what you see is multiple students around a patient. And there's a big difference in training. [LB316]

SENATOR CAMPBELL: Okay. Has the Oklahoma...or has the Kentucky law gone into effect? It's been signed by the governor? [LB316]

CYNTHIA BRADFORD: It was signed by the governor. [LB316]

SENATOR CAMPBELL: Okay. But just recently, correct? [LB316]

CYNTHIA BRADFORD: Just recently, a week ago. [LB316]

SENATOR CAMPBELL: Okay. Any other questions? Thank you very much for your testimony. Next testifier. Good afternoon. [LB316]

THOMAS HEJKAL: (Exhibit 11) Good afternoon. I'm Dr. Thomas Hejkal, H-e-j-k-a-l. Senator Campbell, members of the Health and Human Services Committee, I'm professor and chair of the Department of Ophthalmology and Visual Sciences at the University of Nebraska Medical Center. I've directed the training program for residents in ophthalmology for 15 years. Although I'm employed by UNMC, I'm not speaking as its representative. Any opinions I express are my own. I'm here to speak in opposition to LB316. Let me explain why. After supervising the training of well over 30 residents in my 17 years as a teaching physician, I can assure you that to achieve the competence to safely perform the procedures included in this bill and to safely prescribe or administer the drugs included in this bill requires extensive training and experience, not only in medical problems of the eye, but also medical problems that affect the whole person. Ophthalmologists receive this training; optometrists do not. Differences include, you know, ophthalmologists are medical doctors, physicians. They complete four years of medical school. Optometrists don't go to medical school, get none of that general medical training. And then, of critical importance then, is the four years of residency training that are required to become an ophthalmologist. The first year is devoted to intensive training in general medicine. And under careful supervision of teaching physicians, the ophthalmology residents in that first year see sick people in the office and in the hospital. For example, when an ophthalmologist orders prednisone, he or she

can effectively counsel the patient about side effects and can monitor that patient for those side effects. In medical school and residency, the ophthalmologist is seeing and manage patients with high blood sugars, bleeding ulcers, osteoporosis, psychosis, all of which are possible side effects of steroids. These drugs and other drugs can cause...that are used to treat eye conditions can cause serious and life-threatening side effects. And this bill has no restrictions on what medications the optometrist could prescribe or inject. So, a doctor must not only have the classroom knowledge but also that practical experience achieved in medical school and residency to safely utilize these medications. Ophthalmologists, again, receive extensive supervised surgical training; optometrists do not. In the three years of training following that first general medicine year, ophthalmology residents personally examine several thousand patients with a complete range of eye problems and under direct supervision, gradually progress to independently perform eye surgery by the time they finish. Our residents, which is a typical program, do a total of some 700 up to 900 or more surgical cases, and these include at least 90 cases involving the eyelid and surrounding structures, and they also average, under direct supervision, again, over 50 laser procedures of the type specified in this bill. Optometrists do not receive this level of training. Again, it was mentioned that the residency programs...they undergo a strict accreditation process. We get reviewed externally every three to five years and then have a required internal review in between those external reviews. We're restricted to only two residents per year, because they monitor programs to make sure that there is adequate volume of patients, numbers of procedures, and teaching faculty to adequately train residents in these procedures, and then the care of the patients. That's why we only get two residents per year. So it's really not feasible to train all the Nebraska optometrists to this same level of expertise to perform these procedures. The handout that I passed out briefly describes those differences in training in a graphical form. So eye surgery, even with lasers, is not simple. There's little room for error. For example, laser treatment for glaucoma, which is allowed in this bill, missing the mark by even a few thousandths of an inch can make the glaucoma much worse instead of better. So besides learning the technique, it's very critical to determine whether or not a procedure is necessary to identify patients with increased risks, to follow possible complications after the procedure. So for many practitioners without this expertise to perform these procedures, I think places...does place our patients at risk. And as Dr. Bradford pointed out, some of these things may not come to the level of the Board of Optometry, but still can present some problems to our patients. So I thank you for allowing me the opportunity to share my experience with you, and I'd be glad to answer any questions. [LB316]

SENATOR CAMPBELL: Questions? Doctor, on your chart,... [LB316]

THOMAS HEJKAL: Yeah. [LB316]

SENATOR CAMPBELL: ...on the training boxes as you go down, when would someone begin treating glaucoma from an ophthalmologist standpoint? [LB316]

THOMAS HEJKAL: During the...well, we started in the first year of their...well, so four years of residency training. The first year is general medicine. They generally would not be treating glaucoma during that year. It would start the first year of actual ophthalmology residency which is three years total. [LB316]

SENATOR CAMPBELL: Is the treatment of an infant...and I know I keep going back to them. I've explained why I have a special interest there. When would you start training someone who is treating an infant on a regular basis? [LB316]

THOMAS HEJKAL: They would be trained as assistants and be participating in procedures and the treatment under the supervision of the attending physician, the supervising physician. They really would not be ultimately responsible for that care until a fellowship program generally or maybe the third year, the senior year of training, they may get involved in that somewhat. That's a very high level of expertise. Most...even among glaucoma specialists, many of them do not see infants, because it's so highly specialized and as we pointed out, fairly rare disease that really requires very special training in addition to the residency even. [LB316]

SENATOR CAMPBELL: Of those ophthalmologists that we have in the state of Nebraska, how many treat infants? [LB316]

THOMAS HEJKAL: As far as I know, only about three of them between Lincoln and Omaha, and so, like I say, it's a very specialized type of treatment. We've got one at the university. I think there's somebody in Lincoln that does it, and another one in...I'm not certain of those numbers, but they're very few. [LB316]

SENATOR CAMPBELL: Okay. But every ophthalmologist, though, would treat glaucoma, correct? [LB316]

THOMAS HEJKAL: Treat glaucoma but not infantile glaucoma. [LB316]

SENATOR CAMPBELL: Okay. Any other questions? Thank you very much. Next testifier. Good afternoon. [LB316]

LOU KLEAGER: Good afternoon. I'm Dr. Lou, L-o-u, Kleager, K-l-e-a-g-e-r, and I'm a ear, nose, and throat physician from Scottsbluff, Nebraska, a surgical subspecialist. I've practiced in Scottsbluff since 1980. I am the current president of the Nebraska Medical Association, and I speak for that organization as well. In my 30 years...30 plus years in Scottsbluff, I participated in outreach clinics in Alliance, Bridgeport, Chadron, Gordon, and Valentine. I'm here to speak in opposition to LB316. And one argument you've heard is the lack of access. I'd like to report to you how we're doing in western Nebraska. We have three ophthalmologists in Scottsbluff. They travel to outreach clinics

like I do in Ainsworth, Valentine, Alliance, Ogallala, Oshkosh, Kimball, Sidney, and three locations in Torrington...I mean in Wyoming. They fly to these clinics. They accomplish consultations in exams. They accomplish outpatient surgery as they can do at those locations. And then they fly back the next day for the immediate post-op follow-up which I think is really pretty remarkable, the way they handle that. They used to go to Chadron, but to answer your question, there are four ophthalmologists from Rapid City who come to Chadron, and it didn't make sense to have five ophthalmologists serving a town of 5,000, so our group peeled off from that. So, we don't have an access problem out in western Nebraska. You'll hear from others about the years of training necessary for physicians who are allowed to operate on the eye, and how this bill circumvents those extensive years of training. Further, the practice of invasive procedures in Nebraska--surgery--comes under the purview of the Board of Medicine and Surgery, and this bill would allow surgery to be accomplished outside the review of the Board of Medicine and Surgery. We create a new entity that is guarded only by optometrists. If LB316 is passed, optometry would monitor their own surgeries, and we simply can't support this situation. As spokesman for more than 70 percent of the physicians in Nebraska, we agree with the Chief Medical Officer of the state that we cannot endorse anyone being allowed to perform surgery that has not completed multiyear training similar to a medical residency. And I've thought of several different ways to try and say this, and I can't say it any more delicately than this. But really, no one knows your healthcare better than your physician. So I would welcome any questions. [LB316]

SENATOR CAMPBELL: Questions for Dr. Kleager? Am I saying that right, sir? Kleager? [LB316]

LOU KLEAGER: Kleager, yeah. [LB316]

SENATOR CAMPBELL: Kleager. I was trying to get it right. Any other questions? Thank you very much for coming today. [LB316]

LOU KLEAGER: Thank you. [LB316]

SENATOR CAMPBELL: Next testifier. Good afternoon. [LB316]

MILLICENT PALMER: (Exhibit 12) Good afternoon, Chairman Campbell and members of the committee. My name is Millicent Palmer, P-a-l-m-e-r. I am an ophthalmologist and associate professor with faculty appointments at Creighton University and the University of Nebraska. I am also section chief of ophthalmology for the Omaha VA, and a member of the executive committee for Nebraska Academy of Eye Physicians and Surgeons. I strongly oppose LB316 that has been introduced by the Nebraska Optometric Association. And I would like to share with you some of my concerns based on my experience in residency training. I have had experience with residency teaching since 1991. Residency training is a coordinated and progressive educational experience

in the entire spectrum of ophthalmic diseases and ocular surgery. This is achieved by progressive responsibility for patient management and supervision of residents by a board eligible or board certified teaching faculty. Faculty supervision is provided in the outpatient clinic setting as well as in the operating room. The Accreditation Council for Graduate Medical Education of ACGME...you've heard a little bit about that earlier...is a private, nonprofit council that mandates and evaluates the national standards for residency training of all subspecialties including ophthalmology. And I've provided a flow sheet for your review to indicate the magnitude and the components that contribute to the standards that are provided for residency education. The length of residency education in ophthalmology must be at least 36 months. This is in addition to one year of postgraduate training or internship and four years of medical school. Some residents complete additional fellowship training in a subspecialty area. Thus, ophthalmology training, as you've heard, may be eight to ten years in length. The care of the surgical patient is an integral part of ophthalmology residency. Residents must have the medical and technical knowledge as well as the skills necessary to provide the appropriate care for the surgical patient. This includes medical and ocular evaluations, an understanding of the indications or contraindications to surgery, the risks, benefits, and alternatives, ethics, the informed consent process, anesthesia, anatomy, intraoperative skills, and postoperative management. Postoperative care, as you heard, includes the management of both ocular and medical complications that may be associated with a given procedure or condition. All surgeries, including laser surgeries, are done with a mentored apprenticeship of an experienced faculty ophthalmologist. LB316 would negate the importance of the current medical education and surgical training requirements outlined above. Legislation is no substitute for years of training and experience. As section chief of ophthalmology at our Omaha VA, I work with the University of Nebraska residents on a daily basis and continue to have firsthand experience and an ongoing appreciation of the patient management and surgical skills that must be mastered over time until residents gain the appropriate level of competency, confidence, and independence. The Veterans Health Administration or VHA requires 100 percent supervision of residents. All resident charts are cosigned by staff ophthalmologists. Safety is paramount. The Veterans Health Administration's eyecare delivery model includes complimentary services provided by both ophthalmologists and optometrists. Typically, the ophthalmology section chief is a designated leader of the eye care team. The VA is committed to providing high quality eyecare in a timely fashion and has placed an emphasis on programs for the prevention of blindness and visual impairment of veterans, especially glaucoma, macular degeneration, and diabetic eye disease. In response to the public concerns for the safety of veterans, the VA has been steadfast in prohibiting laser surgery by optometrists. You've already heard about adverse outcomes related to optometric care at the Palo Alto VA, so I will not dwell on this. But just to make a point that one of the issues that was revealed with the investigation was that the optometry department failed to adhere to VA policy requiring consultation with the ophthalmology department for management of glaucoma cases. Therefore, the full range of treatment options were

either delayed or never offered to patients and therefore patients may have lost vision or developed blindness from this condition, namely glaucoma. I'd like to thank you for allowing me to express my concerns in opposition to LB316. [LB316]

SENATOR CAMPBELL: Thank you. Senator Wallman. [LB316]

SENATOR WALLMAN: Thank you, Chairman Campbell. Yeah, thank you for coming. And I can understand your chart pretty well, but how come we have a nonvoting federal rep on? Is that a doctor or from the federal doctors, you know, from the...? [LB316]

MILLICENT PALMER: It's usually someone in medicine, yes. [LB316]

SENATOR WALLMAN: Okay. Thank you. [LB316]

SENATOR CAMPBELL: Senator Bloomfield. [LB316]

SENATOR BLOOMFIELD: Thank you. Ms. Palmer, is...and I probably should have asked one of the proponents this rather than you. But is there a time when an emergency would arise that what they are asking for would be considered an emergency... [LB316]

MILLICENT PALMER: Most of... [LB316]

SENATOR BLOOMFIELD: ...that could save the sight or the life? [LB316]

MILLICENT PALMER: Most of our procedures are elective. And I would say if there's a serious condition that is emergent, then for the most part, those should be referred. There aren't too many procedures that need to be done on an emergency basis. [LB316]

SENATOR BLOOMFIELD: Okay. But are there any, do you know, that would...if something is done now, we can save the sight versus if we put it off four hours to get someplace? [LB316]

MILLICENT PALMER: Yes, there are probably some instances where that might make... [LB316]

SENATOR BLOOMFIELD: With the exception of a stick in the eye. [LB316]

MILLICENT PALMER: ...that might make a difference. But usually those are surgical options... [LB316]

SENATOR BLOOMFIELD: Okay. Thank you. [LB316]

MILLICENT PALMER: ...or surgical alternatives. [LB316]

SENATOR CAMPBELL: Senator Cook. [LB316]

SENATOR COOK: Thank you, Madam Chair. Thank you, Dr. Palmer. Can you say a little bit more about why the Veterans Administration requires the supervision that you mentioned in your testimony? [LB316]

MILLICENT PALMER: For residency training? [LB316]

SENATOR COOK: For residency training. Do you know how they came about...why that came about? [LB316]

MILLICENT PALMER: I think the Veterans Administration has done an excellent job in terms of quality improvement, and this is...the VA is a...is where many residents gain their autonomy and their clinical experience. And they wanted to ensure safety...safe care for veterans. It used to be, years ago,...this was a gradual process. It used to be years ago that it was 80 percent...where 80 percent supervision was required, and pretty much now, 100 percent of supervision is required. And all of our residents' charts are cosigned by staff physicians. [LB316]

SENATOR COOK: Thank you. [LB316]

SENATOR CAMPBELL: Other questions? Thank you, Dr. Palmer, very much. Next testifier. Good afternoon. [LB316]

STEVEN WEES: (Exhibit 13) Good afternoon. Chair Campbell and members of the Health and Human Services Committee, my name is Steven Wees, W-e-e-s. I am a rheumatologist in private practice in Omaha, Nebraska, and I am here representing patients. I'm opposed to LB316 with particular concern regarding language that would allow optometrists to prescribe oral steroids and oral immunosuppressive agents. I believe this bill would very seriously jeopardize patient safety, and I wish to present why I'm opposed to this provision. Rheumatologists frequently use these medications, and we have extensive training and clinical experience in their use. Specifically, after graduating medical school, I completed three years of internal medicine training and two years of rheumatology training. I am board certified in each. I have 30 years of clinical experience using these medications, and the longer I have been in practice, the more careful and respectful I have become regarding the necessity to correctly diagnose the patient's illness and correctly use these potent medications. This is due to the highly significant risk to patients imposed by these medicines. The most commonly used oral steroid is prednisone, oftentimes in high doses, with significant risk, closes the pamphlet we give to patients when discussing these risks. The term "oral immunosuppressive

drugs" is vague. The ones we use most commonly are methotrexate, Azathioprine, and cyclophosphamide. I have also attached pamphlets from the Arthritis Foundation that we give to our patients when we discuss potential risks if they might need these medicines. And there's also additional information regarding black box warning risks. It is essential to properly diagnose the eye condition, and then to decide if this might be associated with a more systemic or general illness. Optometrists do not undergo postgraduate training to be properly trained to achieve this goal. Additionally, patients who use these medications for their eye disease often have numerous other general medical problems and may take an extended list of medications, sometimes 15 to 20. These are medicines that are used beyond those that would be used to treat their eye disease. There is always potential for drug interaction. Optometrists do not have postgraduate training to deal with these issues. I emphasize that it takes years of postgraduate general medical and subspecialty training to become expert in these matters. Indeed, ophthalmologists who have had this training do not feel comfortable prescribing these medicines and, therefore, usually seek consultation with specialists such as theirselves (sic), sometimes oncologists, and occasionally, primary providers who have obtained this expertise. Many primary care individuals, however, are not comfortable prescribing the medicines, and they defer to us. Regrettably, over the years, occasional patients that I've treated with these drugs have developed severe side effects that can involve any of multiple body organs--sometimes irreversible, occasional malignancies, and sometimes death. These are potentially beneficial medications but have significant risk. It is, therefore, essential that only properly trained medical providers have license to use these drugs. In summary, LB316 presents extremely hazardous patient safety issues. I do wish to express my gratitude for being able to appear here, express my views, and thank you for listening. [LB316]

SENATOR CAMPBELL: Thank you, Dr. Wees. Questions. Senator Gloor. [LB316]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Dr. Wees, for your testimony. Would it be possible to put together a restricted formulary for optometrists that would have a smaller group of steroids that might be more appropriate for the treatments that they would most commonly see, or would even those be of concern to you? [LB316]

STEVEN WEES: I don't believe it would be possible. I don't think they have sufficient training to be able to prescribe these medicines and monitor them properly. [LB316]

SENATOR GLOOR: I mean, this is your world, so I understand you take this very seriously in terms of these medications going into people. But aren't there times where, because of their infrequent exposure to them maybe even ophthalmologists might make some of the same mistakes in terms of the prescriptions, the scope of medications, steroids specifically, that they would prescribe? I mean, clearly, you think the level of training makes that less likely with optometrists. I understand that. But is this problem

widespread with the treatment of eye disease? [LB316]

STEVEN WEES: I think the ophthalmologists...they have sufficient enough postgraduate medical school training, that if they start higher dose steroids to treat the eye disease...they almost always get hold of us pretty quickly to become involved in the care of that patient. They also have become very respectful of potential risk, so we work as a team together. [LB316]

SENATOR GLOOR: Okay. I'm trying to decide if we have another issue here which is over prescription of steroids for treatment of eye disease regardless of who the practitioner is. But I understand your issue of trusting the ophthalmologist's judgment. So thank you. [LB316]

STEVEN WEES: Yes, sir. [LB316]

SENATOR CAMPBELL: Any other questions? Thank you, Doctor. [LB316]

STEVEN WEES: Thank you, Chairman. [LB316]

SENATOR CAMPBELL: How many other testifiers do we have? Okay, that's fine. Come on. I thought I counted correctly, but just wanted to make sure. Good afternoon. [LB316]

KATHRYN CHANDRA: (Exhibits 14, 15) Good afternoon, Senator Campbell and members of the committee. I appreciate the opportunity to provide comments in opposition to LB316. My name is Kathryn, K-a-t-h-r-y-n Chandra, C-h-a-n-d-r-a. I am the assistant director of state policy for the American Academy of Dermatology Association, and I'm here today representing the Nebraska Dermatology Society. Much of this afternoon's testimony weighs on the merits of medical and surgical eye care, and those individuals who provide it. On one side, we consider the accessibility of care. On the other side, we reflect on provider competence, quality of treatment, and patient safety. I wish to comment on those aspects of LB316 that pertain to the practice of medicine and dermatology including eyelid surgery. This act will provide that the practice of optometry will include surgical procedures for the drainage of cysts around the eye and the removal of skin lesions from the eyelid. Proponents of the bill allude to this as the lumps and bumps provision. I have provided you with copies of the Nebraska Dermatology Society's letter on this bill which discuss the burden of skin cancer in the United States, and the dangers of mistreating or misdiagnosing skin cancer or melanoma. In addition, I would also like to direct your attention to our attachment which shows patient examples of so-called eyelid lumps. Most eyelid lesions in the general patient population are benign, but malignancies and lethal cancers do exist. Of the four case examples provided, only one of the eyelid lumps represents a noncancerous cyst or sty. The example in the upper right corner is the benign lesion. These cases illustrate the complexity of diagnosis in eyelid lesion management. How challenging it can sometimes

be to tell cancer from noncancer, and how this can lead to delayed correct diagnosis requiring unnecessary additional surgery, additional healthcare costs, patient disfigurement, or even death. I would like to stress the correctness of diagnosis is not the only concern of the Nebraska Dermatology Society in the management of eyelid lesions. The office-based surgery provisions provided in this act requires the provider have knowledge and experience with sedation, including use of anesthesia, control of operative bleeding, and at times, cardiovascular support. In addition, LB316 expands the practice of optometry to include the administration of injectable pharmaceutical agents into the eyelid and ocular adnexa. One might assume this means the use of local injectable anesthesia to accomplish the surgical procedures I've already described. But the bill states pharmaceutical agents, not local anesthetics. These agents are associated with the risk of inducing sudden post-injection blindness requiring immediate specialty medical care. Finally, the Nebraska Dermatology Society believes LB316 expands the practice of optometry to allow the injection of cosmetic Botox and dermal fillers for wrinkle erasure and possibly the performance of eyelid tattooing for permanent eyeliner. This strays far from the proponent request of improving patient access for required healthcare. The Nebraska Dermatology Society asks that you recognize the medical and surgical education, training, and skills of specialty physicians including dermatologists by opposing this inappropriate scope of practice expansion for optometrists. Thank you for the opportunity to share these concerns with you today, and I welcome any questions. [LB316]

SENATOR CAMPBELL: Thank you. Very brief, direct to the point. Questions? Seeing no questions, thank you, Doctor, for coming today. [LB316]

KATHRYN CHANDRA: Thank you. [LB316]

SENATOR CAMPBELL: Next testifier? Any other testifiers? Sir, are you testifying? Okay, that's fine. I just want to make sure. We had someone else walk forward the other day, and we were all expecting that person to sit down, and then they (laughter) left. And so, (laugh) you know, sometimes you get it right. Good afternoon. [LB316]

JOHN PETERS: (Exhibit 16) Thank you for asking before I embarrassed myself. [LB316]

SENATOR CAMPBELL: No, you're fine. I just didn't want to embarrass us by thinking that you were and you were not so. [LB316]

JOHN PETERS: Quite all right. Thank you. Good afternoon, ladies and gentlemen. My name is John Peters. I'm a solo, private-practice ophthalmologist from Omaha. I also... [LB316]

SENATOR CAMPBELL: Could you spell your name, sir? [LB316]

JOHN PETERS: Oh, I'm sorry. Peters, P-e-t-e-r-s. I'm a solo, private-practice ophthalmologist from Omaha, and I'm also actively involved in teaching the residents at the University of Nebraska Medical Center, and I share emergency and trauma call there, and I've done that for 18 years. In 2009, I served on the Technical Review Committee that spent six months intensely reviewing LB417, a bill quite similar to the one before you now, in much greater detail than this committee can possibly hope to perform. Such was the intention of the Legislature when the 407 review process was instituted, and the majority of the discussions held in that review remain pertinent to LB316. An updated, attached chart is provided, comparing several aspects of the two pieces of legislation. Though some features of the previous bill have been removed, many of the same procedures, surgeries, and medications are being requested again in LB316. That being the case, I'd like to bring to the committee's attention a number of important points. Firstly, the disparity in education, training, and experience between optometry and ophthalmology is clear, paramount, and at the very core of our considerations today. Training an ophthalmologist is inherently a much longer and more arduous endeavor as has been discussed, and it is very much necessary. The detailed requirements for ophthalmologists to obtain these privileges are spelled out clearly by an independent, objective, national entity, the ACGME. Optometry has not divulged what training and experience their board would require to certify optometrists to perform and utilize the requested procedures and medications. Though I asked for this during the 407 process, we were simply told that the Optometry Board would decide at a later date, and we heard that again today. And, again, the requirements are not stated in the legislation. Additionally, the certification process would be overseen exclusively by the Board of Optometry. In regard to access, with our primary offices and an additional 51 satellite clinics, ophthalmologists provide care to 63 percent of Nebraskans in their very hometown, and within 30 miles for over 99 percent of its citizens. Additionally, when reviewing this legislation and analyzing it, financial and logistical infeasibility makes it very unlikely that most or all optometrists would purchase the surgical equipment, the lasers, and train inexperienced assistants and, therefore, improve access to care in a meaningful and safe way, let alone meet the same standard of care as a physician. It is unclear to us how they would generate enough surgical cases to obtain, and then maintain, surgical proficiency for such a large number of individuals. Optometry did not provide data to prove that access to care has been improved in the state of Oklahoma in the 12 years since optometric scope was expanded there for similar procedures. Sampling of Medicare data has shown us that only a small percentage of optometrists in Oklahoma actually perform a number of these additional procedures, and those who do are typically in the larger metro areas, thereby generating little or no impact on access to care. In regard to eyelid and periocular procedures requested, these are performed by far more providers than ophthalmologists. A review of Medicare records in Nebraska for the past two years reveals that only an average of 10 percent of these lid procedures were performed by ophthalmologists, the remainder being done by other providers scattered throughout Nebraska. To claim or imply that only ophthalmologists perform

these procedures and that only their offices supply coverage for such is, therefore, inaccurate. In regard to patient preference, I've provided you a National Consumer League Survey. I'd particularly have you pay attention to pages 11 through 13. You don't have to look at the whole thing, but amongst other things, this shows that 95 percent of patients want a medical doctor with appropriate training and experience to perform these procedures. In regard to medications, during the 407 review process, I provided evidence to the committee of the conditions which might require the use of the medications requested in this bill. Particularly with prednisone and immunosuppressants, the conditions requiring their use are uncommon, not typically seen by or managed by optometrists, and for most of these medications the pharmacologic effect is not immediate, yet the side effect profile is exceptional. We talked about infantile glaucoma, and then there is some additional provisions here. I would like to clarify that there is a provision in the bill for removal of lesions of the conjunctiva which is the clear skin of the surface of the eye. We've heard this is only of the eyelids, but there is a provision on page 2 for the conjunctiva, and a vague term, the ocular adnexa which includes other structures to us, meaning the lacrimal gland and other structures of the drainage system of the tears. We talked a little bit about other things that would be allowed as far as other optometrists coming from other states or countries, and optometrists whose license in this state could perform surgical procedures if they were certified under a different state's regulations. I've mentioned only a few topics, because we only have limited time. I would tell you that the 407 process had quite a bit of time. All three of the entities that reviewed it rejected it, two of the three on all four of the criteria. Unfortunately, there are some other states in the country that have not had the foresight of this Legislature to demand thorough evaluation of this type of legislation. It's the opinion of many well-informed individuals that the time, effort, and extensive deliberation required of, and provided by those entities should be respected. With that in mind, I'd like to ask you to oppose LB316 for multiple reasons. Thank you for your time and your consideration. [LB316]

SENATOR CAMPBELL: Thank you, Dr. Peters. Questions? Dr. Peters, I'm going to ask you a similar question, because you have served on the 407 process, and that is in Dr. Schaefer's letter in which she did not feel that the 407 in 2010 did not address the creation of a new certification which is proposed by this legislation. The department believes that this new issue would benefit from a credentialing review. Do you want to make comment on that? [LB316]

JOHN PETERS: She is basically reiterating my statement that we are unaware of what the certification process would be. [LB316]

SENATOR CAMPBELL: I see. [LB316]

JOHN PETERS: And what part of my contention in the 407 process was how can a Legislature or our 407 committee review if this is adequate, if there is no information.

[LB316]

SENATOR CAMPBELL: Okay. I just wanted to be clear for the record. [LB316]

JOHN PETERS: I think that's what she means. [LB316]

SENATOR CAMPBELL: Okay. Any other questions? Thank you, Dr. Peters, for coming today. [LB316]

JOHN PETERS: Thank you. [LB316]

SENATOR CAMPBELL: Any other testifiers in the room opposing the bill? Anyone in the room wishing to testify in a neutral position? Seeing none, Senator Heidemann has waived closing, so we will close the hearing on LB316 for today, and allow our guests who came for that hearing to quietly exit, if they would like to. The emphasis is on quietly. Some of the testifiers that may be here for LB534 may want to come forward. Is Senator Smith here? Would the committee like a short break? No? Okay, after the next one, break. Good afternoon. Please have a chair, Senator Smith, and welcome. We're going to let all the people who want to come in sign in. We are having a number of new people join us, which is great. If you plan to testify this afternoon on LB534, we ask that you complete an orange sign-up sheet. If you've come to just show your support for the bill, there is a white sheet on which you can sign your name and say I support or I oppose. We ask that you silence your cell phone, so you do not bother your neighbors. We do use a light system here, five minutes...so we'll be green for a long time, and then it will go to yellow, and then pretty rapidly, it goes to red, and you'll look up, and I'll be going time, time, time, time, so you need to kind of watch for that. When you come up to testify, if you have copies, we'd like 12 copies of your testimony. If you didn't bring that, there's a sign outside which will direct you to where you can get additional copies. You certainly can ask questions of the pages who are to my left, and Ayisha or Crystal will help you. And with that, we will open the hearing this afternoon on LB534, Senator Smith's bill, to adopt the Phototherapy Practice Act. Welcome, Senator Smith. First time here. (See also Exhibits 17-19) [LB316]

SENATOR SMITH: Yes. Thank you.

SENATOR CAMPBELL: We're glad you're here.

SENATOR SMITH: (Exhibit 20) Good afternoon, Senator Campbell and members of the Health and Human Services Committee. For the record, my name is Jim Smith, J-i-m S-m-i-t-h, and I represent the 14th Legislative District in Sarpy County. And I'm here today to introduce LB534. LB534 would allow for the adoption of the Phototherapy Practice Act which would allow for the voluntary regulation of the practice of phototherapy. You might ask what is phototherapy? Phototherapy is defined as the

provision of ultraviolet light to an individual for the treatment of a condition determined to be treatable by exposing an individual to specific wavelengths of light. Phototherapy is often used to treat dermatological conditions such as eczema, psoriasis, and acne, and is also shown to be a successful treatment for sleep disorders, neonatal jaundice, and seasonal affective disorder, also known as SAD or S-A-D. In addition, exposure to UV light...(Recorder malfunction--some testimony lost)...of medicine recently recommended tripling the daily intake of vitamin D. The purpose of this bill is not only to provide for the regulation of this health service, but it is also to ensure that individuals continue to be able to access affordable phototherapy treatment. LB534 would allow for a business to provide phototherapy or a business to expand to provide phototherapy as a secondary service, either without having to pay a 10 percent federal excise tax. The tax is not currently imposed on others who provide phototherapy such as a dermatologist. The bill would make sure individuals can easily access reasonably priced healthcare when the same services are not available through conventional means, such as going to a dermatologist as per referral from their physician. Under LB534, a three-member board of phototherapy would be created with its members to be appointed by the Governor for three-year terms. The board's duties would include establishing an examination to determine the qualifications necessary for registration and adopting the rules and regulations for carrying out the act. The board would also set registration fees and at a level sufficient enough for the act to be self-funded. And, again, I repeat self-funded. There is no fiscal impact. Again, this registration is completely voluntary. This bill does not impact physicians and dermatologists who currently utilize phototherapy in their practice, but it does allow other qualified individuals to register as phototherapists and to hold themselves out as such. Phototherapy is a legitimate and growing practice and beneficial to a person's health and well-being. I will try to answer any questions, but I want to let you know that there are individuals following me here today who are probably more knowledgeable and well versed in the practice of phototherapy. And I will be back up to close today, Madam Chair, and I have some handouts here by each of our legislator's districts that indicate those constituent businesses that would be impacted by this legislation, so thank you very much. [LB534]

SENATOR CAMPBELL: Okay. Thank you, Senator Smith. Questions? Senator Wallman. [LB534]

SENATOR WALLMAN: Yes, as I was looking over your bill, do we have a demonstration here? Thank you (laugh). [LB534]

SENATOR SMITH: Pardon me? [LB534]

SENATOR WALLMAN: A demonstration? (Laugh) [LB534]

SENATOR SMITH: No, I don't think so, unless there's a booth behind me. [LB534]

SENATOR WALLMAN: Thank you, Senator (laugh). [LB534]

SENATOR CAMPBELL: Any other questions for Senator Smith? Thank you, Senator. We'll have you back for closing then. I'd like to ask how many in the hearing room wish to testify in favor of LB534? Okay. And how many wish to testify in opposition? Okay. And how many in a neutral position? All right. I'd also like to welcome to the hearing room...a special privilege we get to do...former Senator Tim Gay. So, welcome, Senator Gay. We will start with the first proponent. [LB534]

BARTON BONN: (Exhibit 21) I do have a few handouts. Should I give that first? [LB534]

SENATOR CAMPBELL: Okay. That's right. One of the pages will distribute for you. [LB534]

BARTON BONN: The page will do that? Okay. Thank you. [LB534]

SENATOR CAMPBELL: Good afternoon. [LB534]

BARTON BONN: Good afternoon, Chairperson Campbell and members of the committee. My name is Barton D. Bonn. That's B-a-r-t-o-n, middle initial D, B-o-n-n like Bonn, Germany. Before I get into my prepared statements, there's a handout that's going around, and just as it happens, I believe it was yesterday, the World-Herald had a front-page article in the Midlands, that is, about shining light on vitamin D. It's very interesting. Creighton University is noted for their vitamin D research. They're world-leading researchers there, as there are in other places around the country and the world, but we're much benefitted by their research there. I'm the Chair of the Nebraska Indoor Tanning Association. I own and operate Ashley Lynn's Tanning Salons. We have 14 locations in Nebraska, and we also operate in four other states. I'm testifying today in support of LB534. As an initial matter, the committee may wonder why a businessperson would want to see legislation enacted that would regulate his business. Simply put, this legislation creates an option or choice to be regulated. It is not a heavy-handed government mandate. If a business wants to continue in offering cosmetic tanning services without a phototherapy certificate, they may continue to do so. What this bill does is allow those who wish to provide health-related phototherapy services, and who wish to hold themselves out to the public as providing such services an opportunity to provide such a choice to the public. This legislation will ensure proper training, sanitation, and safety for consumers, and will result in health benefits to the public. It will also reduce costs to consumers as well as the state--Medicaid, Medicare--since the same services often cost much more when provided by other sources, using the same or similar equipment for the same purposes. Exactly what is phototherapy? Well, in essence, it's sunlight, and what are the benefits of sunlight to human health? Phototherapy involves the provision of ultraviolet light to an individual for such purposes as treating psoriasis and eczema, acne. Another very important health

benefit from phototherapy is increasing vitamin D levels, and on that, I might add, I've been doing this for 20 years. In the nineties, there may have been a dozen or so reports on vitamin D. Last year there were over 1,200 reports on vitamin D, and the benefits to human health across a very wide spectrum of the medical disciplines. And that's why you should start elevating this conversation and looking at what is the benefit that can occur here? This is really a preventative medicine measure that I think all of us should be interested in, particularly with the high costs of medical care, and what can be treated, and extending life expectancy and also quality of life. So, research shows that most Americans are vitamin D deficient--77 percent of us, in fact. Vitamin D is an important tool in preventing certain types of cancers as well as numerous other very serious diseases. Why is that? Essentially, every cell in the human body needs vitamin D for optimum health, and that's what the last decade has shown us. A phototherapist, under the bill, must pass an examination to ensure their qualification to provide these UV light treatments. The regulatory structure is similar to that used in Nebraska for many years in connection with the barber board. However, the standards would be determined by an appointed board comprised of three members experienced in phototherapy--a nationally-used test is already available to the board as a starting point for assessing necessary proficiency. The committee should understand that we are not talking about rocket science, but rather, training and safe operation of the (inaudible) equipment, otherwise used for tanning. Phototherapists do not diagnose diseases. They provide services to the public which currently require no license. Significant numbers of customers already utilize these services either by referral from a doctor or from self-treatment of conditions such as acne. This bill would facilitate added emphasis on sanitation training and understanding, advances in scientific knowledge in the areas such as preventing vitamin D deficiency. Phototherapy adds to the choices available to consumers to address the personal health needs in a very economical manner. I'd be happy to address any questions that the board may have. [LB534]

SENATOR CAMPBELL: Thank you, Mr. Bonn. Questions? Senator Gloor. [LB534]

SENATOR GLOOR: Thank you, Senator Campbell. Thanks for coming, Mr. Bonn. [LB534]

BARTON BONN: Yes. [LB534]

SENATOR GLOOR: I've got two questions. The first one is easy. The second one kind of escapes me (laugh). Maybe it will come to me. (Laughter) You mentioned that it didn't take rocket science. [LB534]

BARTON BONN: That's right. [LB534]

SENATOR GLOOR: But that there's...and that a test would have to be developed, but there's some standard models that are out there. [LB534]

BARTON BONN: Yes. [LB534]

SENATOR GLOOR: So what kind of...I mean, you reassured me when you said this isn't an attempt...the test doesn't get into getting people into prescribing or, excuse me, diagnosing issues. So what kind of test are we talking about then? [LB534]

BARTON BONN: I'm talking about the knowledge for the employees working in the field. I think that the best way to look at it is like an over-the-counter medicine. If you look at sunlight and what the average individual ought to know, it ought to be about as much information as the back of an aspirin bottle. That's the general knowledge. But when you go to a pharmacist, of course, they answer questions. They don't prescribe the medicine, but they're prepared to answer how to safely use it, and also to direct you to a place where you may need additional assistance. Now, who would be sending these people? Well, a family practitioner, for instance, might say the best way to take care of your psoriasis is to do regular treatments at one of my facilities. And this is where the economics really comes into play. Often if you go to, say, a dermatologist's office, there may be...you know, it's a designated appointment. You're going to make that appointment, and if it's a Medicaid, Medicare expense, it's typically about $65 per visit. If it's an insurance claim, it's usually $85 to $100 per visit. Well, I operate, as do the other around 200 salons around the state...I operate on volume. So that same individual can come in and give me $25 for an entire month worth of treatment. If you have psoriasis, when it acts up, you might have to come several times a week, so you're talking about hundreds of dollars whether it be insurance or Medicaid/Medicare for that single individual or simply coming to us for $25 for a month of use to self-diagnose, kind of like an aspirin. [LB534]

SENATOR GLOOR: But are you saying the test would be...a test that the individual who does the treatments is going to be more like the pharmacist or more like the person who would read instructions that come along with medication? [LB534]

BARTON BONN: No, I think...well, a pharmacist has a wide range of all kinds of drugs. We're talking about the use of a single device. How expert do you need to be in that particular device? And that's what we want to elevate, so it'd be my employees and myself meeting a level that I think that the state needs to be looking at this...what should that level...where is all the science going? Because a plethora of the science came about in the past decade, although its basis goes back for decades, even well beyond that. The treatment of rickets or, I don't know, Olympic athletes for eastern European countries, so (laugh). [LB534]

SENATOR GLOOR: Do you have to have a doctor's prescription in order to be able to waive the 10 percent excise or whatever? I don't know what the term is. [LB534]

BARTON BONN: No. That's actually a side benefit in my view to what occurred to my industry as part of the healthcare bill. We were included as a tax raising revenue, and I don't think it's fair. And in that, I mean, if you're a dermatologist, you don't have to pay that 10 percent tax. If you operate a gym like Gold's Gym, you don't have to pay that 10 percent tax. But you have to pay it if you come into my facility. If you're medically licensed, then you're exempt. Right now, if you walked through the door of my business, you have to pay 17 percent in taxes right off the top. Nobody else in the state is doing that unless they're selling alcohol or cigarettes, and I think that that's put us at a great disadvantage. And I think that there's financial motivations behind that and not medical or scientific motivations behind that. [LB534]

SENATOR GLOOR: But with this...I mean, if I have a prescription from my family practitioner... [LB534]

BARTON BONN: Um-hum. [LB534]

SENATOR GLOOR: ...that I need this for treatment of seasonal adjustive (sic) disorder, can they waive...does that waive that 10 percent if I can come in with a doctor's diagnosis? [LB534]

BARTON BONN: The way that I will argue it with the IRS, present it, my intent is that because the state issues medical licenses, anyone holding a medical license is exempt from that, from collecting that fee. So it's really the facility that winds up being exempt from the 10 percent, not the individual walking through the door. It... [LB534]

SENATOR GLOOR: So we really don't know yet. [LB534]

BARTON D. BONN: No, I'll have to argue that. That's a side benefit of what I think has just been an unfair act against my industry without a lot of thought. You should know that Washington, D.C., did not conduct a single committee hearing. You've heard more about it than anybody in Washington, D.C. did, but it showed up in that bill by...I don't know how it got there, but it's been painful for my industry. It's caused hundreds of salons to go out of business in the past year. It's...17 percent is a high hurdle for any business, so. [LB534]

SENATOR GLOOR: Thank you. [LB534]

SENATOR CAMPBELL: Other questions? Mr. Bonn, if I come in for a particular treatment, on the phototherapy is it a different piece of equipment than if I come in to tan? [LB534]

BARTON BONN: No, it isn't. As it turns out, the cosmetic purpose that many people come in for right now, they want to achieve a tan. Well, in the process, they're also

getting the same benefit that you get from UV light or sunlight anyway that humans are just naturally designed to get. What's different is what the shades of all of us are. There's about six different skin-type levels, and it just indicates how long you can be in it safely, so we have a very controlled environment in having that treatment. If you're outdoors today, it's a nice, sunny day. Well, you might be tricked into thinking that I'm getting plenty of UV light. Well, you're not. It's just too many atmospheric differences. It's winter, so UV light is not...a very marginal amount is penetrating Nebraska today. This summer, the sun will be high. The axis of the earth is different, and you could get as many as 15,000 IUs of sunlight in about...of vitamin D in about 15 minutes during the summer where today you get about zero so. [LB534]

SENATOR CAMPBELL: I can assure you with as many weeks as this committee has been in this room, (laughter) all day, every day, we don't get much sunlight, sir. [LB534]

BARTON BONN: Yeah. [LB534]

SENATOR CAMPBELL: We really don't. [LB534]

BARTON BONN: And I'd make this comment along that line. Laying in one of my tanning equipment for 15 minutes is about equivalent to laying on Waikiki Beach for 15 minutes. [LB534]

SENATOR GLOOR: Do we have a choice? (Laughter) [LB534]

BARTON BONN: If you can't get to Waikiki, you ought to come on down to my place so (laughter). [LB534]

SENATOR CAMPBELL: So I take it that it's not a different piece of equipment. [LB534]

BARTON BONN: No, it is not. [LB534]

SENATOR CAMPBELL: But if the person...would the person have more training to advise me on the health problem that I'm there for, and therefore, the cost would be greater, I'm assuming, if I'm there for phototherapy, because I'm getting a little bit more advice? [LB534]

BARTON BONN: No, I don't see increasing the price. I see increasing the credibility and the relationships to providers. For instance, a family practitioner may determine that that would be a suitable solution to say, psoriasis, again, but referring to me, but referring to me with confidence. So I would be like the pharmacist in that case that I have an over-the-counter type use to satisfy that ailment, and it's a wide range. It really is, because every cell in your body requires vitamin D for optimum health. [LB534]

SENATOR CAMPBELL: Senator Bloomfield. [LB534]

SENATOR BLOOMFIELD: Thank you. If it...is there, at any point, we would get to where you could ask for an insurance company to pay for this treatment? [LB534]

BARTON BONN: That's not my intent. I suppose somebody could go that way. My view of it is, is that we operate at such economical levels, that it would be best for the individual to self-pay over the counter. I mean, do you really want to file a claim for a $25 reimbursement for an entire month's worth of use? I don't know if it would be worth the bureaucracy in doing that, and I would propose that that's probably why it costs $65 to go through a Medicaid claim for a single visit at a dermatologist's office. [LB534]

SENATOR BLOOMFIELD: That's why I was wondering if we were, at some point, going to get where we're asking Medicaid to pay for this. [LB534]

BARTON BONN: No, but what I think you ought to do is, for instance, if you are having claims on Medicaid for psoriasis, for instance, you may determine in this process of working with the chief medical examiner that that might be the first step that a person be referred to rather than the recurring very expensive overqualified, really, for the necessary treatment that needs to occur. Initial prognosis, yes. Ongoing treatment, why? You can come to my place for far less, but it goes beyond that, too. The elderly is another very important area. You know, there's about 300,000 people...you've seen the commercials. Help, help, I've fallen. I've broken my hip is the implication. There's about 300,000 of those a year; 60,000 of those people will not recover and will die within that year. Well, vitamin D...the first level of benefit is bone strength, and as you get greater and greater levels of vitamin D, it affects other aspects of your health. So...all systems of your health, too. Yes. [LB534]

SENATOR BLOOMFIELD: How close does a glass of milk come to equaling 15 minutes in your booth? [LB534]

BARTON BONN: Oh, you'd have to drink a hundred glasses of milk a day. Yeah. It's...really, they talk about food as a source. It's a minimal source. It really has...you know, vitamin D in milk is fortified. The U.S. has been doing that for a very long time, Europe has not. But you need much greater levels. That is for the leading...for what the leading vitamin D researchers around the world are finding, which is different than the current recommendation. The current recommendation is far too conservative. Where does all of this go? And that's why I think now is the time that the state ought to start looking at where is the science going and where do you want to take it? So. [LB534]

SENATOR CAMPBELL: Senator Howard. [LB534]

SENATOR HOWARD: Thank you. Thank you, Chairman Campbell. You know, you

don't have to drink that much milk. I drink a lot of milk, because I like it. But you can take vitamin D tablets. [LB534]

BARTON BONN: Yes, you can take 1,000 tablets...or a single tablet... [LB534]

SENATOR HOWARD: A thousand tablets? [LB534]

BARTON BONN: No, no. (Laughter) [LB534]

SENATOR HOWARD: That would be a lot. (Laughter) [LB534]

BARTON BONN: One tablet typically, a thousand IUs in a tablet. The problem with that currently...and I am a proponent for both of those. I shouldn't downplay it like that, Senator. That is an option. One of the problems with supplements, though, is the quality assurance of the product. Johns Hopkins did a study on ten leading users. When it says 1,000 IUs to pass the FDA, it only has to be 1 percent vitamin D, so you can have a range way out there in what it is. But, yeah, I would definitely take a supplement if you didn't want to go this way. But a vitamin D supplement won't treat psoriasis. [LB534]

SENATOR HOWARD: Thank goodness, I don't have that. Thank you. [LB534]

BARTON BONN: What's that? [LB534]

SENATOR HOWARD: Thank goodness I don't have it and just take a vitamin D, and it's preventative. [LB534]

BARTON BONN: Yeah, it is uncomfortable for...yeah. [LB534]

SENATOR CAMPBELL: Any other questions from the senators? Senator Bloomfield. [LB534]

SENATOR BLOOMFIELD: One more quick one. How much time do you spend in your...? [LB534]

BARTON BONN: In my own tanning salons and stuff? [LB534]

SENATOR BLOOMFIELD: Yes, in your own booth. [LB534]

BARTON BONN: In a particular session, about...no more than 15 minutes. [LB534]

SENATOR BLOOMFIELD: How often? [LB534]

BARTON BONN: How often? You really need to only do that about once, maybe twice a

week. [LB534]

SENATOR BLOOMFIELD: Okay. [LB534]

BARTON BONN: And like I say, that would be equivalent...that 15 minutes is essentially like being on Waikiki Beach for the same number of minutes. It's very comparable to optimum sunshine when you're at the beach, but it's not overkill. It's not like a farmer that spends eight, ten hours a day out there in the field. That's what I think of when you talk about overexposure. It's a life of being in the sun. It's a big difference, I think. [LB534]

SENATOR CAMPBELL: Okay. Thank you, Mr. Bonn. Next proponent, testifier. Oh, I'm sorry, did you have a question? Okay. I apologize. Good afternoon. [LB534]

LAURA ARMAS: (Exhibit 22) Thank you, Senator Campbell and members of the committee. I'm Laura Armas. It's spelled L-a-u-r-a A-r-m-a-s. I'm a physician at Creighton University. I'm in the Osteoporosis Research Center. And I'm speaking in support for a bill, LB534. I'm speaking really from the standpoint of vitamin D. Most of my research has focused on vitamin D, and how best to reach patients. And so, most of my work has dealt with vitamin D supplementation, but I've also done a couple of studies with UVB light, specifically in raising vitamin D levels. Just to give you a little bit of background, vitamin D is commonly obtained from UVB rays from the sun. It strikes the skin, and it converts a precursor in the skin to pre-vitamin D. And the difficulty in obtaining all the needed vitamin D from the sun is there's several factors that interfere with its production including clothing coverage, glass if you're driving in a car, or, you know, in an office with a window as well as age, and he alluded to winter, not being able to produce vitamin D in the skin, and then darker skin tones. And the risks of not having enough vitamin D lead to decreased bone mineral density and osteoporosis, and osteomalacia which is a real severe form of unmineralized bone. And it's apropos that Dr. Heaney's article came out in the World-Herald yesterday, where he talked about the links between vitamin D and many diseases, including cancer, diabetes, multiple sclerosis, autoimmune diseases, and hypertension. So, Senator Howard, you alluded to the fact that most people would be treated with oral vitamin D, and, really, that's the most convenient for most people. But we do have a few patients who aren't able to absorb vitamin D from oral supplements. Either they've had gastric bypass surgery or some other bowel surgery where they're not able to absorb or they have inflammatory bowel disease. And in these particular patients, the use of phototherapy would be needed to produce vitamin D in the skin. So with that, I'll take questions if there are any. [LB534]

SENATOR CAMPBELL: Questions? Very interesting research on your part. How long have you been working on the research, did you say? [LB534]

LAURA ARMAS: I've been working during my training as well. In 2003, I started working with Dr. Heaney on the vitamin D question, so. [LB534]

SENATOR CAMPBELL: Very interesting. Do you yourself use the supplement... [LB534]

LAURA ARMAS: Yes, I do. [LB534]

SENATOR CAMPBELL: ...therapy rather than the phototherapy? [LB534]

LAURA ARMAS: I think it's more convenient to use a supplement, and most patients would use a supplement. I mean, you know, it's two seconds versus 15 minutes, but there are those patients that we come across in practice, and it's not unusual where they...you just can't get enough vitamin D into them. And that would be a case where phototherapy would be used from a physician's standpoint. [LB534]

SENATOR CAMPBELL: While I have you here, a lot of...there would probably be a lot of women in this room or in the Capitol that would take calcium, and they keep saying, well, you need to have fortified that with D... [LB534]

LAURA ARMAS: Um-hum. [LB534]

SENATOR CAMPBELL: Do you agree with that? [LB534]

LAURA ARMAS: Yeah, because calcium only absorbs with the help of vitamin D. (Laugh) [LB534]

SENATOR CAMPBELL: Good (laughter). [LB534]

LAURA ARMAS: So...so you do need that, and they go hand in hand. But vitamin D does a lot more than bone health. It's kind of been shown in the past few years so. [LB534]

SENATOR CAMPBELL: But we're probably not getting enough vitamin D in that supplement to do what your research would tell us. [LB534]

LAURA ARMAS: Yeah. I mean, Dr. Heaney believes you need 4,000 IUs a day from all sources, and so, that's a fair amount so. [LB534]

SENATOR CAMPBELL: Any other questions? Thank you for coming today. It's very interesting. [LB534]

LAURA ARMAS: You're welcome. Thank you. [LB534]

SENATOR CAMPBELL: Okay. Any other...thank you. Thank you very much. [LB534]

LAURA ARMAS: Um-hum. [LB534]

SENATOR CAMPBELL: The next testifier? Next proponent. Okay, seeing none, we will go to the opponents to the bill and take the first opponent. We're right on schedule. Good afternoon. [LB534]

KATHRYN CHANDRA: (Exhibits 23, 24, 25) Good afternoon again. Thank you, again, Senator Campbell and members of the committee. Again, for the record, my name is Kathryn Chandra. It's K-a-t-h-r-y-n C-h-a-n-d-r-a. I am assistant director of state policy for the American Academy of Dermatology Association, and I am, again, representing the Nebraska Dermatology Society today in opposition to LB534. This bill, as you've heard, is chiefly supported by the Nebraska Indoor Tanning Association and seeks to brazenly subvert the practice of medicine and undermine patient safety in Nebraska. Written testimony is being submitted to the committee from the Nebraska Dermatology Society, the Nebraska Medical Association, the Photomedicine Society, and the National Psoriasis Foundation which provide discussion of phototherapy as a medical treatment offered by licensed physicians for skin diseases including acne, eczema, and psoriasis, and a treatment which requires medical knowledge and judgment to perform. When undergoing phototherapy treatments, patients are regularly and closely evaluated for any acute or chronic side effects. Furthermore, in phototherapy units, the output of UV is regularly measured and adjusted to treatment protocols accordingly, and treatment is closely monitored and supervised by a physician. These safety protocols do not occur in commercial tanning salons. The intent of this bill is to allow indoor tanning salons to continue to offer cosmetic tanning bed services under the thin veneer of medical legitimacy to insulate the industry from federal and state regulations. This is unacceptable. I would like to stress to the committee that medical UV devices are not the same as indoor tanning beds. Tanning beds are not designed to treat medical diseases and are not regulated by the U.S. Food and Drug Administration for this purpose. There is no basis to allow tanning salons to offer medical services such as phototherapy. The Nebraska Dermatology Society and the Nebraska Medical Association, along with the aforementioned organizations, oppose LB534 and urge you to oppose this bill. For our purposes here, I would simply like to point out several sections of the bill where this intent is evident. In Section 3, the bill provides for phototherapy to be provided upon referral from a physician or another healthcare provider or in the case of direct treatment when no referral or diagnosis is required by law. This language would clearly permit tanning facility operators to engage in the practice of medicine by providing direct treatment to individuals in Nebraska. This constitutes practicing medicine without a license and is unlawful. Section 4 of this bill would allow tanning salon operators and employees to hold themselves out as medical professionals, and this is a dangerous precedent. In Section 5, the bill indicates the age

requirement to become a licensed phototherapist is at least 17 years old. This would permit high school students to offer medical services through their employment at a tanning salon. This undermines the entire medical profession and puts Nebraskan patients in danger. The practice of medicine should be directed by licensed physicians, not employees of tanning salons or other nonmedical facilities. As a case in point, a study published in the Archives of Dermatology on February 21, which was distributed to you, describes an incident where a 22-year-old woman attempted to self-treat what she believed to be a rash by visiting an indoor tanning facility. She spent approximately eight minutes in the tanning bed. Within hours, her condition worsened and required emergency medical treatment. Six hours following initial treatment from the emergency room, the woman returned with worsening symptoms and was referred to a medical center, and immediately admitted to a burn unit. If this patient had sought medical attention from a licensed physician when the rash had first appeared, she would have avoided very painful and expensive emergency room visits and ultimate admission to the Medical Center Burn Unit. The skin is the largest organ of the body, and, as such, often something that appears as a simple rash is indicative of a systemic illness in the body, as noted in this case. Alternatively, we can imagine a situation where the teenage employees of tanning salons, as licensed phototherapists, would advertise to their peers the ability to treat their acne or other skin conditions easily without needing to see a doctor just by stopping by the tanning salon. There is an increasing trend for patients to seek tanning bed exposure as a means to self-treat various skin conditions. This is dangerous as evidenced by the case I described. LB534 would further exacerbate this issue by providing legal authority for tanning salon employees to offer medical treatments for serious skin conditions. It's abundantly clear that this bill is an attempt by the indoor tanning industry to protect its business interests at the potential risk of the health of Nebraska's citizens. Further evidenced by this fact is the creation of the Board of Phototherapy in Section 10 which doesn't include any licensed physicians. Just quickly, I'd like to point out that this bill is not about taxes as was described by proponents of the bill. I would also like to make clear to the committee that individuals with a prescription for UV therapy which seeks that from a tanning salon would not be required to pay the 10 percent federal tax. Those services are exempted under the Healthcare Reform Bill. I thank you for the opportunity to address you today and would be happy to answer any questions. [LB534]

SENATOR CAMPBELL: Questions? Are you a dermatologist? [LB534]

KATHRYN CHANDRA: No, I'm not. [LB534]

SENATOR CAMPBELL: You represent the association. Are there times when a dermatologist would send someone to a tanning salon? [LB534]

KATHRYN CHANDRA: Yes, I think that's been described earlier today. There are instances where, you know, a patient can't regularly get as many times as would be

required to a dermatologist's office for phototherapy services there, and it could be either a dermatologist or another physician. I think the key difference here with regard to this being a medical treatment is in the diagnosis from the physician, a patient would be adequately followed up with by that physician to look for any signs of skin cancer which is known to be caused by UV radiation that's being emitted from these devices. [LB534]

SENATOR CAMPBELL: Okay. Any other questions? Thank you very much for your testimony. [LB534]

KATHRYN CHANDRA: Thank you. [LB534]

SENATOR CAMPBELL: The next opponent. [LB534]

DAVID BUNTAIN: Senator Campbell, members of the committee, I am David Buntain, B-u-n-t-a-i-n. I am an attorney and the registered lobbyist for the Nebraska Medical Association. We oppose this bill for the same reasons that have previously been stated, and I won't go through those, and you have some other written material related to it. I do want to indicate that it's our opinion that this is a bill that should, if it is going to go forward, be referred to the review of health professions' provisions that we commonly call as the LB407 process. Under state law, any group that comes forward and is asking to be certified by the state to provide medical services is required to go through this process, and it really was set up to deal with exactly the situation you're faced with today, and that is a new group coming in, asking basically for the state to give them the stamp of approval, so that they can go out and hold themselves out as therapists to provide a certain kind of medical service. And the policy behind the 407 process is to obtain expert input from a review committee from the Board of Health and, ultimately, from the chief medical officer as to whether there is a need for it; whether it's safe--the criteria that we're all familiar with. And I really think that's what's needed here. As has been pointed out, there purports to be a description of the practice of phototherapy, but if you look at it, it really is very nonuseful, because, basically, what it says is phototherapy is a practice that you could do if prescribed by a physician or you can come in without a physician's diagnosis where no referral or diagnosis is required by law. It would really put the person who is the phototherapist in the position of having to decide whether a referral or diagnosis is required, which is itself an act of diagnosis. It seems to me that it's...it really doesn't help as far as trying to sort out what would be or wouldn't be legitimate. It talks about being considered a medical professional. Clearly, that is someone that comes through the 407 process. The other thing I just would note as sort of an ancillary issue is the way that this would be set up, you would have a board appointed by the Governor, and we've had an issue earlier this session involving the veterinarians and all other health professions are appointed through the Board of Health. And I think that's something that also would be looked at through the 407 process. So I'd be happy to answer any questions. [LB534]

SENATOR CAMPBELL: Any questions for Mr. Buntain? Thank you, Mr. Buntain. [LB534]

DAVID BUNTAIN: Thank you. [LB534]

SENATOR CAMPBELL: Next testifier. Good afternoon. [LB534]

JULIE ERICKSON: (Exhibit 26) Good afternoon. Senator Campbell, members of the Health and Human Services Committee. My name is Julie Erickson, J-u-l-i-e E-r-i-c-k-s-o-n, and I'm a registered lobbyist here testifying on behalf of the Nebraska Physical Therapy Association which we are passing around a letter in opposition to LB534. I'm not going to reiterate some of the issues that have already been brought up which we are pointing out from the 407 process, but one of the key things here is that there are a number of other health professionals beyond dermatologists that use phototherapy in their practices including physical therapists. There are others out there, and so that the array of folks that are out there to provide the services are available, and we don't have a situation where we don't have access to these services which would be one of the issues that a 407 committee would look at. Beyond that, if I can answer any questions, I'm more than willing. [LB534]

SENATOR CAMPBELL: Any questions for Ms. Erickson? Thank you very much for coming today. [LB534]

JULIE ERICKSON: Thank you. [LB534]

SENATOR CAMPBELL: The next testifier? Anyone wishing to testify in a neutral position? Seeing none, Senator Smith, would you like to close on your bill? [LB534]

SENATOR SMITH: Again, thank you very much, Senator Campbell, and members of the committee. It's, indeed, been a pleasure to be here with you today, and I appreciate the critical thought and consideration that you've given this discussion today and with the introduction of this bill. A few things I just wanted to touch on and wrap up in my closing comments. I wanted to close by summarizing by what I see as the major components of the intent of this bill. First, there's the public safety and public well-being component. And through a standardized licensing or registration process of this growing treatment, the public will be better served and will be better protected. And in some of the opposition testimony you heard here today, they made the case very well for this, that there is a need to have a standardized process, training, and oversight. And this bill would, at least, begin the process for providing that. There's also the affordability-for-patient component. With services offered by a phototherapist, whether the services are primary or secondary in the business operations, the public will have a more affordable option for their related treatments. And Mr. Bonn provided some excellent testimony on this. He gave some idea--indication as to what it would cost for

some of those treatments that a patient would otherwise may be going to a different type of an office or a physician, and incurring much higher costs. And then the final component is market fairness and business protection. And we have a case here where small business is being destroyed, literally destroyed, by placing an excise tax on a narrow segment of an industry. And you saw that in the handout that I provided you. You saw some of the impacts to your individual districts. This bill would allow this segment that is currently being isolated and damaged to be able to compete fairly, and to continue to exist. And I might also remind you that there's no fiscal note, so at no cost to the state of Nebraska. It is an independently-funded process. Self-treatment is currently occurring. People are using tanning operations today for these medical treatments, and this is simply an opportunity for us to ensure the public safety, affordability of these services for the consumer, and, again, ensure market fairness. Clarification...Senator Gloor, you were asking earlier, I think, some questions about the excise tax, and under the Patient and Affordable Care Act, 10 percent excise tax is imposed on tanning salons. This is an additional tax, 10 percent, to the 7 percent sales tax the state already imposes. Since LB534 would include tanning salons in the practice of phototherapy, this language is necessary to make sure these small businesses are not put at a disadvantage by being taxed at the rate of 17 percent. Again, 17 percent to provide some of the same services that other offices, other locations are providing. The PPACA exempts licensed medical professionals who provide phototherapy from the 10 percent excise tax. And we're not running away from that or shying away from that. That is, indeed, a component to the intent of this bill. And, once again, I appreciate your consideration of this bill. I thank you for allowing me to be here today, and I would ask you to allow this bill to advance. Thank you very much. [LB534]

SENATOR CAMPBELL: Thank you, Senator Smith. Any other comments, questions? Senator Gloor. [LB534]

SENATOR GLOOR: Thank you, Chairperson Campbell. Senator Smith, I just want to make sure I understand. Just because you're a recognized phototherapist by the state doesn't mean that all of the services you provide are exempt or have a 10 percent exemption. I mean, wouldn't it be...you still have to come in with a healthcare diagnosis of some kind to avoid that 10 percent. [LB534]

SENATOR SMITH: Under the proposal or currently? [LB534]

SENATOR GLOOR: Well, under your proposal, under this legislation. If we recognize phototherapists, just because you're a phototherapist doesn't mean automatically everybody that you'd provide tanning services to is exempt from the 10 percent, or does it? [LB534]

SENATOR SMITH: I do not believe that this currently addresses the full extent. [LB534]

SENATOR GLOOR: Okay. [LB534]

SENATOR SMITH: If you're coming for simply cosmetic purposes, we certainly would be willing to consider any type of amendments to address some of those. [LB534]

SENATOR GLOOR: Yeah, I don't...when I read through it, I didn't see that, but I (inaudible)... [LB534]

SENATOR SMITH: It did not specifically address that, my understanding. [LB534]

SENATOR GLOOR: Okay. Thank you. [LB534]

SENATOR CAMPBELL: Any other questions or comments? Thank you very much. [LB534]

SENATOR SMITH: Thank you again. [LB534]

SENATOR CAMPBELL: We will close the hearing on LB534, and the committee will take a five-minute break. And then Senator Gloor will be in charge. (See Exhibits 27, 28) [LB534]

BREAK

SENATOR GLOOR: Good afternoon, everyone. I'm not sure how many people might have come in and not gotten some of the instructions before. But how many people here would like to speak in favor of this particular bill? Put your hands high, so we know a rough count. Okay. How many people would speak in opposition to this bill? Okay. And I'm hopeful those of you who were here earlier understand our light system. When the yellow light comes on, you have a minute left, and when the red light comes on, please begin to wrap up quickly. And other than that, we'll welcome Senator Dubas to the Health and Human Services Committee. Senator. [LB557]

SENATOR DUBAS: (Exhibits 29, 30) Thank you very much, Senator Gloor, members of the Health and Human Services Committee. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I represent Legislative District 34. LB557 requires healthcare facilities to employ certified surgical technologists that have completed a nationally accredited educational program. Currently, surgical techs who work in the sterile field surrounding a patient on the operating table and handing a surgeon instruments during surgery have no statutory educational requirements. But many hospitals in Nebraska are already requiring certified surgical techs. Nebraska is one of 19 states that are in some process of passing or have already passed laws requiring these educational standards. There is a move across the country to ensure patients are protected with a level of training and education for what previously were called scrub nurses. A renewed awareness of

readmission rates and the costs associated with surgical infections has made policymakers and many others much more aware of the need to set standards. The Department of Health and Human Services confirm that since LB557 does not directly regulate the individuals, the Credentialing Review or the 407 process would not apply. And I do have a letter from the department, kind of outlining their thoughts behind this not needing to go through a 407 process, so what they're basically telling us is the provisions of LB557 are contained within the Healthcare Facility Licensure Act. So, again, the credentialing process would not apply in this situation. A surgical technologist is an entry level health profession. Nebraska currently has two accredited surgical technology programs, one at Nebraska Methodist College in Omaha, and the other at Southeast Community College in Lincoln. Both programs are 18 months long and provide graduates with an associates of applied science degree in surgical technology. There are also on-line programs available. The certification exam is administered by the National Board of Surgical Technology, and surgical assisting must be renewed every four years. LB557 defines surgical technologist and surgical technology, listing the tasks and functions performed. Nurses requested that we strike patient care and insert tasks or functions to more accurately describe operating room realities. And I guess I forgot to also hand out the amendment that we have worked on dealing...addressing some of the things that I will be bringing up in the bill today. I'm sorry for not getting that to you sooner. In an attempt to bring a level of professionalism and accountability to the position, LB557 requires licensed healthcare facilities to hire only those surgical technologists who have completed an accredited educational program and become credentialed. Exceptions exist in the bill to grandfather in those trained by the United States armed forces, the federal government, or nurses who are trained on the job and still very capable, but unlikely to return to school to maintain their current employment. The amendment came about when UNMC noted that their surgical techs are occasionally reassigned to other departments and tasks, and so without this amendment addressing that grandfathering, bringing them back to a surgical tech position could possibly have required them to have to go through this process. So, hopefully, we have addressed that through the amendment, so that they could return...if they've been reassigned to another department, and come back to be a surgical tech, they wouldn't have to go through the educational requirements. The bill also contains a continuing education requirement which can be completed at most hospitals or even on-line. Again, the clarifying amendment assures that licensed facilities are not required to offer or pay for these educational credits. The only requirement on hospitals is to verify their employees are credentialed and receiving ongoing education. Also, at the request of nurses, Section 9 of the bill ensures that nurses with a higher level of education and training may perform surgical tech tasks and functions without being credentialed surgical techs, if it is within the scope of their existing license. This bill was brought to me by the Nebraska State Assembly of Surgical Technologists. I've made every effort to take all perspectives into account. We've worked closely with the Hospital Association, registered nurses, and other interested stakeholders. If I've missed somebody or I haven't brought someone into my office, it was not intentional. It was

purely an oversight on my part, but we have worked really hard to try to take everybody's thoughts and concerns about this bill into consideration before bringing it to you. Hopefully, the amendment is a reflection of that. So I hope...and we got this amendment out to the interested stakeholders ahead of the hearing. So it's my hope that when they come up to testify, they'll be testifying to the amendment, not strictly just to the green copy. So, I know there's some very adequately trained and highly professional people behind me who will be coming forward to be able to give you very specific answers to what I hope are your very specific questions, and be happy to try to answer any questions that I may be able to do. But for me, when this was first brought to my attention, and I was asked to consider carrying this legislation, for me, what ultimately caused me to say yes, I'll carry this legislation, it's about patient safety. And I think that was what the surgical techs came to me. That was their concern. They wanted to not only professionalize their profession, but just give that extra level of confidence to our patients, that all the bases are being covered as far as making sure that their health, safety, and well-being is being addressed. So I'd be happy to answer any questions if I can. [LB557]

SENATOR GLOOR: Thank you, Senator Dubas. Are there any questions? Senator Bloomfield. [LB557]

SENATOR BLOOMFIELD: Thank you. Senator Dubas, in scanning over this, and I have not read it carefully, are people that are currently working in that field grandfathered in or do they need to take training? [LB557]

SENATOR DUBAS: No. They should be...if they meet all the...you know, if they are currently in the field of surgical technology,... [LB557]

SENATOR BLOOMFIELD: Yeah. [LB557]

SENATOR DUBAS: ...in fact, the amendment addresses that. You know, prior to the enactment of this, that they should be. [LB557]

SENATOR BLOOMFIELD: Okay. Okay. Thank you. [LB557]

SENATOR GLOOR: Any other questions? Thank you, Senator Dubas. First proponent. [LB557]

CASEY GLASSBURNER: (Exhibits 31-33) Senator Gloor and members of the Health and Human Services Committee, my name is Casey Glassburner. That's C-a-s-e-y G-l-a-s-s-b-u-r-n-e-r. Thank you for the opportunity to testify this afternoon in support of LB557. I am currently serving on the board of directors of the Nebraska State Assembly of the Association of Surgical Technologists, and I am a certified surgical technologist and have been since 2005. Nebraska's 500 surgical technologists are allied health

professionals who are an integral part of the surgical team. They work under the supervision of the surgeon to facilitate the safe and effective conduct of invasive surgical procedures. Surgical technologists ensure that the operating room environment is safe and sterile, that equipment functions properly, and that the operative procedure is conducted under conditions that maximize patient safety and minimize the risk of the patient contracting a postoperative wound infection. Surgical technologists possess expertise in the theory and application of sterile and aseptic technique. They combine the knowledge of human anatomy, surgical procedures, surgical equipment, and technologies to facilitate a surgeon's performance of invasive procedures. As Senator Dubas stated earlier, there are two accredited surgical technology programs in the state, one at Southeast Community College in Lincoln, and one at Nebraska Methodist College in Omaha. Both of these programs do provide graduates with an Associates of Applied Science degree, and both have students who sit for the national certification exam prior to graduation, so they graduate as a certified surgical technologist. The program at SCC in Lincoln also offers their education on-line via their distance program, allowing them to reach students in all areas of the state of Nebraska. LB557 is supported by both accredited surgical technology programs in the state. Hundreds of surgical procedures are performed every day in Nebraska healthcare facilities. In 2008 alone, over 125,000 surgeries were performed in Nebraska hospitals. Surgical technologists assisted in these surgeries, and they assist in surgeries every day, ranging from simple, outpatient procedures in freestanding surgery centers to highly invasive surgeries such as coronary artery bypass and neurosurgery in larger hospitals. Unqualified and uneducated surgical technologists can cause harm to the surgical patient by poorly maintaining the sterility of the operating room and the sterile field which can lead to an increase in surgical site infections. They can also attribute to poorly assembling sophisticated instrumentation and equipment that is utilized during the procedure, and they can cause harm by slowing down the procedure itself which results in unnecessary risk to patients by being under anesthesia for extended periods of time and possibly experiencing excessive amounts of blood loss. Swift surgeries depend on effective and efficient surgical technologists as a member of the operating room team. The Institute of Medicine report, "To Err is Human" that was published in 1999, estimated that over 98,000 patients die from preventable medical errors every year. Sixty percent of the "never events" that were identified in this report happen in the operating room. The potential for accidental and preventable harm to patients in the operating room comes from surgical site infections, foreign objects that can be left behind inside a patient, wrong site surgery, wrong patient surgery, falls, medication errors, positioning the patient, and other perioperative tasks. Surgical site infection rates are a problem, and they continue to increase. According to the 2009 National Healthcare Quality Report, hospital-acquired infection rates are increasing. And the quality measure that increased the most, and that was deteriorating the fastest was postoperative sepsis or postoperative infections following a surgery, which increased in 2009 by 8 percent. Now, a majority of surgical site infections are actually detected after a patient is initially discharged from the healthcare facility. A joint study that was

performed by researchers at the Harvard Medical School and the Centers for Disease Control and Prevention estimated that 47 to 84 percent of surgical site infections are detected after a patient is initially discharged from a hospital. So, therefore, the rate of surgical site infections directly impacts the rate of hospital readmissions. These surgical site infections significantly drive healthcare costs. The costs associated with one surgical site infection is $25,546, and these surgical site infections result in 13,088 deaths nationally per year. The surgical technologist is the professional in the operating room, charged with the responsibility of maintaining the integrity of the sterile field in order to prevent these infections. Thus, this legislation could reduce surgical site infections which would not only reduce hospital readmissions and the costs associated with them, but also reduce overall healthcare costs and save lives. There isn't a lot of data concerning surgical technologists, because, as Senator Dubas alluded to earlier, currently, the profession is unregulated in other states. So this bill before you, hopefully, would establish that everyone in the operating room would be a credentialed person who is a graduate of an accredited program and has obtained a national credential, and has demonstrated their competency, which would be required by this bill. So, if you have any questions, I would be happy to answer them. [LB557]

SENATOR GLOOR: Thank you. Are there any questions for Ms. Glassburner? I think I have a question, and that is, I understand the concerns about reduction in surgical infection sites and whatnot. But the position of having a surgical assistant isn't a brand new one. I mean, there were surgical assistants back in the days... [LB557]

CASEY GLASSBURNER: Um-hum. [LB557]

SENATOR GLOOR: ...when the report came out, showing the instances of adverse outcomes as relates to healthcare. We had surgical assistants back in those days. What problem are we specifically trying to address right now by this legislation that would require that surgical assistants--licensed surgical assistants--be used in healthcare facilities? I mean, what does it do for your profession? [LB557]

CASEY GLASSBURNER: Well, currently, right now, in the state of Nebraska, because there is no regulation, it means that basically anyone...everyone sitting in this room right now is qualified to walk into an operating room and start assisting a surgeon on an open heart bypass. Many facilities do have additional regulations. As Senator Dubas alluded to, there are facilities that already require certification of their surgical technologists. Surgical technology...now there are 465 accredited surgical technology programs across the country, and the majority of them have students who sit for the certification exam in order to demonstrate their competency before they graduate anyway. It's just that right now, there is no level of competency that is assured by not having that credential and that regulation at the state level. [LB557]

SENATOR GLOOR: Do we think we have problems with the consistency of...I mean...

[LB557]

CASEY GLASSBURNER: Yes. [LB557]

SENATOR GLOOR: ...are a lot of heart surgeries actually being done with untrained people assisting the surgical team? Probably not. [LB557]

CASEY GLASSBURNER: No, probably not. I would agree that...yeah, I would agree to that. Probably not. I think, you know, a lot of the hospitals do a good job of regulating themselves, but we just want to prevent the one instance, because one instance and one surgical site infection that leads to a death is detrimental to somebody and also to their family, and that could be me or you laying on that operating room table, and I want to make sure that there's certified surgical technologists in that room. [LB557]

SENATOR GLOOR: Is some of this driven by the proliferation of places you can have surgical and interventional procedures done? [LB557]

CASEY GLASSBURNER: I guess I don't understand what you mean by that. [LB557]

SENATOR GLOOR: Back in 1998, there weren't that many ambulatory surgery centers... [LB557]

CASEY GLASSBURNER: Oh, I see. [LB557]

SENATOR GLOOR: ...there weren't that many places where you could go to have a surgical procedure. Now, there are quite a few. Has that gotten to be a quality issue for us in terms of people who are working in those different healthcare facilities? [LB557]

CASEY GLASSBURNER: I don't think so. Right now, the Bureau of Statistics estimates there's 480 surgical technologists in the state, and 320 of them are certified already anyway, so two-thirds of them are certified surgical technologists already anyway. And many of them may have been certified at one time and just let their certification lapse. I don't think, in the state of Nebraska necessarily, that we are having a problem with errors and people on being unqualified in operating rooms. But the potential is there, and that is what the goal is behind this bill is to prevent that potential from being there. [LB557]

SENATOR GLOOR: Okay. Thank you. Other questions? Thank you for your testimony. Next proponent, please. [LB557]

CATHIE HEMMER: (Exhibit 34) Good afternoon, Senator Gloor and members of the committee. Thank you for your time today. My name is Cathie Hemmer, C-a-t-h-i-e H-e-m-m-e-r, and I am a certified surgical technologist and have been for 11 years. I live

in Nebraska City, home of Arbor Day. After a long career in the banking industry, I became a certified surgical technologist, because I enjoy the rewards of positively impacting patients' lives. I work at St. Mary's Community Hospital in Nebraska City which is owned by the Catholic Health Initiative. My support for LB557 is shared by the management staff at St. Mary's Community Hospital. My job description as a certified surgical technologist in a rural hospital is a diverse one. I am responsible for terminally cleaning the operating rooms, and I prepare them for surgery by opening sterile supplies while maintaining the sterile field, and preparing electronic equipment. One of my major responsibilities is watching for contamination and breaks in aseptic technique. I stand next to or across from the doctor, always being aware of each step of the procedure the doctor is performing. I must anticipate two to three steps ahead of the doctor with the next instruments in hand, while being aware that each step can vary, according to the patient's specific anatomy and physiology. I prepare medications on the sterile field during the surgical procedure. I assist the surgical team according to their needs in order to expedite the procedure. The purchasing, cleaning, preparation, and sterilization of surgical instruments is also a major responsibility. I am required to be on call for emergency surgeries, of which I may have 10 to 15 nights a month including one to two weekends a month. A certified surgical technologist is required to have 15 continuing education credits per year for a total of 60 contact hours in four years. This requirement allows us to stay updated on the cutting-edge technology and surgical techniques, new instrumentation, and computerized equipment. I personally look forward to attending workshops because of the opportunity for hands-on training. We have 12 doctors that provide surgical services at our facility. Our surgeries range from C-sections, general surgery, gynecology, ear, nose and throat, urology, and orthopedics. We also have a GI lab once a week. Our orthopedic program has expanded to include total knee replacement surgery, and, as of yesterday, we performed our first total hip replacement. This has opened the door for surgery expansion in our facility. LB557 ensures a high standard of competency and quality of care in the operating room. A certified surgical technologist is a critical member of the team that is able to provide this level of care. We are detailed professionals that work towards the best outcome for the patient. Having a certified surgical technologist positively affects all of us with less surgical time, reduced surgical infections, reduced hospital readmissions, and lower healthcare costs. Living in a rural community, I've discovered that the distance on-line program for surgical technologists at Southeast Community College-Lincoln provides an excellent alternative for students who are unable to commute to college. I precepted a student from Hamburg, Iowa, in this program that was well prepared for clinicals. She was able to complete all her coursework on-line and then perform her clinical rotations in Nebraska City at St. Mary's Community Hospital. I was so impressed with her abilities that I requested the director of our department hire this student following graduation. And we have been very pleased with her knowledge base. Because I support all members of the surgical team to be properly credentialed, I wanted to personally thank Senator Annette Dubas, and I ask the committee to support LB557 and advance this bill to the floor of the Legislature.

Thank you, and I'm available for questions. [LB557]

SENATOR GLOOR: Any questions for Ms. Hemmer? Please, Senator Howard. [LB557]

SENATOR HOWARD: I just wanted to say thank you. Gosh, what a big responsibility. And then the next day you come down to us (laugh). That's really impressive. Thank you. [LB557]

SENATOR GLOOR: Any other questions? Is Dan still your CEO? [LB557]

CATHIE HEMMER: He is. [LB557]

SENATOR GLOOR: Well, step on his cowboy boots if you're brave enough to do it tomorrow and say (laughter) Senator Gloor says hello and congratulations on your first hip procedure. Thank you for your testimony. [LB557]

CATHIE HEMMER: Thank you. Thank you. [LB557]

SENATOR GLOOR: Next proponent. Good afternoon. [LB557]

CATHERINE SPARKMAN: Good afternoon. Feel a little short here. [LB557]

SENATOR GLOOR: It's on purpose, I think (inaudible) (laughter). [LB557]

CATHERINE SPARKMAN: Senator Gloor, members of the committee, thank you very much for allowing me the opportunity to testify here today in support of LB557. My name is Catherine Sparkman, C-a-t-h-e-r-i-n-e S-p-a-r-k-m-a-n. I am the director of Government and Public Affairs for the Association of Surgical Technologists. It is the national professional association of 32,000 members, comprised of practitioners, educators, students in the field of surgical technology. I am not a practitioner. Actually, I am a recovering lawyer (laughter), and having practiced 30 years primarily in medical malpractice defense, from the hospital's perspective, what we called Enterprise Liability. I am a surgical patient. I had two kids in unremarkable pregnancies. I suppose I should say remarkable kids in unremarkable pregnancies, but my father had a seven-hour cardiovascular surgery; my mother had cancer surgery; my brother had extensive orthopedic reconstructive surgery; my sister's husband had an emergency aortic aneurysm surgery that saved his life. And I expect each of you have had some intersection, either personally or by family or friends with the healthcare system and a surgical suite. I'm here to tell you something you probably already know just like a lawyer usually does (laughter). Every surgical patient deserves the best, most qualified and most competent surgical team. I prepared a packet which Casey Glassburner handed out to you. I just wanted to tell you some of the things that are in it. The bill is there, but not the amendment, and my apologies for that. There was a white paper in it,

seven or eight pages with the information and data about surgical technologists, surgical patient safety, and the current situation. There are also photographs of surgical procedures, just to let you know who is in the OR, who's behind that mask? They could be a registered nurse, a surgeon, a surgeon's assistant, a surgical technologist. In fact, you can't really tell who's behind that mask if you look at those...that collage of pictures. The only one not required to be credentialed in any of those pictures, of course, is the surgical technologist. I also have included a DVD of a mock surgery that AST members joined and supported by their nursing and medical colleagues--surgical colleagues--performed in the state capitol in Indianapolis in support of a jointly advanced bill in 2009, which did pass. It is a total knee replacement and revision. And it is interesting. It is just a few minutes long as is a synopsis, but gives you an interesting idea in case you don't want to subject yourself to really what goes on in the operating room. I also have included letters supporting accredited education and certification of surgical technologists that were submitted by the American College of Surgeons by resolution, and also, by the Association of periOperative Registered Nurses. Both of those letters of support are on the right-hand side of your packet. I wanted to just briefly talk a little bit about AST because, as Senator Gloor said, they've been around for a while. The notion of having someone assisting and passing instruments to a surgeon is not a new thing. AST used to be part of the Association of periOperative Registered Nurses, and about three decades ago, the two organizations went independent of one another, and...it was called AORT at that point. It formed its own professional organization of about a few hundred members--1,800 members. At that time, about 80 percent of persons in the OR suite in the scrub role were nurses. Everyone remembers Hot Lips Houlihan. Everyone thinks about that. And, I said, boy, I'm not going to get halfway through this, but I will say, there were a few established programs. The average surgery utilized about 45 instruments. Today AST has 32,000 members. It has doubled its membership in the last eight years and is growing at 11 percent per year. There are 465 programs, and today, 75 percent of persons in the scrub role nationally are surgical technologists. There has been a paradigm shift in the operating room. I don't think you can call this an emerging profession as the Virginia Department of Health Professions called it in supporting credentialing of surgical technologists there. But healthcare is looking to these individuals to play an important role in securing patient safety. Is it a worthy goal? Well, certainly, most everyone who is involved in surgical patient safety thinks so. The IOM which...there are a number of studies that are referenced in the materials, talks about the deaths resulting from preventable medical errors. The CDC talks about the number of infections, surgical site infections that continue to plague our patients, and the Department of Health and Human Services, who in the Affordable Healthcare Act now rewards hospitals and facilities in the top quartile of patient safety, including indices of surgical patient safety while penalizing the bottom quartile to make sure that those facilities do conduct the safest possible quality healthcare. I want to just...end with just a couple of things. Dr. Wendell is not here. He is a very gifted surgeon in Nebraska. I have not met him personally, but if he were here, he would tell you that every minute that a patient is under anesthesia, it gets worse for them. A

qualified, competent, skilled technologist reduces that time. Surgeons have told me in every state of which...that we are active in, the same thing--Wisconsin, Minnesota, Oregon, Texas, that a qualified and trained surgical technologist improves the ability for a surgeon to do his job. Dr. Robert Zerloss (phonetic), an M.D. and anesthesiologist and a sponsor of the surgical technologists bill almost identical to this one, that passed in Texas in its last session, said the exact same thing. So I just want to say that there's a lot of things this bill is not. It's not a licensure bill. It's not a regulatory bill. It's not a supervisory bill. It's not an independent practice bill. It is not an inflexible bill. It is not about scope of practice or turf. It is about competent medical professionals. The motto of AST is Aeger Primo--The Patient First, and that is really what this bill is about. [LB557]

SENATOR GLOOR: Okay. Thank you. [LB557]

CATHERINE SPARKMAN: Thank you. [LB557]

SENATOR GLOOR: Any questions of Ms. Sparkman? Seeing none, thank you very much. [LB557]

CATHERINE SPARKMAN: Thank you, Senator. Thank you, committee. [LB557]

SENATOR GLOOR: Next proponent. Any more proponents? People who would like to speak in opposition to this bill? Welcome. [LB557]

KAREN RUSTERMIER: (Exhibit 35) Hello, Senator Gloor and members of the committee. My name is Karen Rustermier. That's K-a-r-e-n R-u-s-t-e-r-m-i-e-r. I represent AORN which is the Association of periOperative Registered Nurses. We represent over 40,000 nurses, and there are approximately 350 members of that association in Nebraska. We are a specialty organization whose mission is to promote safety and optimal outcomes for patients undergoing invasive procedures. I have been an OR nurse for 40 years, and during that time, I have also served as adjunct faculty in the surgical tech program at Metro Community College. They no longer have that program, but I have served in that function in the past, so I'm pretty familiar with surgery techs and what their education is, and what they do. We ask you to oppose LB557 as it was introduced and amended. We strongly feel that the way it is written will deter from quality patient care. I have a few points that I want to make. We've gone over this that surgical technologists are unlicensed assistive personnel, and they are currently directly supervised by the circulating registered nurse, and their actions are directed by the operating physician during the intraoperative phase of the surgical experience. This bill does not provide for direct supervision by a licensed registered nurse. Surgical technologists don't actually have the educational preparation to function independently without direct licensed supervision nor do they have the education to assess a patient's needs. Physicians are not present in the operating room, and I'm pulling this from the

section that says they are directly supervised by a physician. They are not in the operating room in the pre-op phase where we would be doing the preparation for the operation and the planning portions. And then they are not there during the immediate post-op phase unless the patient's condition would warrant that they would stick around. The bill should reflect the relationship between the supervising RN circulator and the surgical technologist to ensure that equipment is functioning properly. That is not delineated. That is mandated by Medicare conditions for coverage. It should be amended to clearly state that the surgical technologist is supervised by the registered nurse. And the term "practice" is used throughout the bill which is inappropriate since this is not a licensed individual, and this is not a licensing bill. And I think we've gone over with licensing--there's no regulation, no registration, no really oversight by the state. And so each facility is responsible for assessing continuing competence. There's a number of individuals working today that have not graduated from surgical technology programs. However, they've been trained on the job, and have been working for many years, so we've kind of cleaned up that grandfathering language, and we are very happy with that. As I was saying, they were not educated to function independently. Their focus is more narrow. They are very well trained in instrumentation, supplies, procedures, assisting the physician in specific tasks. The nurse is more broad-focused in coordinating the activities of all providers within the surgical team. Like I said, this is not a licensure bill. We would like to see the word "functions" everywhere where it says "practice," and we really need to see that RNs are the supervising person. The physician, who's an independent practitioner most times...I don't know how they could say they're supervised by a physician when they're employed by a facility. So, anyway, those are the really crux issues. We do have some other issues, but I don't have really time to go through those, and they're minimal. AORN supports the education piece. We want to see graduates of programs. These are valuable people in our team. We encourage them to be certified. We don't want to destroy our team. We want it to remain a team. We don't want two separate entities working here. We need to stay together, so that is why we are opposing this bill, and we would recommend that you postpone this bill until such time as all the interested parties can sit down and come to consensus language regarding these issues. I'd be happy to answer any questions that you might have. [LB557]

SENATOR GLOOR: Thank you. Are there any questions? Karen, because you and I have visited... [LB557]

KAREN RUSTERMIER: Um-hum. [LB557]

SENATOR GLOOR: Let me kind of cut to the chase as far as I'm concerned anyway. Understanding that there are language issues and concern issues, in general, are we better off with surgical technologists who are certified in the OR? [LB557]

KAREN RUSTERMIER: Yes, we are. [LB557]

SENATOR GLOOR: Okay. I mean, and I understand that their concerns about...as you and I talked about, I agree. They need to take their direction however is deemed appropriate by the surgical team and the institution as they sit down, as opposed to just the physician... [LB557]

KAREN RUSTERMIER: Um-hum. [LB557]

SENATOR GLOOR: ...because that can, in fact, be problematic. But surgical technologists, in general, you're comfortable that they have a role in the surgical suite... [LB557]

KAREN RUSTERMIER: Absolutely. They're very valuable...we need them. [LB557]

SENATOR GLOOR: Okay. Okay. [LB557]

KAREN RUSTERMIER: And...but we need to work together, and that's our main thing that we see as a very big problem here. [LB557]

SENATOR GLOOR: Okay. Any other questions? Thank you. [LB557]

KAREN RUSTERMIER: Okay. [LB557]

DON WESELY: (Exhibit 36) Senator Gloor, members of the Health and Human Services Committee, my name is Don Wesely, W-e-s-e-l-y, representing Nebraska Nurses Association. We would echo what you just heard from Karen Rustermier, and the handout from Linda Stones gives you pretty much a similar outline of concerns. We want to commend Senator Dubas. We did have the opportunity to talk to her last week. I should also mention that I am the registered lobbyist for the ambulatory surgical centers, and they were involved with the meeting last week. Back to your point, Senator Gloor. We're heading in the direction that we probably need to head, but we need a little more time and a little more work to make this bill in the shape that people feel comfortable with. And so my recommendation is, along the lines that was mentioned, we address some of the supervision issues. If we address some of the language in this, if we recognize how it would actually work and take a little more time with the legislation, I think you'll find that we can probably come together on the issue. And so that's what I'm here to say. We're opposed to the bill as drafted, and even with the amendment, we really haven't had much time to look at it. We just got it. But we need more time, but we're willing to work together to figure this out, so thank you very much. [LB557]

SENATOR GLOOR: Are there questions for Senator Wesely? Seeing none, thank you. [LB557]

DAVID BUNTAIN: Senator Gloor, members of the committee, I'm David Buntain, B-u-n-t-a-i-n, attorney and registered lobbyist for the Nebraska Medical Association, and we are here in opposition today to the bill as written. We have been aware of conversations that have been going on by various parties, but we have not been directly involved in them, but we share the concerns that have been raised, particularly with some of the wording in the bill. And I believe you have been supplied with a neutral letter from the Hospital Association, which we would essentially echo the concerns that they have and the reference to practice, for example. I think the other concern that the physicians have in some of our surgeons is that it's still not exactly clear what effect this is going to have on some of our programs, particularly in outstate Nebraska. I think everyone agrees that it's important for surgical techs to be trained and to be certified. We should certainly go in that direction. The Medical Association supports that kind of competency across the board, and our surgeons certainly value the role of their surgical techs. The question would be, are there areas where, if this bill is passed, there will be a time where it will be difficult to obtain the people that are needed to assist, because the way the bill is written currently, the day that it's enacted, you either have to hire a surgical tech who's certified or someone who is currently practicing or has done it in the past. And that, by definition, limits the pool of people you can hire from. And, unfortunately, we don't have a lot of data to indicate what the effect of that is. And it strikes me a little bit like the issue that we had years ago when there was a move to...for the state to license limited-scope radiographers, who are a subset of your licensed radiographers now. And we actually provided a transition period to the point where there was a requirement that limited scope radiographers have that credential. That may be a solution to this...to that concern. In other words, do we need to require it immediately, or can there be some kind of a phase-in period to this requirement? I think we can get there. We certainly support it. We've had good conversations with Julie Erickson, who has been working on behalf of the surgical technologists, and we offer to work with those interested parties to get this in shape, so it can be passed. [LB557]

SENATOR GLOOR: Are there any questions for Mr. Buntain? Seeing none, thank you for your testimony. [LB557]

DAVID BUNTAIN: Thank you. [LB557]

SENATOR GLOOR: And I'd remind the group that this is my friend, Senator Wallman, in case the loss of his nameplate confuses (inaudible)(laughter). Any other opponents? Anybody who would like to speak in a neutral capacity? Seeing none, Senator Dubas. [LB557]

SENATOR DUBAS: Thank you very much, Senator Gloor and members of the committee, for your kind attention and good questions. I would like to thank especially everybody who came forward to testify today. I don't think we're very far apart on what we're trying to do with this bill. Very obviously, everyone agrees that the duties of the

surgical technologists are very critical to the success of anyone's surgery. As was stated before, the surgical technologist is the only member of that surgical team who is not required to meet minimum standards. This bill does not require licensure. There is no fiscal impact associated with this bill. It's just one more way to assure our patients that they're in capable and competent hands, and I have no question that that is going on right now. If there's anything we can do to assure our patients of that, I think only serves everybody's best interest. This bill is about establishing competency. It's not about scope of practice. I think the concerns that were raised are concerns that I hope can be worked out very simply and easily through additional amendments. I'm committed to working with the groups who have concerns in trying to address those concerns. [LB557]

SENATOR GLOOR: Any questions of Senator Dubas? Thank you very much. And with that, we'll close this hearing. The committee now has to go into an Executive Session, not on this bill, but other business we have. And we need to ask people to clear from the room... (See also Exhibits 37, 38) [LB557]